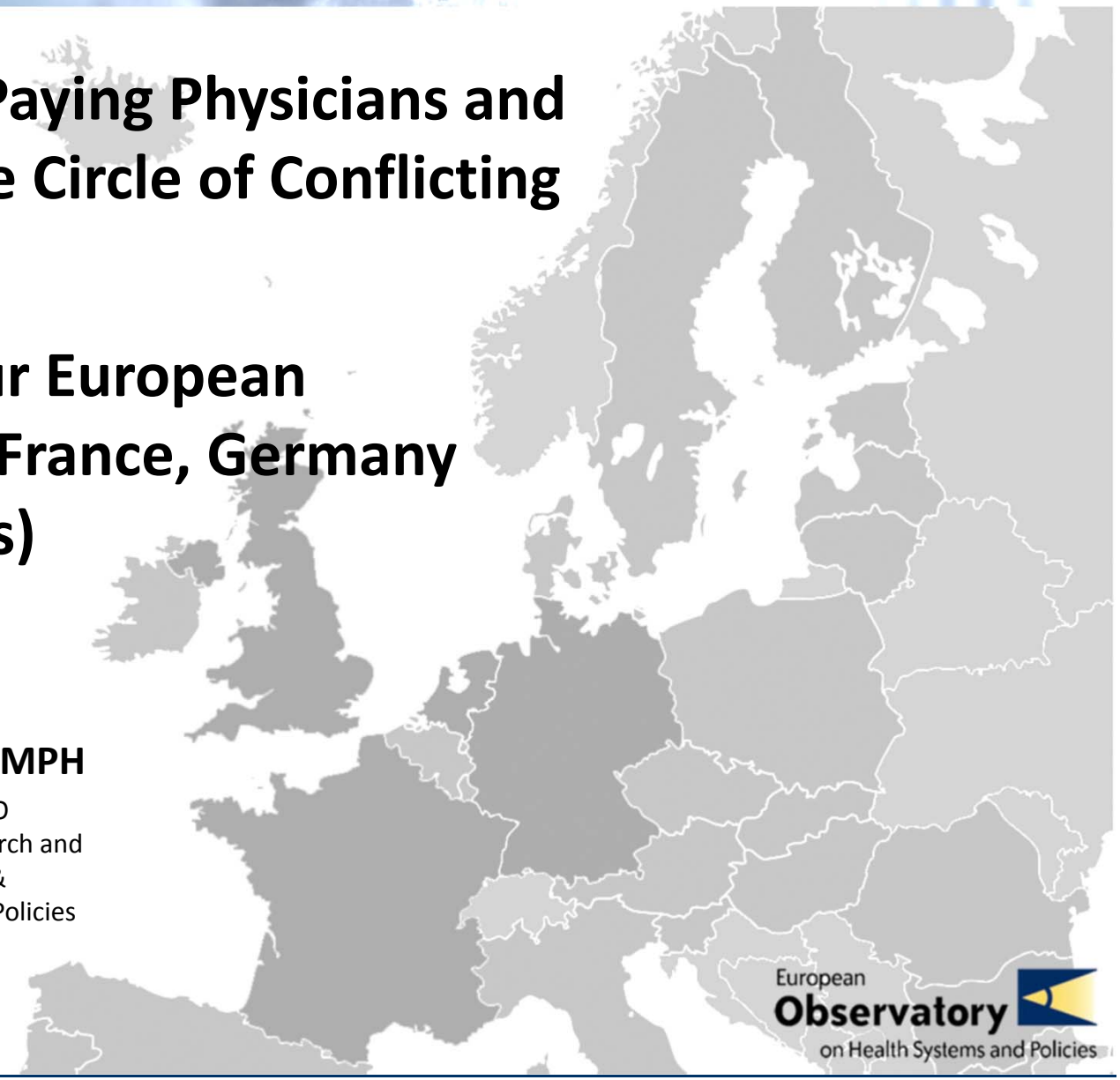
Can Innovations in Paying Physicians and Hospitals Square the Circle of Conflicting Incentives?

Experience from four European countries (England, France, Germany and the Netherlands)



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Provider payment mechanisms are key to the performance of any health system, and the demands placed on them are high.

