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Learning from alternative approaches to paying providers in western Europe

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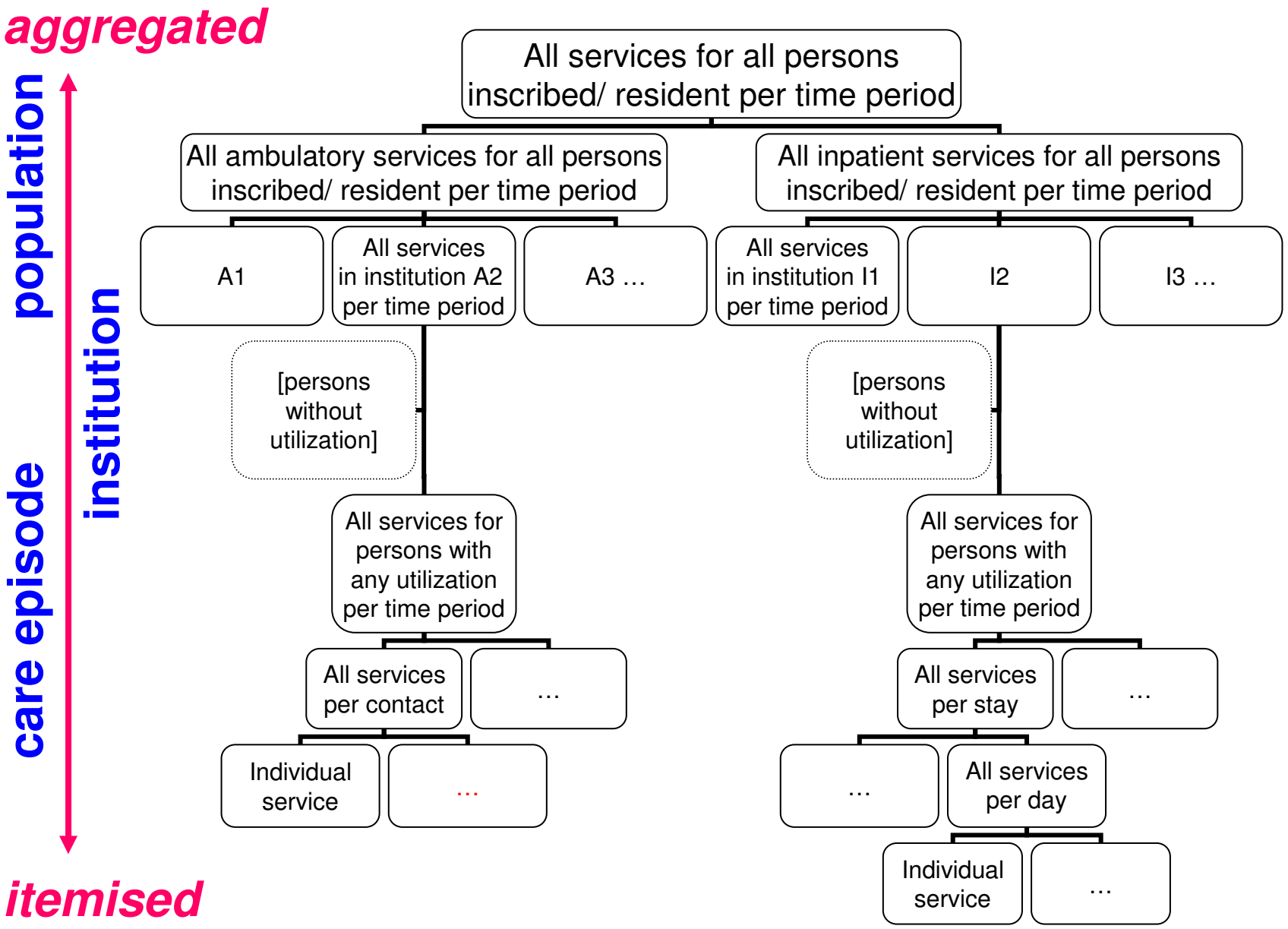
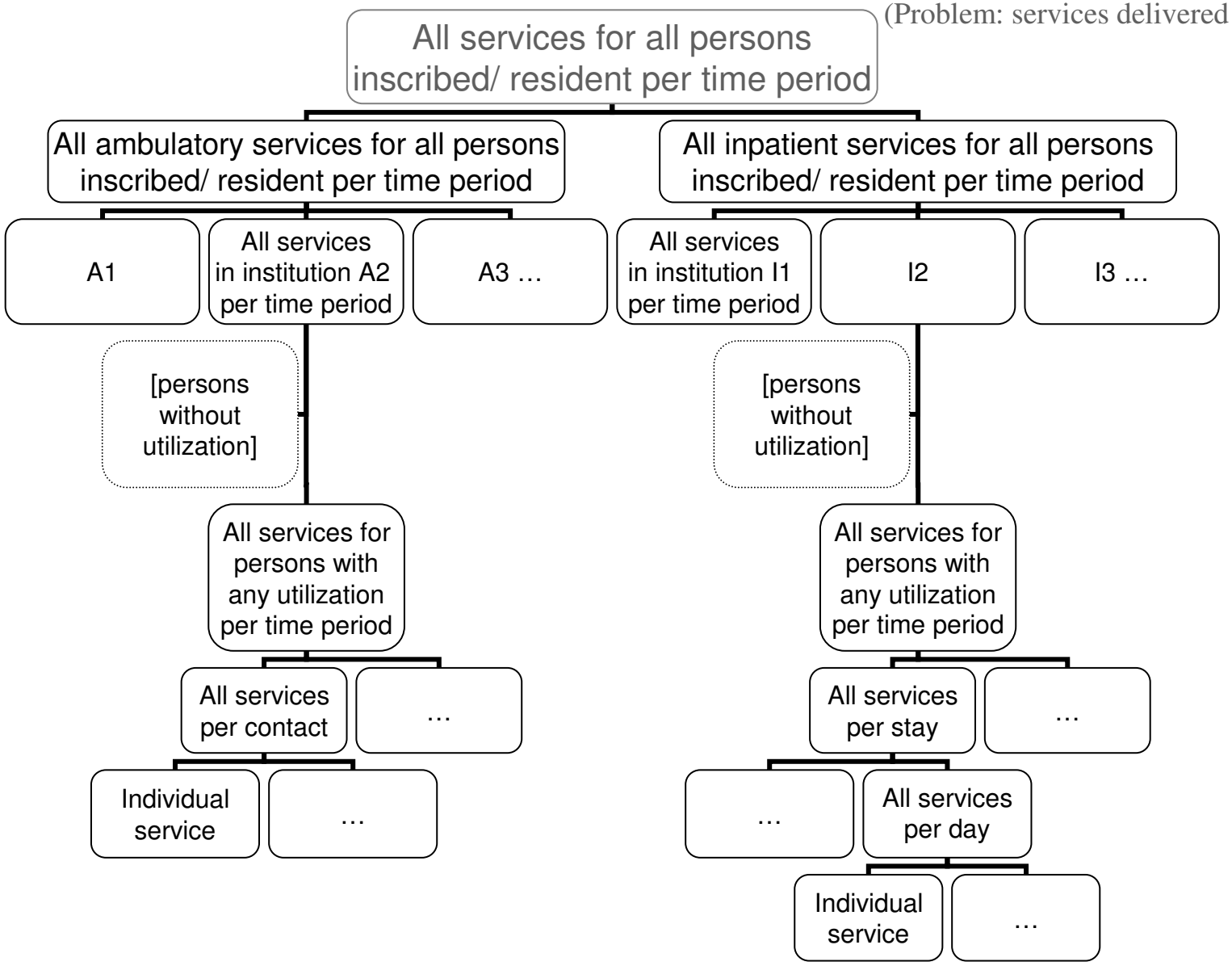
Possible units for payment



