Reimbursement Mechanisms in Health Care

Policy and Fiscal Tools
Expected Impacts

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Demand and Supply Side Approaches for Cost Containment and Improving Efficiency

Supply side approaches

*Indirect mechanisms*
- Changing behavior via reimbursement mechanism
- Changing market structure and behavior by changing overall ownership (e.g., privatization of hospitals and facilities)
- **Using global budgets, possibly in combination with other efficiency targets (e.g., staffing)**

*Changing care delivery*
- **Adopting treatment protocols**
- Introducing performance management (e.g., setting targets for length of stay, promoting day surgery)
- Implementing business process reengineering
- Adapting cost-reduction and efficiency targets

*Planning approaches*
- Implementing hospital closure and reconfiguration programs

Demand side approaches

*Indirect mechanisms*
- Employing payment incentives to encourage treatment of patients in primary or ambulatory care
- Introducing user charges and co-payments

*Demand management*
- Initiating an appropriateness and utilization review
- Introducing “evidence-based purchasing”, specifying explicit rationing of treatments, specifying a basic package of interventions
- Developing primary care substitutes
- Promoting social and domiciliary care
- Strengthening disease prevention activities
- Adopting managed care or disease management

Source: M. Henscher
# Health Financing Functions and Objectives

<table>
<thead>
<tr>
<th>Functions</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue Collection</strong></td>
<td>raise <em>sufficient</em> and <em>sustainable</em> revenues in an <em>efficient</em> and <em>equitable</em> manner to provide individuals with both a <em>basic package of essential services</em> and <em>financial protection against</em> unpredictable catastrophic financial losses caused by illness and injury</td>
</tr>
<tr>
<td><strong>Pooling</strong></td>
<td>manage these revenues to <em>equitably</em> and <em>efficiently</em> pool health risks</td>
</tr>
<tr>
<td><strong>Purchasing</strong></td>
<td>assure the purchase of health services in an <em>allocatively</em> and <em>technically efficient</em> manner</td>
</tr>
</tbody>
</table>
Increased Pooling: cut administrative costs

• Minimize costs of premium collection and targeting

• Increase leverage and purchasing power

• Keep administrative costs < 15% at startup on new systems, <10% of existing systems
  – Exceptions…managed care organizations
If no Pooling…
set a Single Set of Payment Rules

DELIVERY SYSTEM

PUBLIC FACILITIES AND PHYSICIANS

PRIVATE FACILITIES AND PHYSICIANS

PUBLIC

PRIVATE

UNINSURED

BUDGET

FEE SCHEDULES

CHARGES

SOURCES OF INSURANCE COVERAGE
Purchasing

The Capacity to Contain Costs (1)

• **Benefits Package**: Design of the benefits package according to the resources available
  – reimbursement/funding of the only goods and services with proved medical effectiveness
  – benefits not included in the benefits package due to insufficient resources covered by voluntary health insurance or out-of-pocket payments
  – Ongoing Process: build-in analytic capacity: CEA, technology assessment, new protocols

• **Contracts** Well-designed contractual arrangements
  – include a set of rights and obligations for health care providers

Source: Rahola, 2005
Contracting
“Easier Said than Done”

• Eastern Europe and CIS region
  – Soft relational contracts
  – Little or no “selective contracting”
  – Still most often excludes private sector
  – Issues: Lack of stable funding, Lack of good MIS Systems (non-standard, non-secure)

• Latin America
  – More aggressive with private providers (Soc Ins)
  – MOH contracting out of priority services (maternal and child health) e.g., Bolivia, Peru, Ecuador
  – Issues: Overcomplexity, MIS, Management capacity
Purchasing
The Capacity to Contain Costs (2)

• Incentives and Provider Payment Systems
  Mechanisms used to ‘pay’ medical care providers/organizations for services rendered to their clients

• In last 2 decades, new incentive-based systems emergent
  – money follows patients

• No Optimal Model…depends…”What’s the Problem?”

