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Final Report – Regional Forum on Provider Payment Mechanisms

(Lima, Peru, 16-17 November, 1998)

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1. INTRODUCTION

The Regional Forum on Provider Payment Mechanisms was held in Lima, Peru, on 16 and 17 November 1998. The forum was convened by the Division of Health Systems and Services Development of the Pan American Health Organization. Professionals from Latin America and the Caribbean participated. The purpose was to provide an opportunity to reflect on the subject, in which representatives of various institutions involved in the relationship between payers (insurers and/or purchasers) and providers of health services would take part.

This forum was held as a part of the activities planned in the framework of the Health Sector Reform Initiative being carried out by PAHO, USAID, and the USAID projects Family Planning Management Development (FPMD), Partnerships for Health Reform (PHR), and Data for Decision Making (DDM).

One of the principal components of the reform processes taking place in the health sector in the Americas is the identification and implementation of new forms of provider payment. Implicit in every payment mechanism are a set of incentives and a level of financial risk that influence in the provider's behavior and therefore the final outcomes. Providers' decisions on the quantity and quality of health services are shaped by the way in which they are paid. Thus, these mechanisms have a direct impact on the performance of health systems and services, as well as on the achievement of some of the stated objectives of health sector reform, namely, efficiency, quality, and cost containment.

The meeting was organized in a workshop format in order to facilitate sharing and analysis of the participants' experiences in their countries and identification of both positive developments and negative aspects that need to be reviewed and modified. During the two-day meeting, the participants devoted themselves to examining the current situation of payment mechanisms, identifying lessons to be learned, and establishing future areas of work.

This document contains the rapporteur's report on the Regional Forum on Provider Payment Mechanisms. It is not a transcription or compilation of the various presentations, but rather seeks to organize and summarize the most important points that emerged from the discussions.

The report includes the following chapters:

- Frame of reference: background on the health sector reform processes under way in Latin America and the Caribbean and on the Health Sector Reform Initiative.
- Characterization and criteria for evaluating payment mechanisms: examines different payment mechanisms and the difference with sectoral financing, describes the various mechanisms and their use as an instrument for achieving sectoral objectives.

- Conclusions and a proposal for technical cooperation: summarizes the problems examined and the recommendations made by the working groups and suggests possible areas for technical cooperation.
- Annexes: the agenda of the meeting and a list of the participants, with their respective positions and addresses.

2. FRAMEWORK¹

In its dual role as a specialized health agency within the inter-American system and the Regional Office for the Americas of WHO, the basic mandate of PAHO is to serve as the directing and coordinating authority on international health efforts in the Region. Its functions are to provide technical cooperation, seek consensus on the priority problems identified by the countries, mobilize international resources and action to support efforts aimed at resolving those problems, and support and cooperate with the countries in the areas of health in human development, health systems and services development, health promotion and protection, environmental protection and development, and disease prevention and control.

The first Summit of the Americas, held in Miami in 1994, included a discussion of national health reform processes. Among other things, the Summit convened a special meeting of governments, interested donors, and international technical cooperation agencies, which was co-organized by PAHO, the IDB, and the World Bank, to establish the conceptual framework for these processes and define the role of PAHO/WHO in monitoring and evaluating the plans and programs for health sector reform in the countries of the Region.

The Special Meeting on Health Sector Reform was held at the headquarters of PAHO/WHO in September 1995. It confirmed the growing interest of the countries, the agencies, and other cooperation organizations in the Region in reform strategies, policies, instruments, and outcomes. Since then, national authorities, international organizations, and other interested parties have frequently requested information on the objectives, plans, programs, dynamics, contents, instruments, and institutional and individual experiences in the different areas encompassed by health sector reform. Until recently, most of this information was unpublished or its dissemination was quite limited.

At the conclusion of the Special Meeting, the Directing Council of PAHO adopted a resolution in which, among other things, the Director was requested, in accordance with the recommendations of the Summit of the Americas, taking into account the discussions at the Special Meeting on Health Sector Reform, to continue to work with the Member States and agencies in the design and development of a process for monitoring health sector reform in the Americas.

In response to the mandate for interagency collaboration, and in support of health sector reform initiatives in the countries, the United States Agency for International Development (USAID) and PAHO initiated discussions aimed at identifying priority areas for regional cooperation on health reform. To this end, an effort was made to involve other actors who might contribute to the achievement of the common objectives in this area.

¹ The sources for this chapter are:

- *La cooperación de la Organización Panamericana de la Salud ante los procesos de reforma del sector salud.* Publication of the Pan American Health Organization. June 1998.
- Presentation made by Karen Cavanaugh, Health System Advisor, LAC/RSD – PHN USAID, at the Regional Forum on Provider Payment Mechanisms.
- *Metodología para el seguimiento y la evaluación de las reformas del sector salud en América Latina y el Caribe.* Document of the Health Sector Reform Initiative.

In 1997, the Initiative for Health Sector Reform in the Countries of Latin America and the Caribbean was launched. This is a five-year project (1997-2002) involving PAHO/WHO, USAID, Partnership for Health Sector Reform (PHR), Data for Decision-Making (DDM), and Family Planning Management Development (FPMD), whose central objective is to provide regional support to foster equitable access to basic services of good quality in the Region of the Americas. The initiative is being financed by USAID and PAHO, which have provided US\$7.4 million and US\$2.8 million, respectively, in non-reimbursable funds. The Regional Forum on Provider Payment Mechanisms is one result of this initiative.

In the Region of the Americas, health sector reform is seen as a process aimed at introducing substantive changes in the various entities and functions of the sector with a view to increasing the equity of its services, the efficiency of its management, and the effectiveness of its actions and thus meeting the health needs of the population. It is an intensive process of transformation of health systems being carried out over a specific period of time in response to situations that justify it and make it viable.

The conceptual framework and criteria for action in reform processes have been developed during the past several years, building on the contributions of the following events and documents, among others:

- the Plan of Action of the Miami summit
- the country contributions to the Special Meeting on Health Sector Reform and the subsequent Resolution of the Directing Council (Washington DC, September 1995)
- the report on monitoring of health sector reform activities presented to the Directing Council of the Organization (September 1996)
- the document entitled PAHO Cooperation in the Health Sector Reform Processes
- the report on the steering role of the ministries of health in health sector reform processes presented to the Directing Council of the Organization (September 1997)
- discussions on health reform at the meetings of ministers of health of Central America, the Andean Area, MERCOSUR, and the countries of the English-speaking Caribbean
- ongoing activities and support from the national commissions and groups formed to promote health reform in the various countries of the Region.

The criteria that guide PAHO cooperation in the area of health reform—derived from the aforementioned activities and supported by the experience of the majority of health reform initiatives underway—are the following: equity, quality, efficiency, sustainability, and social participation.