Important forms of payment

Sickness fund‘s budget/ Integrated Care Provider

(Problem: services delivered elsewhere)

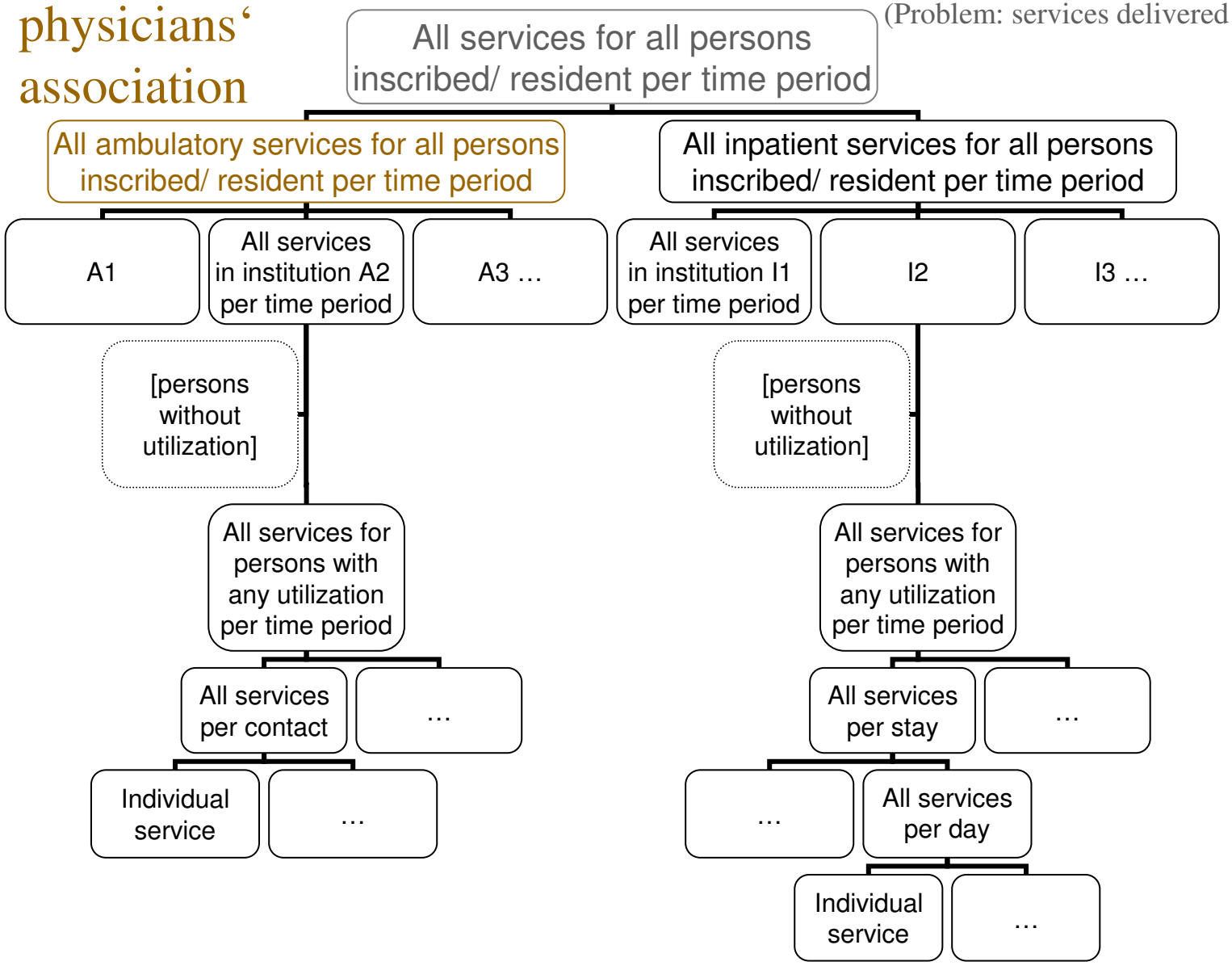


Important forms of payment

Budget for physicians' association

Sickness fund's budget/ Integrated Care Provider

(Problem: services delivered elsewhere)