- **Allocate resources fairly among different providers of care**
- **Motivate actors within the system to be productive**
- **Account for patients' needs, the appropriateness of the services, and outcomes**
- **Be administratively easy and contribute to an overall efficient health system.**

Aiming to overcome the limitations of traditional provider payment mechanisms, England, France, Germany, and the Netherlands have developed a range of innovative approaches to provider payment over the past decade. How do they work? Do they work – can they square the circle?

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Theory and Practice in the Design of Physician Payment Incentives

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There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of "ping-pong" referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem. But American medicine exhibits numerous interesting compensation systems that blend elements of retrospective and prospective payment, of fee-for-service, salary, and capitation. These innovations seek a middle ground between high- and low-intensity incentives, between piece rates and straight salary. Payment

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Basic forms of payment mechanisms and their expected incentives in regard to selected objectives

Payment mechanism	Productivity and number of services	Patient needs (risk acceptance)	Appropriateness and adherence to evidence-based medicine (quality of processes)	Quality of outcomes	Administrative simplicity and ease of cost-containment
Physician payment (ambulatory care)					
FFS	+	(+)	(—)	(—)	—
Salary	(—)	O	O	O	+
Capitation	—	— [if not risk-adjusted] / (+)	(+)	O	(+)/(—)

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Capitation	—	— [if not risk-adjusted] / (+)	(+)	O	(+)/(—)
Hospital payment (inpatient/outpatient)					
FFS	+	(+)	(—)	(—)	—
Per diems	(+)	O	O	(—)	(+)
Global budget	—	(—)	(—)	O	+
„Pure“ DRGs	+ [cases] — [services/ case]	(—) [if insufficient consideration of severity] / (+)	(—) [if insufficient consideration of necessary services]	(—) [if complication = co-morbidity]	(—)

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Physician payment (ambulatory care)					
FFS				(—)	—
Sala				O	+
Capi				O	(+)/(—)
Hos					
FFS				(—)	—
Per				(—)	(+)
Glob				O	+
„Pur	— [services/ case]	consideration of severity] / (+)	consideration of necessary services]	(—) [if complication = co-morbidity]	(—)

Two observations stand out:

1) basically all payment mechanisms provide conflicting incentives for "production of services" and "cost-containment" (an unsurprising but politically worrisome observation); and

2) none provide positive incentives for producing high quality outcomes.