All of these are concepts that make it possible to judge whether reforms that are planned or in progress are on target from the standpoint of achieving the stated ultimate objective. Certainly, no reform should run counter to these criteria, and the "ideal reform" would be one in which all five qualities had been improved by the end of the process.

Equity in health conditions implies reducing avoidable and unfair differences to a minimum. Equity in health services means receiving care in proportion to need (equity of coverage, access, and use) and ability to pay (financial equity).

Effectiveness and technical quality imply that users of health services receive effective, safe, and timely care; quality implies that they receive it under appropriate physical and ethical conditions (perceived quality).

Efficiency implies a favorable ratio between the outcomes obtained and the costs of the resources utilized. It has two dimensions: one is related to the allocation of resources and one to the productivity of the health services. Resources are allocated efficiently if they generate the maximum possible health gain per unit of cost, and they are used efficiently when a unit or product is obtained at the lowest possible cost or when more product units are obtained for a given cost, maintaining the level of quality.

Sustainability has both a social and a financial dimension and is defined as the capacity of the system to solve its current problems of legitimacy and financing, as well as the challenges of maintenance and future development. Consequently, sustainability implies social acceptance and support and the availability of the necessary resources.

Social participation has to do with the procedures for ensuring that the general population and the various agents take part in the planning, management, provision, and evaluation of health systems and services and that they benefit from the results this participation.

Finally, as affirmed by the Regional Forum on Provider Payment Mechanisms, some of the main trends and characteristics of health reform processes in the Region are:

- separation of the functions of financing and health service delivery;
- modification of the public-private mix;
- new modalities for financing health services;
- new forms of provider payment.

3. CHARACTERIZATION AND CRITERIA FOR EVALUATION

3.1 WHAT ARE PAYMENT MECHANISMS?²

The financial flow in a health system can initially be addressed at three levels:

- Financing - which refers to the form in which the Health System is financed as a whole.
- Funding - which refers to the allocation of resources within the Health System. It is usually carried out through payments to public or private institutions.
- Remuneration - which refers to the compensation of individuals that are employed in the Health System.

The distinction between financing, funding and remuneration can in some cases not be evident. For example, when an individual pays the full cost of a service to a health provider, the act of paying simultaneously finances and funds the service and remunerates the supplier. It should be pointed out that this is the simplest of the systems; all the others introduce separations between two or more of the three components.

The money for financing the Health System can come from different sources:

- direct payment,
- insurance premiums,
- contributions to social security,
- taxes,
- loans,
- national or international donations.

Direct payment includes what the consumer pays for health care in the absence of insurance, and the co-payment that he has to make in the presence of insurance.

The private insurance premiums represent the payments to an insurer for health service expenditures that are anticipated for a defined period in the future. The individual pays the premium regardless of whether he utilizes or receives services.

² The source for this section is:

Presentation made at the Regional Forum on Provider Payment Mechanisms by Pedro Crocco, Advisor on Health Sector Reform, Pan American Health Organization.

The contributions to social security embody compulsory payments given to entities of health insurance, usually public, which may or may not be integrated into more comprehensive social security institutions.

Resources from taxes are usually important as a percentage of total financing.

Another source of financing, although potentially less sustainable, is debt. The government obtains credit from internal or external agencies in order to supplement its earnings.

Donations, usually obtained by way of bilateral and/or multilateral assistance, also constitute a source of financing.

Once the money has been obtained by way of some form of financing mechanism, we face the problem of allocating the resources to health care organizations and individual providers.

Both funding and remuneration imply reimbursing an activity and are subject to many of the same principles. When matters that pertain to funding and remuneration are being discussed, the term “payment” or “payment scheme” is used to refer to the delivery of financial resources in compensation for health care delivery.

The payment schemes are made up of two basic elements:

- The entities that participate in the exchange (government, insurers, providers and beneficiaries).
- The payment mechanism, which refers to the basis on which money is exchanged among the different entities (fee for service and capitation are some of the examples).

Although many entities can participate in payment schemes, the majority falls into one or more of the following categories:

- beneficiary (as payer),
- financial intermediary,
- Individual provider / organization of providers.

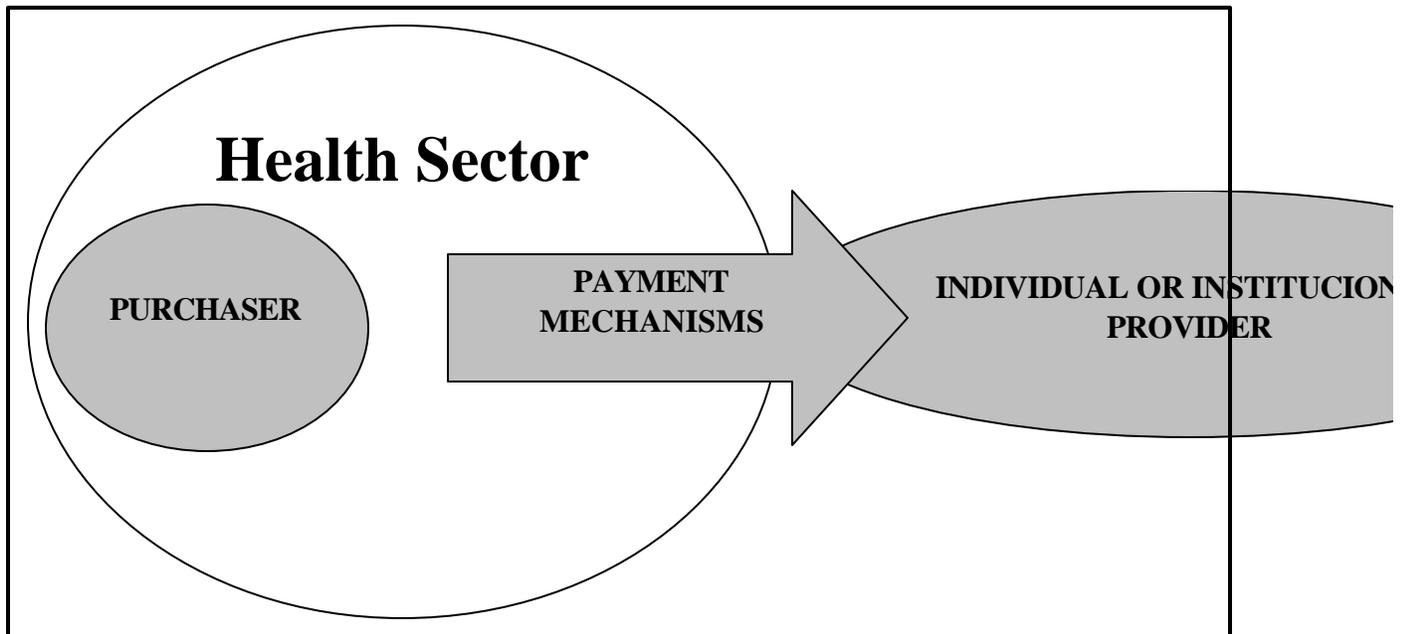
Beneficiaries, acting as payers, are the individuals covered by a health plan. In a public system these are the residents of a jurisdiction or the members of the social security system. In a private plan these are the members of the insurance plan.