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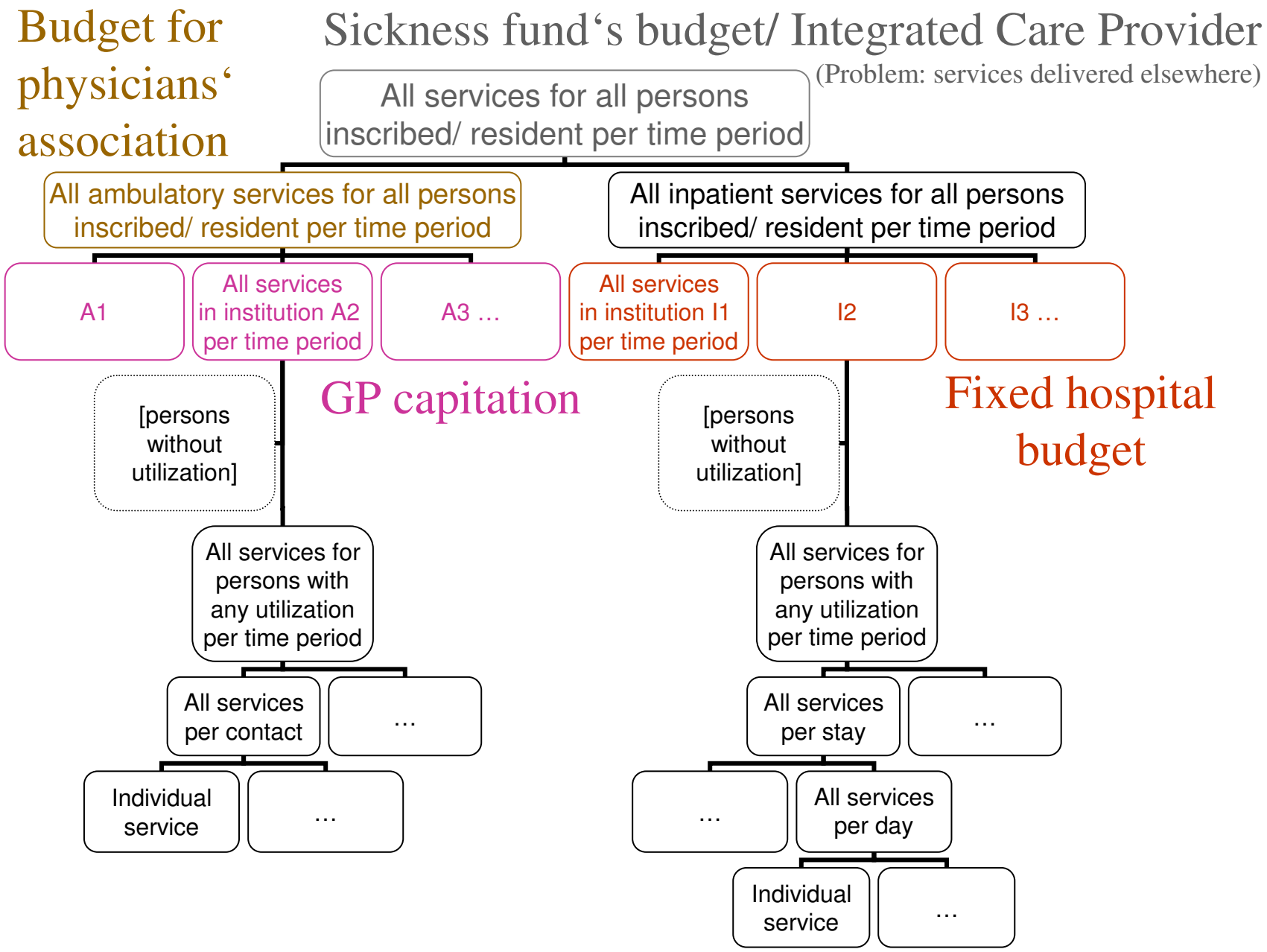

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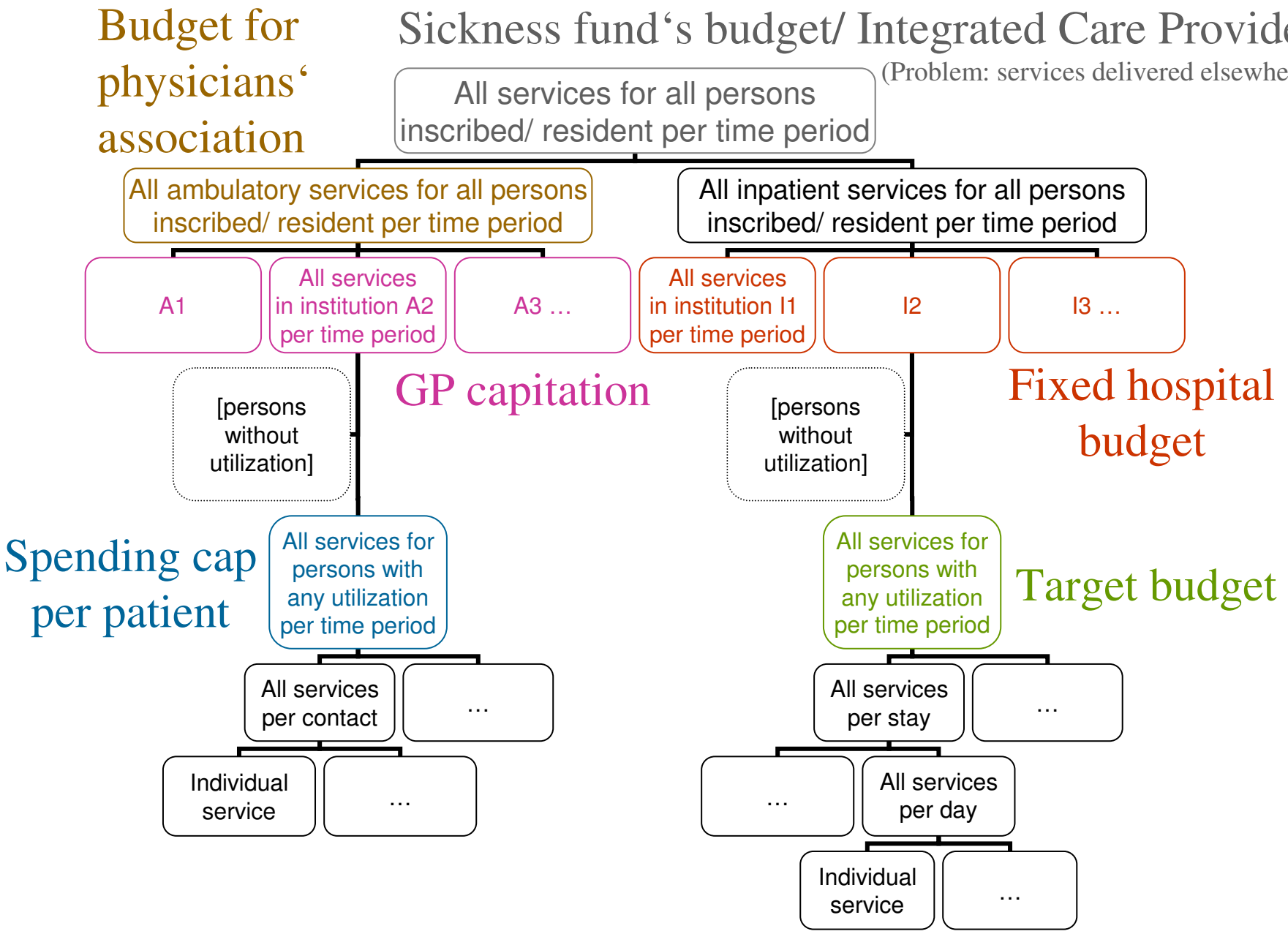