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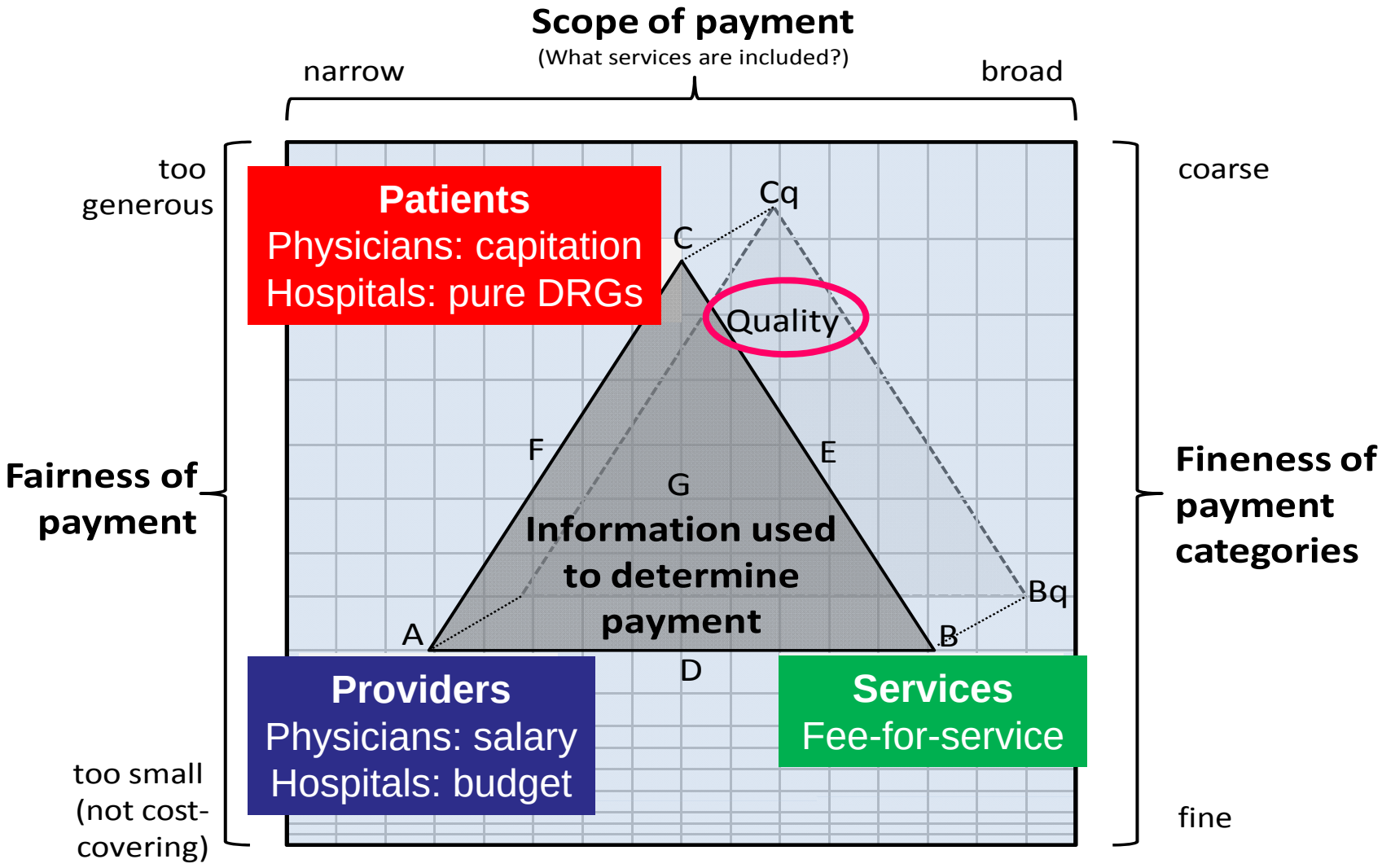