Financial intermediaries are the organizations that collect or receive money that is used to fund health care insurance and health care services and to remunerate providers. In a public financing system, a financial intermediary would normally be a governmental agency at the central or local level. In a private system it can be the employer who collects and pays premiums on behalf of its employees, or a private insurance organization. There can be multiple layers of financial intermediaries within a funding and payment scheme.

The providers are the individuals or institutions that deliver health care. The individuals are the physicians, dentists, and other professionals in private practice. The institutions are the hospitals, clinics and health centers.

The term “payment mechanisms” refers to the manner in which financial resources are allotted from an entity (or financier), such as a government or insurance company or the beneficiary of a service, to a health institution or an individual provider, such as a physician or a nurse.

PAYMENT MECHANISMS



3.2 DESCRIPTION OF THE PAYMENT MECHANISMS³

3.2.1 Physician Payment Mechanisms

Presented below is a brief description of various mechanisms used to pay physicians or other individual providers.

- **Fixed Salary:** Physicians are paid a salary that is not dependent on the number of patients seen or the volume of services provided.

³ The source for this section is:

Presentation made at the Regional Forum on Provider Payment Mechanisms by Rena Eichler, Health Economist/Senior Associate Health Financing Program Management Sciences for Health

- Fee-for-service: Physicians are paid a fee for each service provided.
- Capitation: Physicians receive a fixed payment per person regardless of the amount of services rendered.
- Bonuses: Physicians receive a bonus for controlling the number of referrals or diagnostic tests.
- Withholds: A portion of a physician capitation payment or salary is withheld until the end of a period. At the end of the period, if the physician manages costs within the agreed guidelines, the funds are released.
- Hybrid: Any combination of the above payment mechanisms.

3.2.2 Hospital Payment Mechanisms

Presented below are various methods of hospital payment used both within the Region and elsewhere in the world.

- Historical budget: Hospitals are allocated a fixed budget, that is usually based on history, not on actual services provided or actual costs incurred.
- Fee-for-service: Hospitals are paid a fee for each service provided.
- Per-hospital-day payment: Hospitals are paid a fixed amount per day in the hospital that includes all clinical and hotel services.
- Procedure-based payment: Hospitals are paid a lump sum payment to treat a patient for a specified procedure (for example: appendectomy, normal delivery). Payment includes all services required to treat the patient.
- Diagnosis-related payment: Hospitals are paid a lump sum to treat a patient for a specified diagnosis (for example: diagnosis-related groups (DRGs) in the United States).
- Payment per enrolled beneficiary: The hospital receives a fixed payment per enrolled beneficiary, independent of the number of services provided.

3.3 A SIMPLE ANALYTICAL MODEL ⁴

The specialized literature identifies a common characteristic of all payment mechanisms: all of them can be described in terms of two dimensions:

⁴ The source for this section is:

- Systems for Payment to Health Care Providers in Latin American and OECD Countries. Study for the Pan American Sanitary Bureau. Begoña Álvarez, Félix Lobo, and Laura Pellisé. October 1998
- Presentation made at the Regional Forum on Provider Payment Mechanisms by Félix Lobo and Laura Pellisé.

- the “unit of payment,” which describes what health services are included in the compensation that is being paid,
- the sharing of financial risk between the buyer and seller of services.

The two dimensions will be examined separately and then in combination in an attempt to link together the principal payment mechanisms within this conceptual framework.

3.3.1 The First Dimension: The Unit of Payment

Unit of payments are distinguished by the degree to which the services purchased are aggregated. For example, the difference between payment by capitation and by hospital stay is that the latter includes expenditures per day of inpatient care, while the former, in addition to these expenditures, includes any other expenditure that might be associated with the individual involved. Similarly, payment for a hospital stay of eight days is a form of aggregating eight payments for a single stay.

Thus, we have a criterion for ranking unit of payments according to their degree of aggregation, ranging from the least inclusive or aggregated unit, which is fee-for-service, to the most aggregated, which would be payment for an entire care process, hospital stay, hospital admission, or all care provided to a patient over a given period of time (capitation or any form of comprehensive health insurance), etc.

This ranking criterion is extremely important because it determines the type of incentive that the payer offers the provider by determining what products and what inputs play a part in the concept of efficiency that is being encouraged. For example, in a capitation system, incentive is that providers will earn additional income if they increase the number of enrolled individuals they serve, while their income will not change regardless of how much the intensity of care increases per enrolled individual. In other words, the provider’s income will increase in direct relation to the increase in individuals in his/her care, but it will not increase because he/she offers each of them more care. If this capitation payment occurs in the framework of an integrated health care system (as with HMOs in the United States, or the family doctors under the reformed British system “GP fundholders,” or the mutual insurance companies in Spain), then the pro-efficiency incentives will have an impact on all the care provided. It will be possible to satisfy the enrolled members (assuming the possibility of choice and economies of scale) and incur minimum costs thanks to rational use of health services.

If, on the other hand, payment is made per hospital admission (as in case of DRGs), the provider will understand that his/her marginal income is directly related to the number of patients admitted, not to the number of services or days of hospital per patient admitted. In this case, pro-efficiency incentives are related to a concept of “product” meaning hospital admissions and a concept of “input” meaning the cost per admission (the intensity of use of hospital resources). As a result, the product that defines the concept of efficiency under a DRG payment system is the number of hospital admissions, not the restoration, maintenance, or improvement of health.

3.3.2 The Second Dimension: Financial Risk

Once the unit of payment has been established, there is a broad range of possibilities for defining the payment formula. For example, if hospital admission is to be the unit of payment, one of a multiplicity of

possible payment formulas must be selected: flat fee, regardless of the origin and reason for the admission; a DRG-based rate; or a rate determined on the basis of the number of differentiated “hospital products” (types of stay) recognized by the payer.

In order to understand this second dimension of provider payment mechanisms, it is necessary to consider the unequal distribution of health costs and the distribution of the payment on a scale with various graduations or intervals.