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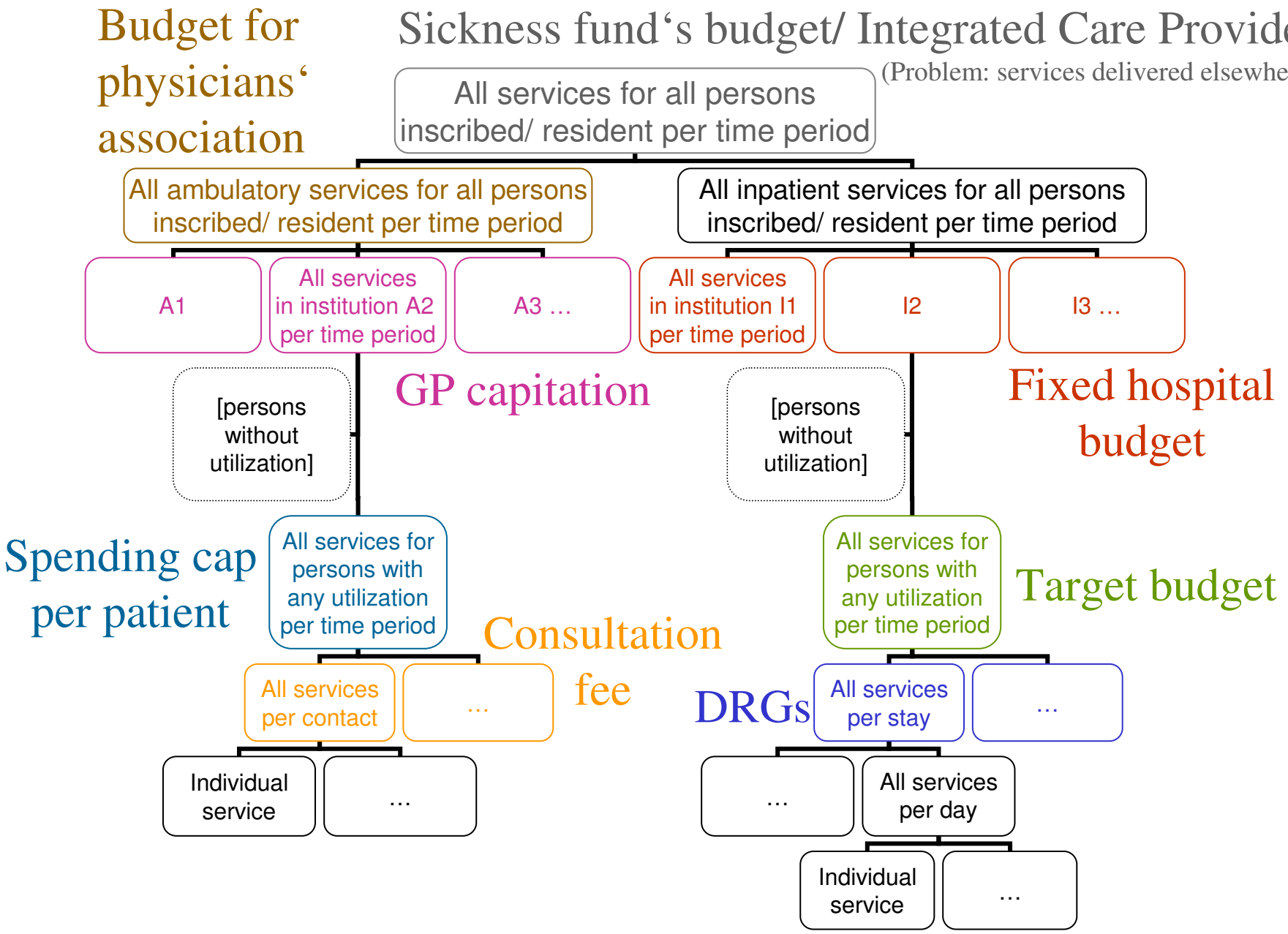