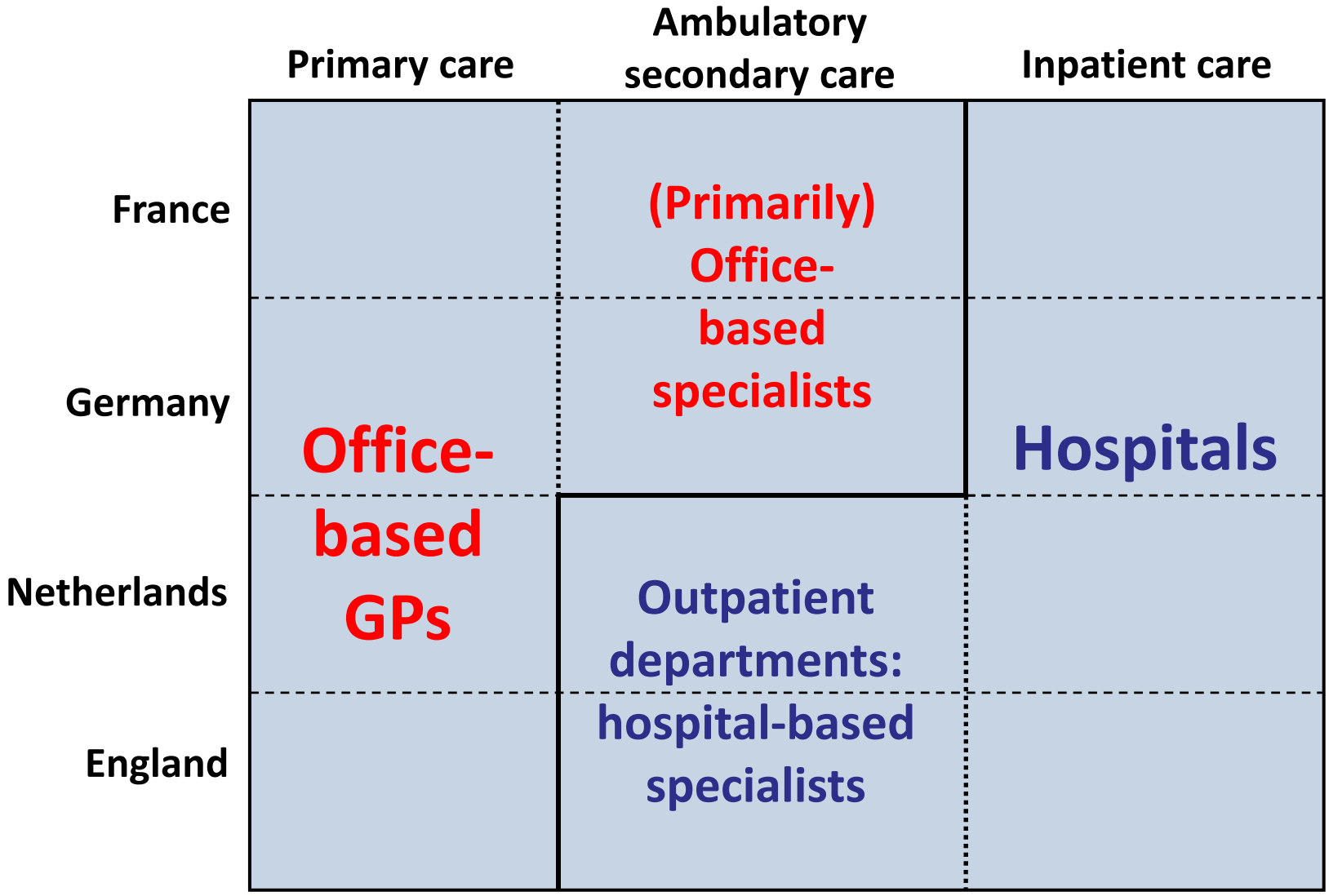
Conceptual framework for analyzing provider payment systems