3.3.2.1 Inequality of health costs

Let us take hospital admissions as the unit of payment. One might ask if all admissions cost more or less the same. If this were the case, 50% of the least expensive hospital admissions would be associated with 50% of the hospital’s costs. However, the majority of hospitals do not have uniform costs for every admission. In general the costs are unequal. There are a high percentage of relatively inexpensive admissions and a smaller percentage of admissions that generate very high costs. An unequal distribution may therefore occur in which the relatively small percentage of admissions that generate high costs account for a high percentage of total costs. For example, it may be that the least expensive admissions make up 80% of all admissions, but they account for scarcely 20% of the hospital’s total costs, which means that the most expensive admissions only make up 20% of total admissions but account for 80% of total costs.

The same can be said of other unit of payments, such as capitation payments. Some patients generate very high costs, and even though they represent only a small percentage of the total number of patients served, they account for a high percentage of the total costs.

3.3.2.2 Differentiation of products, costs, and prices

With regard to the distribution of payments on a scale, if, for example, a single (public) insurer chooses hospital admissions as a unit of payment, once this decision is made, the insurer must still decide how it will pay hospitals for each admission. At one extreme, it might pay a single fixed amount, which would imply that all admissions are same. This is the case with the payments that MUFACE transfers to private insurers in Spain and of the “GP fundholders” in the United Kingdom. Basically, these are capitation payments, with a single rate equivalent to the mean cost.

Alternatively, the payer might establish a flat fee and distinguish three different types of admissions, each to be paid at a different rate. Or the payer might establish a complex rate scale with some 500 different rates corresponding to 500 different products, as occurs in the DRG-based hospital payment system in the United States.

Finally, at the other extreme, the insurer might pay a different amount for each admission, which presupposes that each stay in each hospital is a different product in the sense that it generates a singular cost. Thus, there could be as many different rates as admissions.

United States insurance companies provide another example. They may establish as many different premium rates (comparable to capitation payments) as they deem necessary for a given unit of payment, taking into account the annual costs incurred by individuals, families, or others. In other words, they can

adjust their premiums to the characteristics of their beneficiaries. The opposite is true in Spain. Up to a few years ago, health insurance companies could not discriminate and were required to charge a single rate.

3.3.2.3 Distribution of financial risks

Bearing in mind the foregoing considerations, it can be deduced that for a given unit of payment, the closer we get to a flat fee—that is, the fewer different rates and, therefore, the broader the range of services provided for the same rate—the greater the risk to the provider if costs vary. In other words, the greater the cost variability for a given rate, the more financial risk is transferred from the payer to the provider.

Taking as an example the extreme case of a flat fee for all hospital admissions (what implies a single “product” and a single rate), which might be set on the basis of the mean national cost of hospital admissions over the last five years, providers reimbursed under this method run a relatively high risk of serving comparatively expensive patients in the course of a year. Regardless of how efficient the provider is, when he/she receives a flat fee, he runs a high risk of not being able covering his/her costs, which are likely to vary substantially from patient to patient.

At the opposite extreme, if a rate scale is established with a large number of different rates (a thousand, for example) for the same unit of payment (i.e., the hospital admission), the hospital will incur losses unrelated to its efficiency in the utilization of resources only if the cases it treats for each rate (of the thousand) generate costs above the established level of payment. The rules of probability would indicate that the likelihood of this happening is much smaller when there are many different rates than when there is a single flat fee for the same variability of costs.

Finally, if there are as many different rates as there are potential cases in the population, the costs will not vary for every rate established, and therefore the financial risk to the provider will be nil. This is precisely what occurs with so-called retrospective payment methods. Implicit in the establishment of an infinite range of possible rates is the recognition that each service rendered is different in the sense that it entails different costs. Hence, only the fee-for-service system implies no financial risk for the provider.

In summary, at one extreme is the flat fee method of payment, which is a single rate. This is the “purest” of the prospective payment methods, in that it allows for no adjustments. Examples include the capitation payment made by MUFACE in Spain to independent insurance companies or the “GP fundholders” in England. With a preset rate and a given unit of payment, providers bear all the financial risk deriving from cost variability. At the other extreme is the retrospective fee-for-service method of payment, which an infinite range of possible rates. The risk incurred by the provider is nil: whatever the cost of the unit produced, the payment will cover it, and it will be the payer who bears all the financial risk associated with cost variability.

Neither extreme seems optimal. The distribution of risks between providers and payers is very important, as is the choice of the unit of payment to be used. The issue, then, is to how to choose a payment system from the array of possible systems.

3.4 PAYMENT MECHANISMS AND INCENTIVES

This chapter will describe the basic types of payment mechanisms, including in each case the unit of payment and the distribution of risk between the payer and provider/supplier of health services.

It will also examine the following aspects of each system:

- Basic economic incentives
- Characteristics and foreseeable effects
- Relation to efficiency
- Relation to quality
- Possibilities for public action

It should be emphasized that this section refers only to economic incentives and the ways in which they might influence human behavior (that of health professionals, in this case) in the absence of any other motivation. Naturally, this implies a simplification, since it does not take into account other, noneconomic motivations that might be as important or more important than these, such as altruism and reputation.

3.4.1 Payments to Physicians

3.4.1.1 Fee-for-service

Unit of payment

Paying the physician for each service rendered is a long-standing tradition and occurs in all countries. It is mainly private physicians who are paid by this method, although fee-for-service payment is not totally unknown in publicly financed medical care. Under this payment formula, the unit of payment or account is the individual or isolated service, or—to use another term—the "medical act" performed. It may be a visit or consultation, a diagnostic test, a surgical operation, an emergency procedure, etc.

Basic economic incentive

The basic incentive in this case is to maximize income by maximizing the number of medical acts performed.

Distribution of risks

The fee-for-service system tends to be an extreme case that shifts all the financial risk to the payer. Under this formula, providers will tend to cover all costs retrospectively, since they bill after the fact. Thus, they are not affected by variability in health care costs because they can adjust their rates to each case.

Characteristics and foreseeable effects

- This formula does not especially favor disease prevention activities, since they often generate no earnings for the physician. For example, if patients do physical exercise following the recommendations made by the physician during a visit, he/she can charge for the visit, but will not be able to charge for each time the patients do their exercises.
- It may encourage the use of complex technology and the provision of secondary and tertiary care.
- It may generate increased demand.
- It may foster corruption, for example collusion between a physician and diagnostic testing facility.
- By its very nature, fee-for-service encourages price discrimination between different patients, depending on their level of income, which in non-competitive conditions may be what is most efficient.
- It may lead to geographic and social inequalities, since it encourages geographic concentration of services in higher-income areas.

Fee-for-service and efficiency

There is widespread consensus concerning the serious efficiency problems that this system tends to create. It encourages the performance of more medical acts, sometimes without regard to the costs they will entail, which means that it tends to promote overuse and squandering of resources. This occurs in a context of health care markets that largely exclude competition, as a result of which there are no sanctions for inefficiency among providers. Empirical evidence has shown an association between fee-for-service and higher surgery rates.