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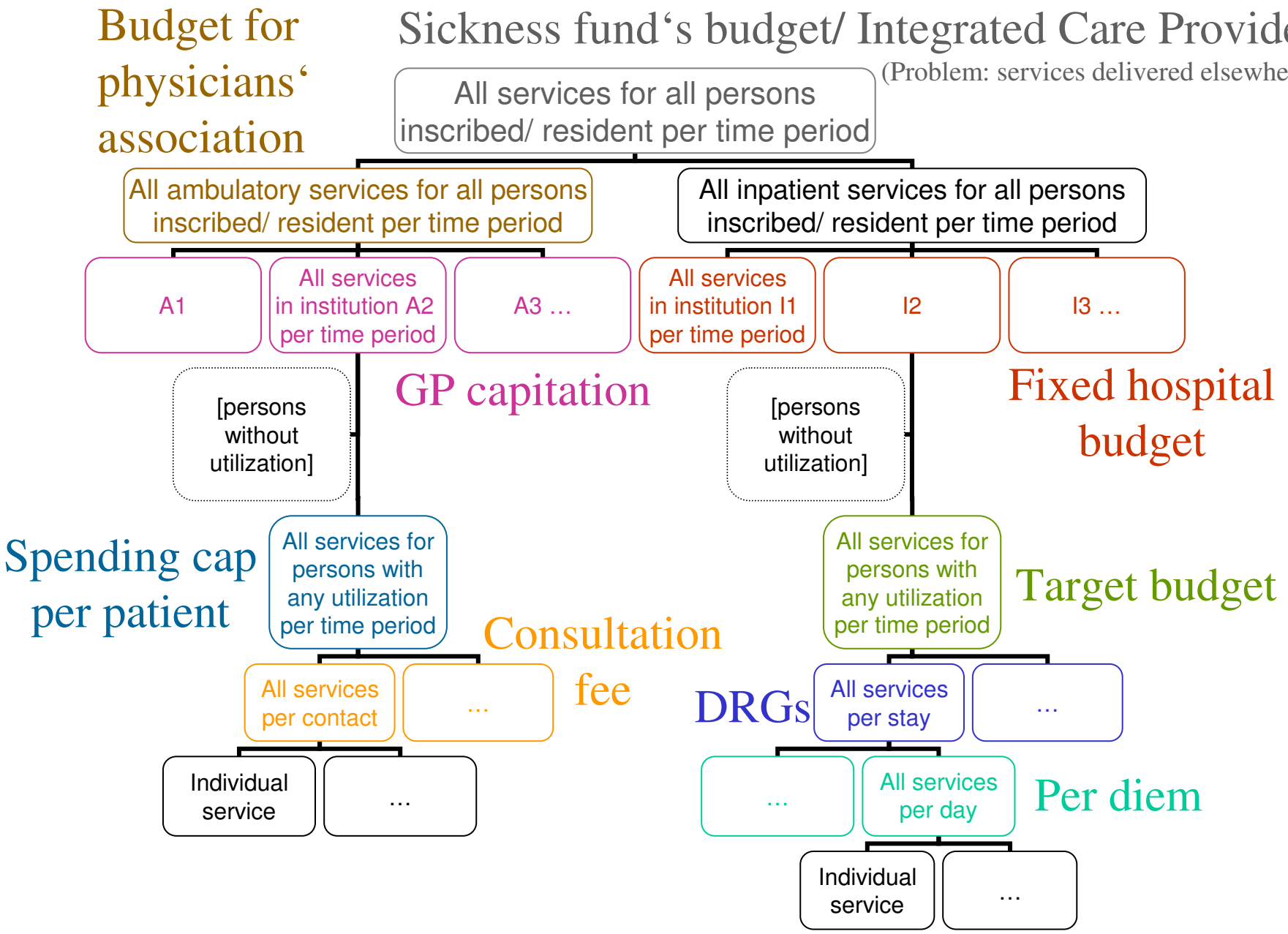
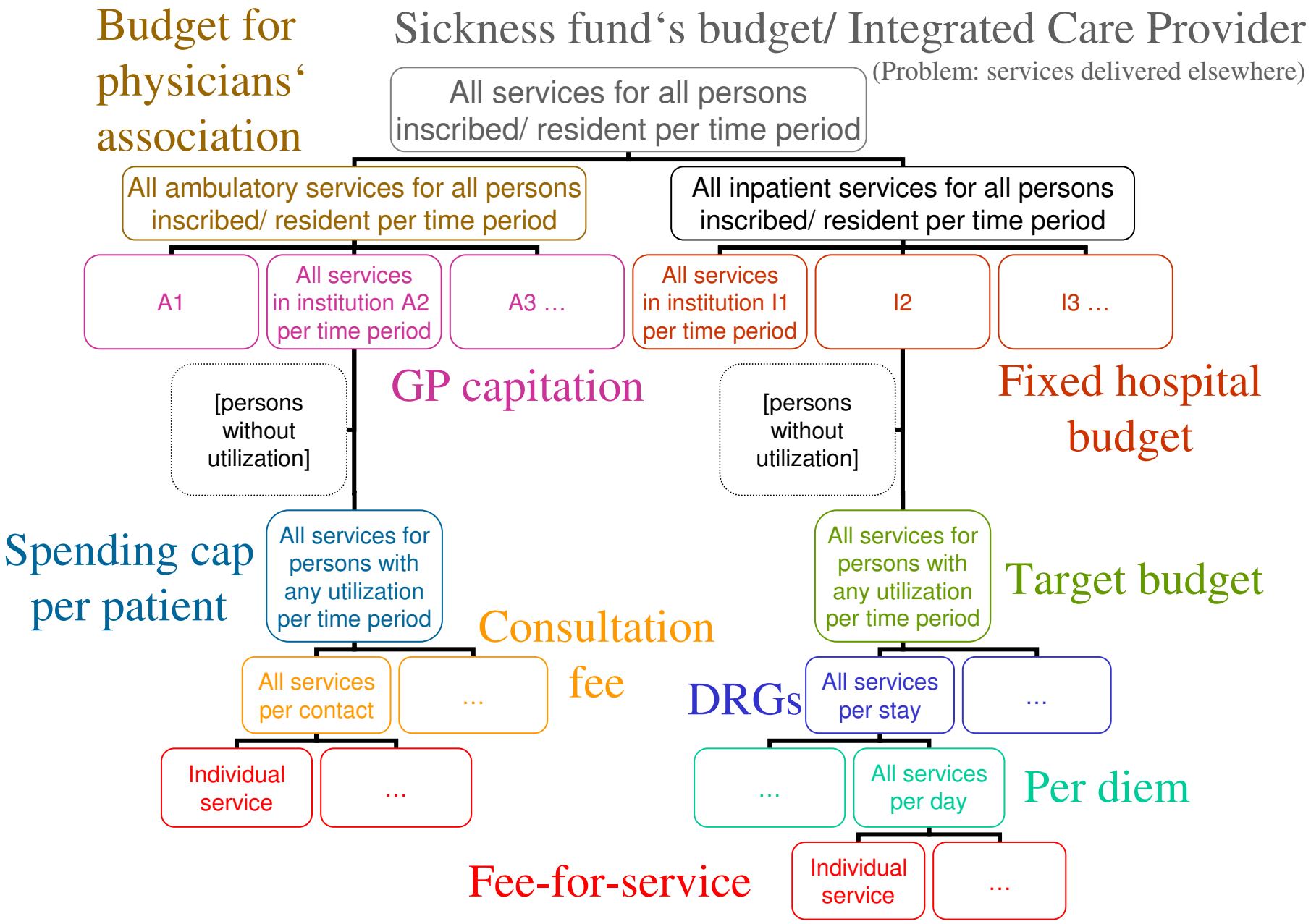


Important forms of payment



Unwanted side effects

- Incentive is to maximise the number of paid units (inscribed patients, contacts/ admissions, days or services) – *endangers cost-containment, quality (overprovision) and cost-effectiveness*
- Incentive is to minimise included services: by not providing them, early discharge or referral – *endangers access, quality (underprovision) and cost-effectiveness*

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Measures to address unwanted effects