Source: Rahola, 2005
### Payment Mechanisms for Physicians

#### Financial Risk and Incentives

<table>
<thead>
<tr>
<th>Payment mechanism</th>
<th>Basket of services paid for</th>
<th>Risk borne by</th>
<th>Provider incentives to pay by provider</th>
<th>increase no. of patients</th>
<th>decrease activity per consultation</th>
<th>increase reported illness severity</th>
<th>select healthier patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>each item of service and consultation one week or one month work bonus based on no. of patients all covered services for one person in a given period</td>
<td>payer by provider</td>
<td>provider incentives to payer</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Salary</td>
<td>work</td>
<td>all risk borne by payer</td>
<td>no risk borne by provider</td>
<td>no</td>
<td>n/a</td>
<td>n/a</td>
<td>yes</td>
</tr>
<tr>
<td>Salary and bonus</td>
<td>all risk borne by payer all risk borne by physician bonus based on no. of patients all covered services for one person in a given period</td>
<td>salary portion</td>
<td>all risk borne by provider</td>
<td>yes</td>
<td>n/a</td>
<td>n/a</td>
<td>yes</td>
</tr>
<tr>
<td>Capitation</td>
<td>all risk above ‘stop-loss’ ceiling</td>
<td>bonus portion</td>
<td>bonus portion</td>
<td>yes</td>
<td>n/a</td>
<td>n/a</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>all risk above ‘stop-loss’ ceiling</td>
<td>all risk borne by provider up to a given ceiling (stop-loss)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Maynard and Bloor
# Hospital Payment Mechanisms: Financial Risk and Incentives

<table>
<thead>
<tr>
<th>Payment mechanism</th>
<th>Basket of services paid for</th>
<th>Risk borne by</th>
<th>Provider incentives to</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>each agreed item of service and consultation</td>
<td>payer by provider</td>
<td>increase no. of patients</td>
</tr>
<tr>
<td>Case payment (e.g. DRG)</td>
<td>payment rates vary by case each admission</td>
<td>all risk borne by payer risk of no. of cases and severity classification risk of number of admissions</td>
<td>yes no yes no</td>
</tr>
<tr>
<td>Admission</td>
<td>each patient day all covered services for one person in a given period</td>
<td>all risk borne by payer amount above ‘stop-loss’ ceiling</td>
<td>yes yes no yes</td>
</tr>
<tr>
<td>Per diem</td>
<td>all services provided by an institution in a given period</td>
<td>no risk borne by the payer</td>
<td>yes n/a no yes</td>
</tr>
<tr>
<td>Capitation</td>
<td>all services provided by an institution in a given period</td>
<td>no risk borne by the payer</td>
<td>no n/a n/a yes</td>
</tr>
<tr>
<td>Global budget</td>
<td>all services provided by an institution in a given period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Maynard and Bloor
FEE-FOR-SERVICE

ACCESS

QUALITY

COST-CONTAINMENT
EPISODE-BASED e.g., DRGs

ACCESS

QUALITY

COST-CONTAINMENT
CAPITATION

ACCESS

QUALITY

COST-CONTAINMENT
Containing Costs (3)
Pharmaceutical Sector

- Often largest part of health care spending – 25-40 percent of health spending in ECA and MENA countries
  - generally largest item of household medical expenditures

- Cost control requires control of price and volume of prescribing

- Efficiency requires demand and supply side regulation

- Equity may be reduced by user charges

Source: Maynard
The rising costs of pharmaceuticals is not a problem in MICs and LICs only.....
Implementation Issues

- Payment Design
- Quality Assurance
- Information Systems
- Provider Autonomy
The Relationship between Payment mechanisms and provider organization

Figure 5.6  Provider Payment Mechanisms and Health System Organization

Source: Guterman et al. 2009.
Note: DRG = Diagnosis-related group; FFS = fee for service.
Supply Side Regulation: Licensing and Reimbursement

• **Registration** procedures broadly similar: evidence of safety and efficacy

• Many countries restrict **reimbursement** by positive lists or negative lists
  – Increasingly, governments are encouraging provision of economic data and evidence of **cost-effectiveness** (RCTs and actual practice)

Source: Maynard
Supply Side Payment and Regulation: Price Controls

- **Reference price systems**: patients pay any difference between the brand price and a reference price (for generics or same therapeutic group)

- **Direct cost-plus pricing**

- **External comparison pricing**, e.g., across markets and countries

- **To achieve cost containment, essential to control not just price but also volume**

Source: Maynard
Supply Side Regulation: Retailers and Wholesalers

• **Fixed profit margins** to facilitate cost control

• **Require generic substitution**

Source: Maynard
Demand Side Regulation and Payment: Influencing Patients

- Cost sharing – deductibles, copayments, coinsurance
- Reference prices
- Caps on volume
- Consumer education

Source: Maynard