Fee-for-service and quality

The quality of care is not compromised under this system; on the contrary, it may be enhanced because the physician has an incentive to provide more care to the patient.

Possibilities for public action

Public authorities have intervened in different countries at different times to correct the negative effects of this system. A common course of action has been price-fixing and the establishment of maximum rates for each service. This does not solve all the problems, however. It can be quite difficult to define an "act" or "service." But the fundamental problem with price controls is that they do nothing to control the quantity of services provided. As a result, they may not have the desired effect because physicians may provide a larger number of medical services.

3.4.1.2 Salary

Unit of payment

As is well known, the unit of payment here is the health professional's time. In a "pure" salary system, neither the number of patients treated nor the excellence of the work is related to the salary. There is therefore a tendency to establish more complex, differentiated salary structures in order to encourage dedication and effort. But it is not easy to adjust salaries to reflect performance and quality, partly because it is difficult to find a reliable method of performance monitoring for professionals and then implement such monitoring. There are also often difficulties stemming from medical corporatism, in which equal salaries for all are preferred because salary incentives tend to create rivalry and ill will.

Payment based on time worked is very common in cases in which both the funding and the production of health services is under the aegis of the public sector, especially payment of hospital physicians. However, this method of payment is also used in private-sector health services.

Basic incentive

Here the basic incentive is to minimize costs (especially in terms of personal effort), based on a known and fixed level of earnings. This economic incentive tends to reduce the number of patients served and the number of treatments considered, administered, and supervised, as well as the number hours worked.

Distribution of risks

In a pure salary system, once the salary has been established, there is no risk for the payer. Regardless of the fact that the provider sees many patients in a single hour, the payment will not vary and the medical cost will not increase for the payer. However, if productivity-based adjustments are introduced, the payer will incur the risk of having to make unanticipated payments should performance exceed expectations.

Characteristics and foreseeable effects

- When payment is by salary and the salary structure is relatively rigid, issues relating to career advancement and promotion within the hierarchy of the health organization in question become very important. Professional advancement may be the only way toward higher income levels; however, at the same time, professional satisfaction may become a substitute for higher salary. The economic incentive is thus complemented or replaced by the incentive of professional reputation.
- The salary formula promotes growth in the number of staff professionals employed, as this reduces the workload of each professional.

- This formula does not discourage cooperation among physicians, as can occur with other systems, because they have no reason to compete excessively for patients.
- In contrast to the fee-for-service system, the salary system may increase behaviors that imply abuse of confidence or moral risks for patients (for example, abuse of prescription drugs), since excessive visits to obtain the necessary prescriptions will not result in extra payments to the physician. Under a non-salary system, such abuses would be contested and curtailed by an insurance plan (public or private).

Salary and efficiency

A salary system of payment for physicians can have various consequences for efficiency. While it does not implicitly encourage spending and waste like a fee-for-service system, a salary structure, especially if it is very rigid, favors corporatist unionization, which may drive salaries up, given the strong bargaining power of physicians. In addition, it may promote the maintenance of rigid and overstaffed personnel structures, which may be a formidable obstacle to efficiency.

Salary and quality

The principal problem with a rigid salary system may be that it does not encourage quality of care. It has been suggested that such systems breed insensitivity toward the patient (Ortun Rubio, 1990), since lazy and irresponsible providers can earn the same as conscientious professionals who are devoted to their patients. This is highly discouraging for professionals.

Possibilities for public action

The public sector will always have to negotiate the salary structures and levels with its own medical professionals and other health workers. But, as was noted above, these professionals have considerable bargaining power, which tends to be reinforced by public opinion and the media.

In order to ensure quality of care under this payment system, public authorities have the option of establishing regulations, both in the private and public sectors—for example, by establishing and supporting general hospital commissions on quality control, infection control, rational use of drugs, etc. Another option is to establish a system of treatment protocols and an accreditation system.

A third option is to design a differential system of compensation that includes incentives for quality, which is far from being a simple task.

3.4.1.3 Capitation

Unit of payment

In a system of payment by capitation, or payment per person or "per capita," the unit of payment is the subscriber, who receives comprehensive health care, or at least a broad range of health services, from

a single provider. It has been said that this system follows the maxim of Confucius: "Pay the physician as long as you are well."

This formula has a long tradition, especially in rural areas (where historically people have earned lower incomes than city-dwellers, who could afford fee-for-service). Capitation is becoming increasingly common, not just as a payment method for physicians, but also for health organizations that assume responsibility for comprehensive care of their members.

Basic incentive

The basic incentive in this case is to reduce the costs and the services provided to each of the subscribers served by the provider and to increase the number of subscribers.

Distribution of risks

If the capitation payment is not linked to the characteristics of the members (age, sex, health problems, etc.), then the risk is borne by the service provider. A system of this type is called pure or unadjusted capitation. However, if the capitation payment varies in relation to the characteristics of the subscribers and/or the expected costs of care, then the risk is shifted to the payer.

Characteristics and foreseeable effects

- Facilitates prevention activities since reducing morbidity reduces costs
- In a non-integrated system, when the contract is only with the family doctor or primary care physician, capitation encourages referrals to specialists and use of drugs (paid for by the patient).
- In a system that provides comprehensive care for a single rate (without adjustments), specific problems such as risk selection arise.

Capitation and efficiency

Despite the problems mentioned above, there is broad consensus concerning the relative merits of this formula in terms of efficiency, especially because it promotes integration of the "chain of health services," eliminating those that are least efficient (in terms of costs, etc.).

Capitation and quality

Clearly, this system may cause difficulties in terms of the quality (and also quantity) of the services provided.

Possibilities for public action

For the reasons cited above, it is essential for public authorities to establish some kind of control over outcomes and quality.

This includes providing information to consumers on the performance of the health care facilities funded by means of this payment formula.

Another way of reducing quality-related problems is to allow subscribers to select their providers in a competitive context. Thus, when the quality or quantity of a provider's services falls below that of other providers with whom he/she is competing, the subscriber can change providers, which will penalize the provider economically.

3.4.2 Payment to Hospitals

Fee-for-service or payment by "hospital act" has the same unit of payment, produces the same incentives and distribution of risks and has the same characteristics as fee-for-service payment of physicians. The only difference is in the recipient of the payment and the party responsible for providing the service. The frequency with which this payment formula is used makes it essential to mention it here. However, in order to avoid redundancy, the characteristics of this formula will not be explored in depth here, since they are virtually the same as those described under "Payment to physicians."

3.4.2.1 Per diem

Unit of payment

Per diem is a payment formula in which the unit of payment is the stay at a hospital center. In general, a stay is considered to occur anytime an individual spends the night as an inpatient in a hospital center.