- Use payment systems from different levels, e.g. one for physicians‘ association, one for individual physicians
- Ensure that population-based payments include payment of providers outside the territory/ HMO
- Mandate that institutions with capitation or budget do not overlap, i.e. GPs with their lists or hospitals with their catchment areas – and that they financially participate in referrals (or are rewarded for low referral/ prescription rates)

Measures to address unwanted effects

- Assure quality to avoid both over- and under-provision (as well as mis-provision) by a mixture of requirements, incentives and control:

  - licensing; certification; minimum volumes; participation in quality assurance; *guidelines*

  - bonus/ malus for quality documentation/ treating according to guidelines/ reaching targets

  - utilization review (actual utilization vs. average, benchmark or theoretical "best practice")

A concrete example: DRGs

- *Expected effects:*

  - DRGs vs. fixed budgets: hospital activity will go up; activities not included in DRGs (e.g. teaching; emergency care at night) might be abolished

  - DRGs vs. fee-for-service: hospital activity and length-of-stay will go down; referrals will go up
- Calculation of DRG fee level should include anticipated effects
- Expected effects should be explicitly counter-balanced (e.g. through supplements for teaching, emergency care)
- Regulation/ incentives/ controls are needed to ensure that hospitals treat appropriately and of high quality – and not only respond to the economic incentives of DRGs!

Further points for discussion

- Who can decide upon type of provider payment and on actual size of payment? Parliament (law), government (ordinance), sickness funds and providers (contract)?
- Collective vs. selective contracting (one sickness fund picks one provider): transaction costs, trade-off vs. access and quality (usually no competition for high-level and complicated care)
- “Combined budgets“, e.g. ambulatory care and pharmaceuticals (found unconstitutional in France)

Germany: Budgets and spending caps

	Ambulatory care	Hospitals	Pharmaceuticals
1989 to 1992	negotiated regional fixed budgets	negotiated target budgets at hospital level	no budget or spending cap
1993	legally set regional fixed budgets	legally set fixed budgets at hospital level	legally set national spending cap
1994			negotiated regional spending caps
1995			
1996	negotiated regional fixed budgets		
1997		negotiated target budgets at hospital level	
1998	(target volumes for individual practice)*		negotiated target volumes for individual practices
1999	**Failed attempt to introduce global budget**		legally set regional spending caps
2000	negotiated regional fixed budgets with legally set limit	negotiated target budgets at hospital level with legally set limit	negotiated regional spending caps
2001/ 2002			negotiated target volumes for individual practices
2003	legally set regional budgets, fixed at 2002 level	target budgets at hospital level, legally fixed at 2002 level**	
2004	negotiated regional fixed budgets with legally set limit	negotiated target budgets At hospital level with legally set limit	

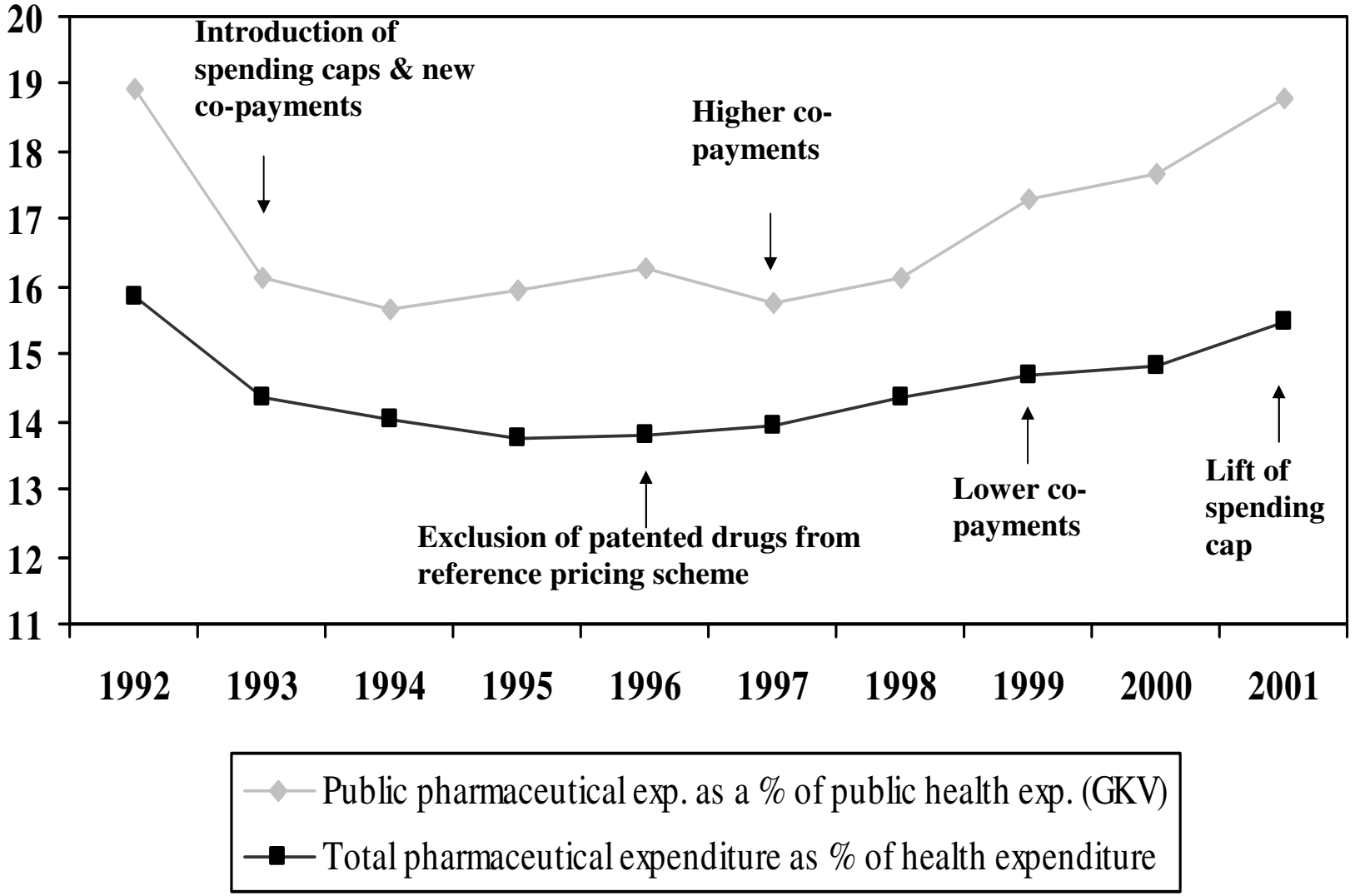
Source: Busse & Riesberg 2004 (HiT)

Pharmaceuticals: Balancing politically contentious spending caps with collective liability and individualised target volumes ….