Examined sectors



Physician payment (ambulatory care)

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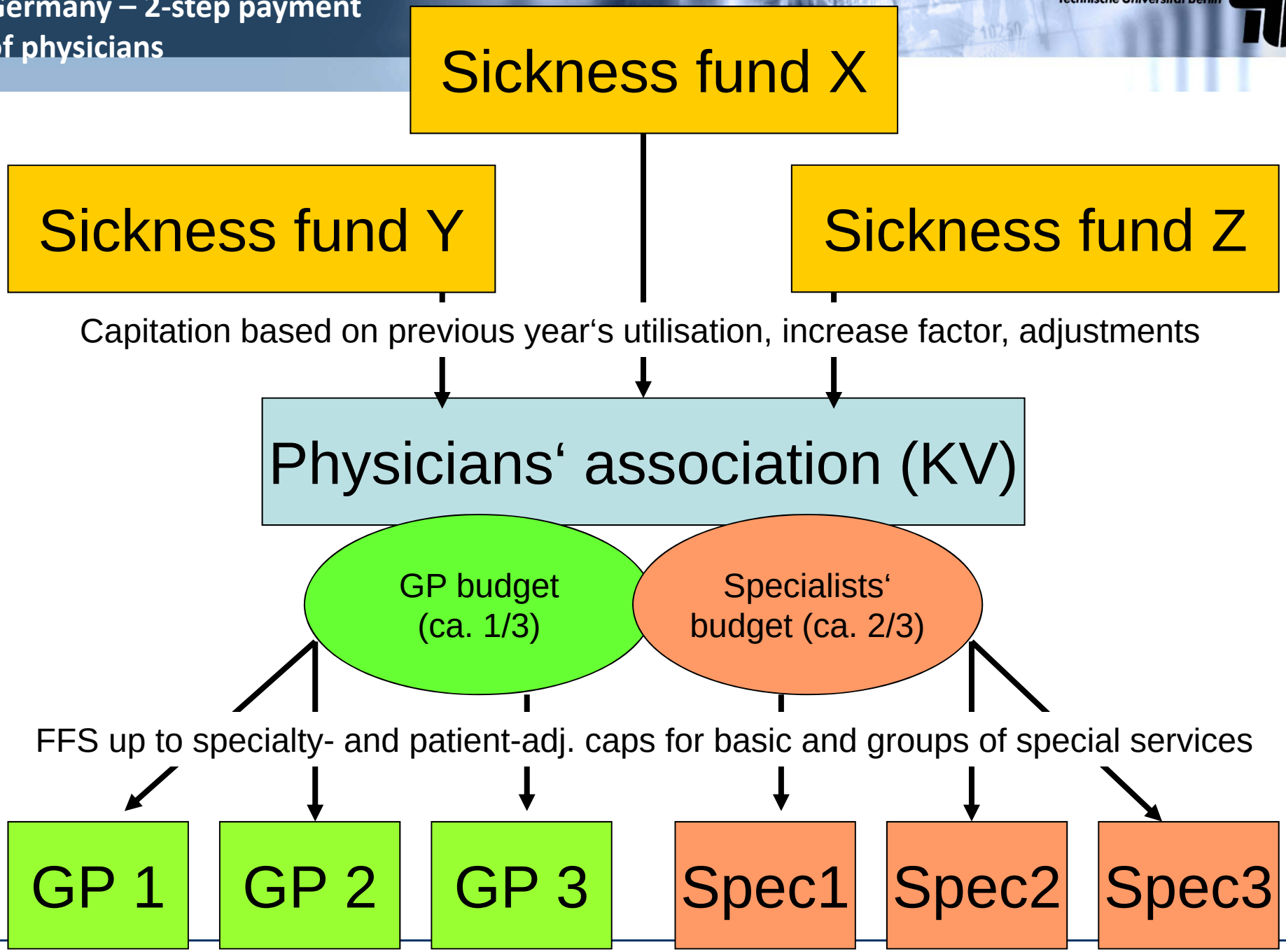
	England	France	Germany	Netherlands
GPs				
FFS	Fees for enhanced services (if contracted with PCT)	FFS for self-employed GPs	FFS for self-employed GPs up to cap (CVAPC)	Consultation fees
Capitation	Flat fee per patient for essential services; fixed allowance for costs related to setting up or maintaining practices	For management of patients with long-term-diseases (ADL) and involvement in provider network (symbolic)	Additional payment for involvement in Disease Management Programs (DMP)	Flat fee per year and registered patient
Quality-related adjustments	QOF; new P4P contracts for GPs	For individual contracts for practice improvement (substantial)	--	As a pilot model
Salary	GPs working in hospitals, in service of a GP practice or PCT	GPs working in hospitals, in service of a GP or in health centers and preventive and social services	GPs working in hospitals, in service of a GP practice or in health care centers	GPs working in service of a GP practice or in primary care centers
Specialists				
FFS	For work in private practice (i.e., not within NHS)	For self-employed specialists (including specialists practicing in private for profit clinics)	For self-employed specialists up to cap (CVAPC)	75% of specialists (i.e., working independently in hospitals)
Capitation	--	--	--	--
Quality-related adjustments	New contracts for specialists; Clinical Excellence Awards	--	--	--
Salary	Physicians working under the NHS contract	Specialists working in hospitals	Specialists working in hospitals	25% of specialists working in hospitals