The per diem payment covers all the hospital services provided to the patient in the course of a day (room and board, physician and nursing services, diagnostic tests, medication, etc.).

Basic economic incentive

The basic incentive is to maximize occupancy of hospital beds by increasing the number of stays and, especially, by maximizing the length of the average stay. Since hospital care costs are highest during the first days of a patient's stay, lengthening the stay is particularly profitable for a hospital. As the patient recovers, the cost of care is reduced to the cost of room and board.

Distribution of risks

If all stays are paid at the same rate, the hospital assumes the risk for variability of the costs included in one day of hospital stay. The payer assumes the risk that many hospital stays may occur (depending on the complexity of the pathologies treated).

Characteristics and foreseeable effects

- Encourages longer hospital stays.
- Encourages cost containment behaviors for every day of hospital stay.
- May encourage unnecessary admissions (especially for non-surgical care).
- May discourage outpatient surgery.

Per diem and efficiency

Per diem payment may cause efficiency problems since it encourages inexpensive and lengthy hospital stays, which may not be really necessary.

Per diem and quality

Quality of care may be compromised if the hospital attempts to cut costs too much. However, this payment method ensures that the patient will not be discharged prematurely, which may lead to better outcomes and fewer readmissions.

Possibilities for public action

Public authorities have intervened on numerous occasions to limit the negative effects of per diem payment, setting limits on the average stay based on the pathologies for which patients are admitted and establishing economic sanctions for hospitals that exceed those limits.

3.4.2.2 Per admission

Unit of payment

The practice of paying hospitals per admission is growing in all countries. It was first tried in the early 1980s under the Medicare program in the United States. With this payment formula, the unit of payment is the hospital admission. The payment may include any and all desired components of care, although it does not generally include payment to hospital physicians.

Basic economic incentive

The basic incentive is to maximize the number of admissions and minimize the cost of care associated with each hospital admission.

Distribution of risks

Under the per-admission payment system, the payer assumes the risks associated with variations in the number of admissions. The provider assumes the risk that the number of admissions might exceed the preestablished per-admission rate.

Characteristics and foreseeable effects

- Encourages hospitalization.
- Encourages reduction of the average length of stay.
- May lead to an increase in hospital readmissions if patients are discharged prematurely.
- May be at odds with efforts to improve health without resorting to hospital care.
- May promote discrimination against patients based on their pathologies and the severity thereof, if the rates have not been adequately adjusted to reflect the different types of foreseeable hospital admissions.

Per-admission payment and efficiency

Per-admission payment encourages minimization of the hospital care costs associated with each admission and thus promotes efficient care of each admitted patient. However, from a macroeconomic standpoint, this payment system implies serious problems of efficiency in health spending, since it rewards hospital activity regardless of need.

Per-admission payment and quality

Quality of care may be compromised by efforts to reduce the care costs associated with each admission.

Possibilities for public action

Public authorities have intervened in various ways to attempt to mitigate some of the negative effects of per-admission payment mechanisms. In some cases, economic penalties have been established for readmissions within a short period of time. In other cases, admissions for conditions requiring exceptionally

expensive care have been excluded from this payment system, in order to avoid discrimination against patients.

One of the challenges associated with the design of per-admission payment systems is refining the formula, establishing various rates, depending on the intensity of the care required. This is intended to protect hospitals from excessive financial risk arising from variations in cost per hospital admission. diagnosis-related groups (DRGs) and Patient Management Categories (PMCs) are two mechanisms that have been developed for that purpose.

3.4.2.3 Budget

Unit of payment

Traditionally, especially in public health care systems, hospitals have been financed through a budget. In theory, this would mean that each hospital is allocated a predetermined fixed amount to cover a certain period of time (generally one year) in exchange for providing the hospital care demanded of it.

In practice, in many countries with publicly funded hospitals, the budget has restricted expenditures to a preset level. On the contrary, the budget has done little more than serve as a guide for planning expected hospital spending, based on actual spending in previous financial periods. In addition, it has been relatively easy for hospitals to obtain extrabudgetary funding. Practice has shown that, as a result, hospital budgets have often been more of a retrospective (or inflationist) method than a prospective payment formula. In such cases, all the characteristics of fee-for-service payments described above are applicable to budget payment mechanisms.

Basic incentive

If the budget is rigorously adhered to, it can encourage minimization of hospital costs by reducing the number of admissions, the length of hospital stays, and the intensity of the services provided in the course of a stay.

Distribution of risks

If the budget is used correctly, then the provider assumes all financial risks associated with variability in the quantity of care and the cost thereof. In some cases, budgets are adjusted for the characteristics of the care provided, the specific needs of the population residing in the area of influence, the social and health objectives that planners set for each center, or any other criteria considered desirable. In these cases, part of the financial risks are shifted to the payer.

Characteristics and foreseeable effects

- In its purest form, this can be very a expensive system to implement. It requires that the payer collect a large amount of information about budgetary needs in order to prevent the budget from becoming an inflationist and retrospective financing mechanism. This information is especially

expensive to obtain, owing to the information imbalances between providers and payers in the health sector.

- It makes it possible to harmonize hospital care objectives with other objectives related to the health of the population, public health, and prevention.
- Except for fee-for-service, the budget is the system that allows the provider the greatest possible maneuvering room.
- The distribution of risks may hinder efforts to provide hospital services of better quality and in greater quantity, unless the budget formula is accompanied by adequate incentives for physicians and hospital managers.

Budget and efficiency

A budget payment system can have various consequences for efficiency. On the one hand, it does not include incentives to maximize the quantity of hospital services. However, providers possess more information regarding what expenditures are necessary (justifiable), which places the planner at a disadvantage and may decrease the potential efficiency of budget payment.

Budget and quality

Just as the budget does not encourage greater quantity of hospital care, neither does it encourage higher quality. This situation changes radically if the budget of a hospital is linked to its capacity to attract patients, in a context of competition with fixed budgets.

Possibilities for public action

Budget financing mechanisms require a major effort from the payer in terms of negotiation, information collection, and monitoring. If this effort is not made, the budget becomes a form of fee-for-service payment.

This explains why many countries with publicly funded health systems have abandoned the budget as a hospital payment formula. However, its advantages as a mechanism for controlling activities and integrating multiple planning objectives explain its persistence. The budget system prevails in relatively small countries in Europe. In other countries, the budget formula is combined with a fee-for-service (or per diem or per admission) system in an attempt to take advantage of both systems of hospital payment.