	Spending caps (collective liability)	**Target volumes (Individual liability)**
1989 to 1992	No spending caps required	Target volumes legally required but not implemented due to lack of data
1993	Legally set national spending caps	
1994 to 1997	Negotiated regional spending caps	
1998	No spending caps required	Negotiated target volumes for individual practices (lack of legal liability)
1999	Legally set regional spending caps	
2000 to 2001	Negotiated regional spending caps	
Since 2002	No spending caps	Legal liability for negotiated target volumes for individual practices

Source: Schreyögg & Busse 2004

Collective spending caps = effective for cost-containment (but politically unsustainable)

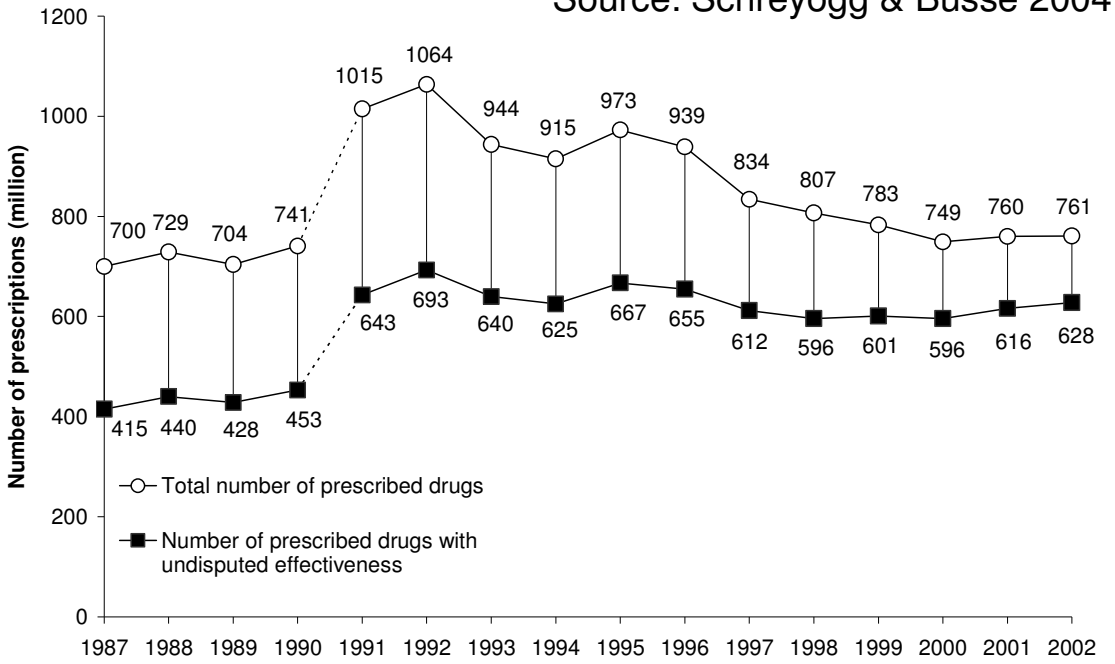


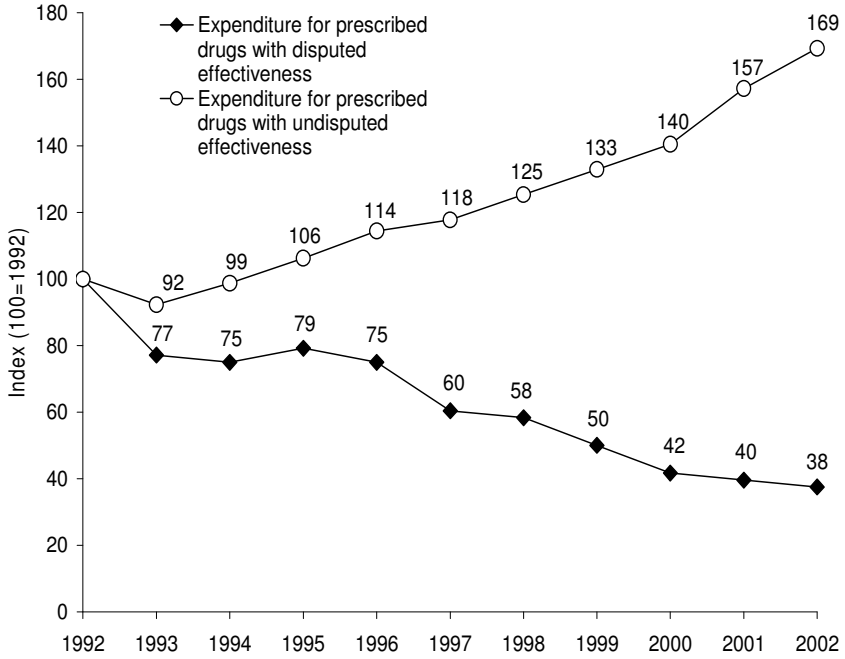
Source: Busse et al. 2004

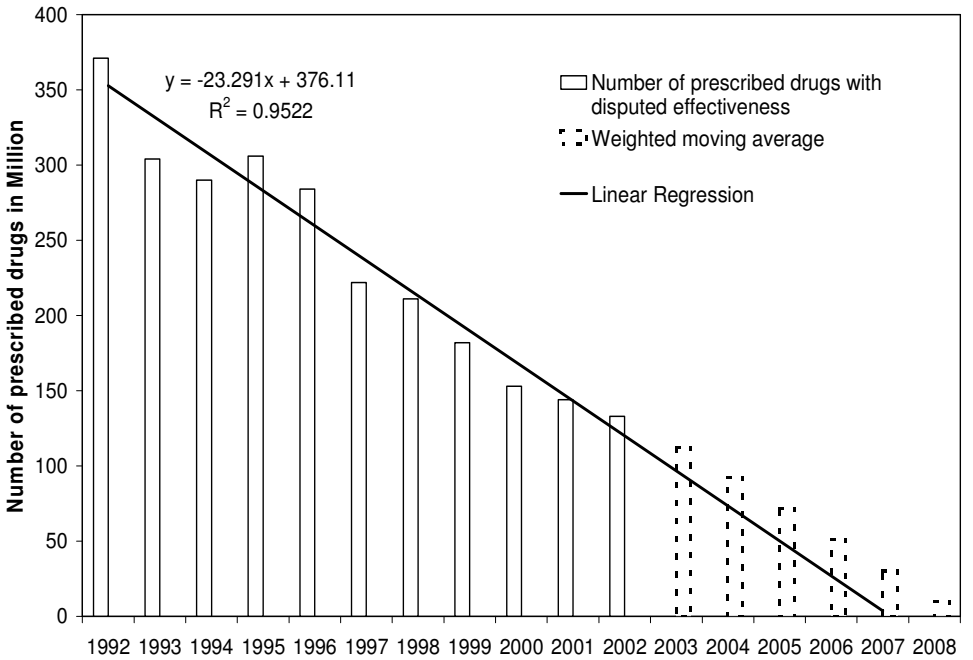
Often quoted negative impact on quality:

but prescriptions for drugs with disputed effectiveness virtually disappeared …

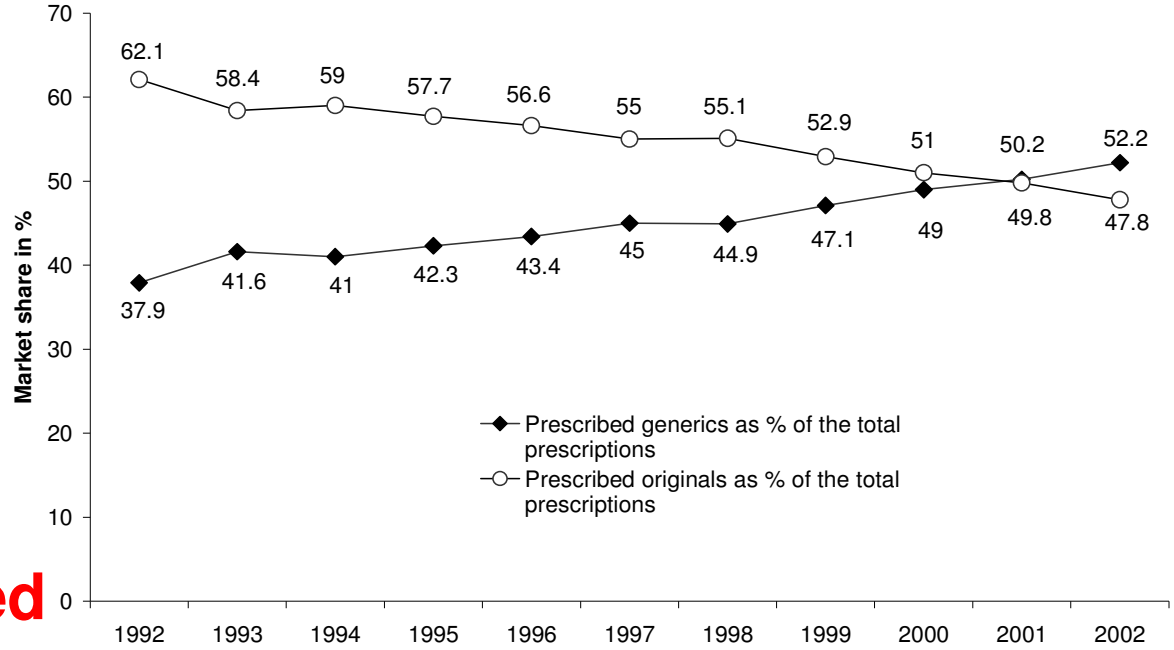
Source: Schreyögg & Busse 2004

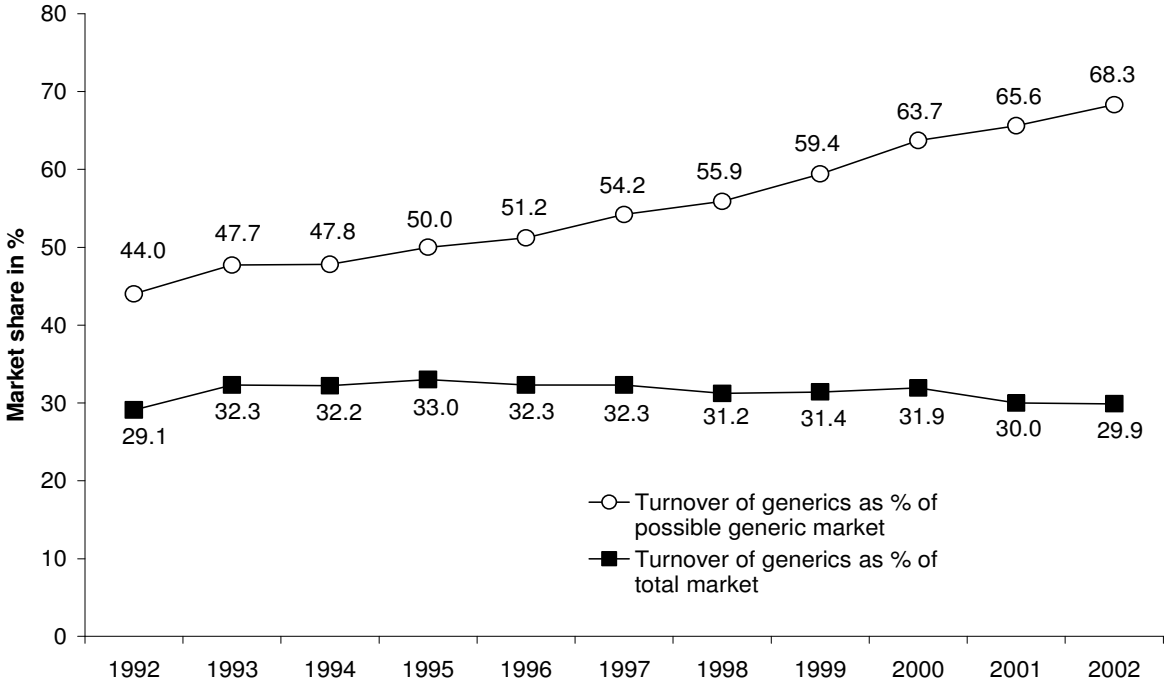






… and generic prescription increased





Source: Schreyögg & Busse 2004

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Presentation, articles etc. are available at:

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