Part of DBC payment

Germany – 2-step payment of physicians



Payment components in GP care

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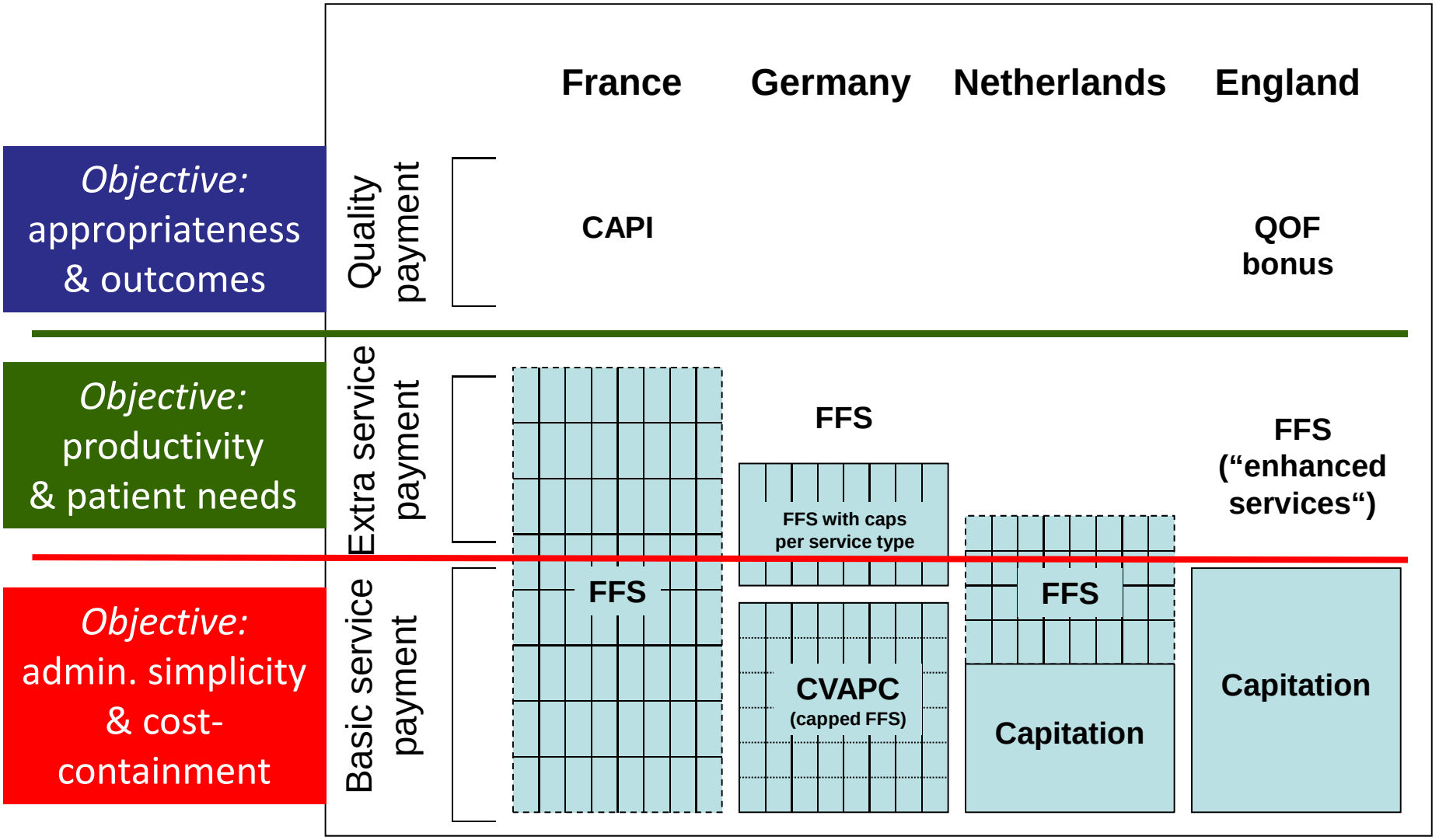

Global budgets *(prospective)*		Good for cost-containment, but bad for productivity and patient needs (→ low quality and efficiency)
Per diems		A bit better for productivity (→ efficiency higher), but still negative for appropriateness of care or outcomes
DRGs	- related to acitivity (but not quality) - incentives to increase macro- and micro-efficiency	- if payment inadequate: "dumping" (avoidance), "creaming" (selection) and "skimping" (undertreatment) of patients - up/wrong-coding, gaming - more admissions → increasing expenditure - administratively complex
Fee-for-service *(retrospective)*	USA 1980s	Good for "productivity" and patient needs (but → overtreatment) and expensive (→ low quality and efficiency)

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Hospital payment by DRG-type systems

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	England	France	Germany	Netherlands
Patient classification system	Healthcare Resource Group (HRG)	Groupe Homogène des Malades (GHM)	German DRG (G-DRG)	Diagnose Behandeling Combinaties (DBC)
DRG-type hospital payments as % of total acute care hospital revenues	70%	≈80%	≈80%	≈85%
Applied to	all hospitals treating NHS patients	all hospitals (public and private)	all hospitals (public and private)	all hospitals
Year of introduction	2003/04	2004/05	2003	2005
Frequency of revisions	Annual	Annual	Annual	Irregular
Included services				
Inpatient care and day cases	Yes	Yes	Yes	Yes
Outpatient	Yes	Yes (?)	No	Yes
Rehabilitation	Yes	pilot test starting 2010	No	Yes
Psychiatry	No	No	starting 2013	Yes
Cost categories				
Recurrent costs	Yes	Yes (in public hospitals; in private hospitals, physician fees and diagnostic tests are paid separately	Yes	Yes
Capital costs	Yes	Yes (but not all)	No (only some)	Yes