4. CONCLUSIONS AND A PROPOSAL FOR TECHNICAL COOPERATION

This chapter presents the principal thoughts of the working groups on the potential that provider payment mechanisms have to be instruments for facilitating the achievement of the objectives of reform processes in the Region. The difficulties encountered in the implementation phase, and the technical cooperation needs in this area, are also addressed. On the basis of these ideas, a proposal is presented for PAHO technical cooperation to support the countries in the introduction of changes in provider payment mechanisms.

4.1 PROBLEMS IDENTIFIED AND RECOMMENDATIONS FROM THE WORKING GROUPS

The groups carried out their discussions following a guide focused in four main topics:

- Identification of problems to be addressed through the implementation of changes in provider payment mechanisms;
- The potential of payment mechanisms for achieving objectives of equity, efficiency, quality, financial sustainability, and social participation;
- Identification of obstacles that may hinder effective implementation of changes in payment mechanisms; and
- The international cooperation requirements and modalities to support the countries in the design, implementation, and impact evaluation of changes in payment mechanisms.

In a plenary session, the rapporteurs of each group reported on the topics discussed and the conclusions and recommendations that emerged.

One point that stood out, from the description of the situations and problems to be addressed, was the fact that the health systems in each country are at different levels of development. In order to provide a clearer context for their viewpoints, the participants began their interventions with a brief account of the current situation in their respective countries. Wide variations were noted in the socioeconomic development situation of the countries as well as in their institutional structure and the progress made in sector reform processes. Appropriate identification of provider payment mechanisms requires that these differences and special country characteristics be adequately recognized. This is important also in for the design and analysis of the technical and political feasibility of various payment options.

A second element that emerged from the reports, and one which is somewhat related to the diversity of situations, is concern over the identification of a single payment mechanism as the most appropriate in all circumstances. Specifically, the participants expressed the desire to avoid a situation in which a certain payment mechanism might be seen as “fashionable” and its adoption might be promoted on the basis of a single successful experience that might be difficult to replicate elsewhere. The sharing of experiences confirmed the view that, in general, when several objectives are being pursued at the same time, it is more

effective to seek a combination of payment mechanisms. In the same vein, the participants noted the existence of a certain “margin of compromise” that is unavoidable in circumstances in which multiple objectives are being sought.

With regard to the objectives pursued, the participants described the problems faced in each of their countries and the priorities that have been established in the search of solutions. Although, as mentioned above, the problems vary from country to country, the groups confirmed that objectives pursued are the ones identified in the process of health sector reform in the Americas.

4.1.1 Identification of Problems

Presented below is a description of the problems identified by the working groups. It is recognized that only some of these problems can be effectively addressed through changes in payment mechanisms; the solution of some of the problems affecting health systems will require the implementation of policies and complementary instruments in other spheres of action.

- Low productivity and inefficiency in the allocation of resources, which points out the need to rationalize the system;
- Inadequate quality in the provision of services, which has a negative impact on the level of effectiveness. This adds up to an already diminished due to an inappropriate combination of interventions that are being provided to the population;
- Limited management capacity on the part of providers;
- Limited coverage of health services;
- In general, allocation of funds is not linked to production;
- The goal of equity is not always explicitly stated, and problems of vulnerability are therefore not adequately addressed prior to tackling problems related to lack of access to health services;
- The existence of a model of care that has not been adapted to the current epidemiological profile of the countries;
- Little social participation in decision-making;
- Difficulties in achieving sustainability of health systems;
- Existence of multiple payment channels and financing mechanisms, which sometimes intersect. In this context, duplication of payment for services tends to occur.

4.1.3 The Impact of Payment Mechanisms

During the discussion, there was consensus that the introduction of changes in payment mechanisms is not an objective in itself. They are instruments that involve a set of incentives, under those

circumstances they become one of the determinants of providers' decisions with regard to the level and composition of the services provided.

Theoretical analysis as well as experience show that some payment mechanisms can have a positive impact in reducing costs without affecting the quality of care. It is thus feasible to achieve improvements in the efficiency with which health services are produced. With regard to the objective of improving the quality and effectiveness of care, the participants pointed out the need for entities to monitor and ensure certain levels of quality. On the subject of equity, they noted that it is difficult to identify direct effects due to the introduction of payments mechanisms such as those described in Chapter III of this report. However, it would be reasonable to expect improvements in equity, in terms of access to health services, in cases in which a correction component is included in the design of the mechanism. An example of this mechanism would be a capitation system that is adjusted for age or income level of population served, so as to give priority to the delivery of care to the groups that have been identified as most vulnerable.

It would also be possible to expect an indirect impact if savings generated through improvements in efficiency were channeled into activities aimed at enhancing equity. In essence, this would be an impact achieved through reallocation of financial resources. To summarize, although the participants found that the potential impact of changes in payment mechanisms on efficiency is quite clear, they noted that further analysis is needed in order to determine their impact on equity. They found no relationship between changes in payment mechanisms and the objective of social participation. In the working groups, it was pointed out that the final impact will depend largely on the manner in which the instrument is implemented.

4.1.3 Identification of Obstacles

During the sharing of experiences, the participants identified a series of obstacles which, in their opinion, hinder the full implementation of changes in payment mechanisms. Presented below are some of the difficulties identified.

- Rigidity in legislative frameworks. This issue was raised repeatedly, and it became evident that legal changes may be a prerequisite for the introduction of changes in payment mechanisms;
- Social and cultural value judgments implicit in the organizational characteristics of the sector, which become serious obstacles to the implementation of changes;
- Resistance to change within the sector. This point was mentioned by all the groups in relation to the conflicts of interests that must be resolved in order to effectively implement the changes that will make health sector reform possible;
- Lack of technical knowledge on the part of the agents involved, which makes it difficult to fully exploit the potential of these instruments and points up the need for training in the relevant areas;
- Lack of negotiating capacity. Although this problem was mentioned in a separate manner, in fact it is linked to the preceding issue;
- Public financing problems. There is the perception that reductions in fiscal resources might lead to a preference for line-item or global budgets as a payment mechanism, instead of a mechanism that would truly link the level of financial resource allocation to the volume of production. The

appearance of central-level indebtedness to providers is an illustration of the seriousness of this problem;

- The characteristics of the existing capacity in the public sector make it fairly inflexible, which in turn makes it difficult to modify the composition of the care provided. For this reason, it is likely that the introduction of changes in payment mechanisms will have a lesser impact than anticipated, since it will be determined by the characteristics of supply;
- Limited information system development. This reduces the availability of information needed for decision-making in the design, implementation, and evaluation phases. The end result is that the potential impact of changes in payment mechanisms is reduced.