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Information used to determine payments in European DRG-type hospital payment systems

Basis for payment	England (HRG)	France (GHM)	Germany (G-DRG)	Netherlands (DBC)
Patient Characteristics				
Diagnoses	X	X	X	X
Age	X	X	X	—
Body Weight (Newborn)	—	X	X	—
Service Characteristics				
Procedures	X	X	X	X
Type of care	—	—	—	X
Length of stay	X	X	X	—
Mechanical ventilation	—	X (or other life-support system)	X	—
Discharge type (e.g., death)	X	X	X	—
Provider Characteristics				
Setting	X (when determining payment rates, not explicitly part of classification algorithm)	X (?)	—	X
Medical specialty	—	—	—	X
Admission type	X	—	—	—

More emphasis on procedures and length-of-stay than in US

Dutch system closest to FFS

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Fairness of payment: data collection and calculation of hospital payment

	England	France	Germany	Netherlands
Cost data collection methodology to determine payment rate				
Sample size (% of all hospitals)	All NHS hospitals	99 hospitals (5%)	253 hospitals (13%)	Resource use: all hospitals; unit costs: 15-25 hospitals (24%)
Cost accounting methodology	Top down	Mix of top-down and bottom-up	Mainly bottom-up	Mainly bottom-up
Calculation of hospital payment				
Payment calculation	Direct (price)	Indirect	Indirect (cost-weight)	Direct (price)
Applicability	Nationwide (but adjusted for market-forces-factor)	Nationwide(but separate for public and private hospitals, and regional adjustments for higher labor costs)	Cost-weights nationwide; monetary conversion state-wide (but very similar across states)	List A: nationwide List B: hospital specific
Volume/ expenditure limits	No (plans exist for volume cap)	Yes	Yes	List A: Yes List B: Yes/No

All countries spend great emphasis on valid calculation of costs → fair payments

Scope of DRG-type hospital payment in European DRG-type hospital payment systems

	England	France	Germany	Netherlands
Payments per hospital stay	One	One	One	Several possible
Payments for specific high-cost services	Unbundled HRGs for e.g.: • Chemotherapy •Radiotherapy •Renal dialysis •Diagnostic imaging •High-cost drugs	Séances GHM for e.g.: • Chemotherapy •Radiotherapy •Renal dialysis Additional payments: • ICU • Emergency care • High-cost drugs	Supplementary payments for e.g.: • Chemotherapy •Radiotherapy •Renal dialysis •Diagnostic imaging •High-cost drugs	No
Innovation-related additional payments	Yes	Yes	Yes	Yes (for drugs)

All countries pay for certain services essentially FFS on top of DRGs

Fineness of the Patient Classification System

	England (HRG)	France (GHM)	Germany (G-DRG)	Netherlands (DBC)
Number of DRGs in current version	1,400	2,291	1,200	≈30,000 (to be reduced to ≈3,000 from 2012)
90% of patients fall into X DRGs (% of all DRGs)	420 (30%)	504 (22%)	408 (34%)	Unknown
Severity levels per base DRG	≤3	4	unlimited	Not applicable

In all countries much more detailed than in US!

Quality consideration in DRG payments

- England & Germany: no extra payment if patient readmitted within 30 days
- Germany: deduction for not submitting quality data
- England: up 1.5% reduction if quality standards are not met
- England: average → „best practice“ payment for 4 indications

Conclusions

- In ambulatory care, countries are moving toward a "European model":
  - (1) capitation to pay for providing basic services;
  - (2) capitations for specific patient groups + FFS for underprovided services and/or requiring special expertise or technology; and
  - (3) quality-related bonus for reaching certain targets.
- In hospital care, countries have developed their own DRG systems, which give a higher weight to procedures and to setting, base payment rates on actual average (or best-practice) costs, pay separately for high-cost and innovative technologies, classify patients into more groups, and thus reduce, or even avoid, the potential of risk selection and under-provision of services.