4.2 A PROPOSAL FOR TECHNICAL COOPERATION

Based on the identification of problems to be addressed through the implementation of changes in payment mechanisms and the obstacles standing in the way of that process, the forum participants identified a set of technical cooperation activities that they believed would be useful to facilitate the country's efforts. In response to these proposals, the Pan American Health Organization will revise its agenda for technical cooperation in this area. PAHO will collaborate with national teams from the earliest stages, when the need for certain types of studies will be assessed in light of the information currently available. This is linked to a request from the participants to international cooperation agencies in order to coordinate their work and share studies and available information, so as to make a more cost-effective use of human and financial resources in the preinvestment stages.

It is proposed that technical cooperation activities be carried out in the following four areas:

4.2.1 Study and Design of Payment Mechanisms

Work in this area will focus on the development and transfer of methodologies and analysis of the impact and implications of the various payment mechanisms for health systems.

There will be collaboration with national teams at all stages of the preinvestment studies. This includes everything related to analysis of technical, financial, and political feasibility in the design stages, as well as identification and development of the pre-conditions for implementation. Recognizing that payment mechanisms relate to an area different than the one covered by sectoral financing, emphasis will be placed on the identification of mechanisms which, in addition to having the potential to effect a positive change in efficiency, can have also an impact on three other dimensions: (a) quality, (b) appropriateness of care; and (c) practices that reorient the provision of health services.

4.2.1.1 Strengthening the Steering Role of the State in regard to Payment Mechanisms

In this area, technical cooperation will respond to a specific request to improve the steering capacity of the State in this area. In particular, also in response to an explicit request, training will be offered in specific areas that will improve both technical capabilities and political and negotiating capacity. Accordingly, support will be provided to improve the capacity to calculate costs, establish billing systems,

and evaluate the financial costs associated with the implementation of changes in payment mechanisms. The latter include the costs of information systems and management and transactional costs.

4.2.1.2 Monitoring of Processes and Impact Evaluation

In response to the need to monitor the implementation of payment mechanisms in relation to the progress of sectoral reform processes, some of the indicators that are being utilized to monitor reform processes in the framework of the Health Sector Reform Initiative will be refined. In this same vein, labor incentives will be analyzed in greater depth as a guide for labor policy development.

4.2.1.3 Exchange of Information

The importance of forums such as this one for facilitating the sharing of experiences among country representatives was underscored. Collaboration was requested for the establishment of a formal exchange network that will make it possible to share and analyze both successful and unsuccessful experiences, as well as the conditioning factors that contributed to those outcomes. This will provide documented input for dialogue and decision-making within each country. Specific technical cooperation activities will include the compilation of information to be included on the Web page of the Health Sector Reform Initiative. The subject of payment mechanisms will also be included in the exchange activities and study tours envisaged under the Initiative. In addition, a comparative study will be extended to include a greater number of countries.

ANNEX A: AGENDA

MONDAY, 16 NOVEMBER

8:30–9:00

OPENING SESSION

Dr. Marie-Andree Diouf, PAHO/WHO Representative in Peru

Dr. Karen Cavanaugh. Adviser on Health Systems for USAID and Coordinator of the Health Sector Reform Initiative for Latin America and the Caribbean

Dr. Daniel López Acuña. Director of the Division of Health Systems and Services Development, PAHO.

Dr. Alejandro Aguinaga. Vice-Minister of Health of Peru.

SESSION I

Framework for the Forum

Moderator:

Dr. Daniel López-Acuña. Director, Division of Health Systems and Services Development, PAHO

9:00–9:10

Presentation on the Health Sector Reform Initiative for Latin America and the Caribbean, Ms. Karen Cavanaugh

9:10–9:30

Introductory Framework for the Regional Forum on Provider Payment Systems. Dr. Pedro Crocco, Pan American Health Organization (PAHO)

SESSION II

Presentation of Studies that Provide a Taxonomy and Analysis of Provider Payment Mechanisms

Moderator:

Dr. Augusto Meloni. Director-General of the Office of International Cooperation, Ministry of Health, Peru.

9:30--10:30

Alternative Provider Payment Mechanisms

Dr. Alexander Telyukov, Partnerships for Health Reform Project (PHR)

10:30–11:00

Break

11:00 - 12:00

Criteria for the Analysis of Payment Mechanisms

Dr. Rena Eichler, Family Planning Management Development Project (FPMD)

12:00–13:30

Lunch

SESSION II (CONTINUED)

13:30–14:30

Comparative Analysis of Payments Systems in a Selected Group of Member Countries of the Organization for Economic Cooperation and Development (OECD) and Latin America

Professors Félix Lobo and Laura Pellisé, University Carlos III, Madrid

14:30–15:00

Break

SESSION III

Panel on Analysis from Three Perspectives: Economics, Provision of Care, and Providers

15:00–17:00

Moderator:

Dr. Faustino Centurión, National Superintendent of Health, Paraguay

Participants:

Dr. Eduardo Levcovitz, Professor, Institute for Socialized Medicine, Rio de Janeiro State University, Brazil

Dr. Bruce Davis, Director of Health Insurance, Health Canada

Dr. Juan Antonio Larzabal, Secretary, Latin American Federation of Hospitals

Dr. Jaime Johnson, President, Coordination Unit for the Modernization of the Public Health Subsector of Peru

18.00

Welcome reception

TUESDAY, 17 NOVEMBER

SESSION IV

Group Workshops

8:30–9:00

Plenary session: Division of groups

9:00 - 10:30

Topic I: Impact of different payment mechanisms on quality, efficiency, and equity in access

10:30 - 11:00

Break

11:00 - 12:30

Topic II: Priority Areas and Modalities of Technical Cooperation

12:30 - 14:00

Lunch

SESSION V

Discussion and Conclusions of the Working Groups

Moderator:

Dr. Anuar Abisab, Assistant Administrative Director, Ministry of Public Health of Uruguay

14:00–14:45

Group Presentations on Topic I.

14:45–15:15

Technical Panel. Comments on the Group Presentations on Topic I.

Participants:

Dr. Pedro Crocco, PAHO

Dr. Rena Eichler, FPMD

Professor Laura Pellisé, University Carlos III of Madrid

Dr. Alexander Telyukov, PHR

15:15–15:45

Break

15:45–16:30

Group Presentations on Topic II

16:30–17:00

Panel of International Cooperation Institutions, Comments on the Group Presentations on Topic II.

Participants:

Dr. Daniel López-Acuña.

Pan American Health Organization (PAHO)

Ms. Karen Cavanaugh

United States Agency for International Development (USAID)

17:00

Preliminary Final Report. Matilde Pinto. Economist, Division of Health Systems and Services Development, PAHO

17:15

Closing Session

Dr. Gustavo Rondón Fudinaga

General Director for Health, Arequipa, Perú

Ministry of Health of Peru

Dr. Daniel López-Acuña.

Pan American Health Organization (PAHO)

Dr. Marie-Andrée Diouf

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