Session 4: Purchasing and payment for primary care

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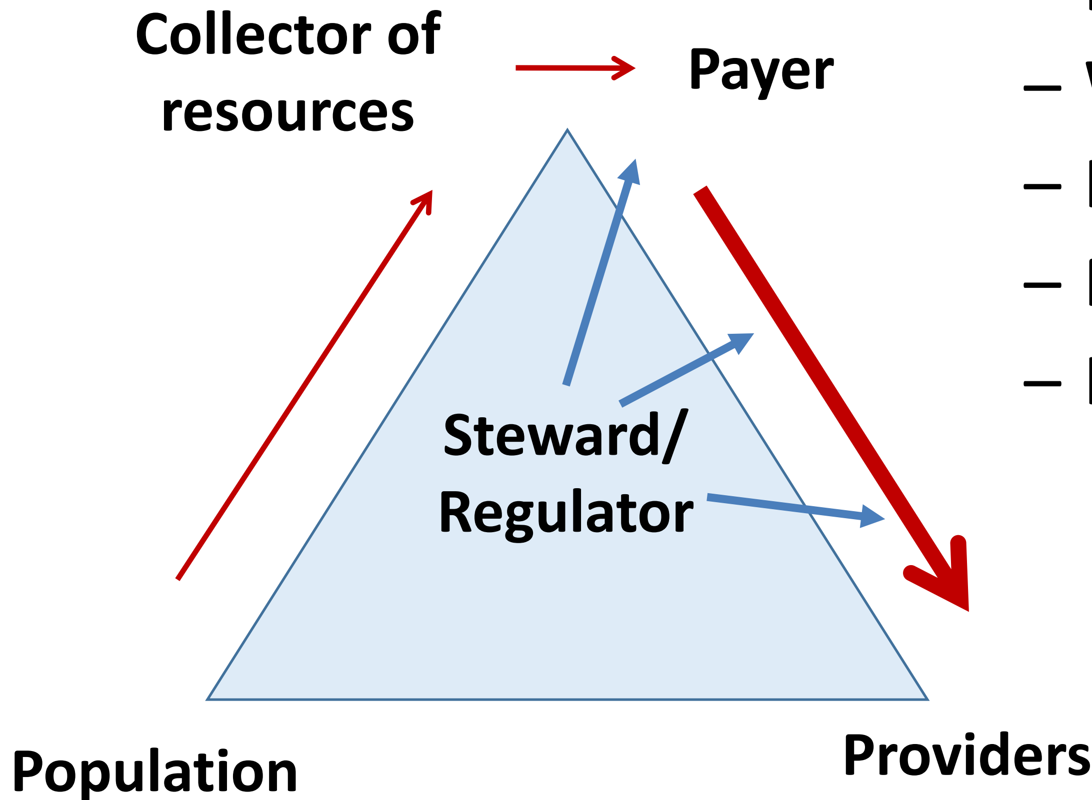
Purchasing



- Who should buy?
- For whom?
- What services?
- How much?
- From whom?
- How to buy?

Strategic purchasing = "proactive decisions … about which services should be purchased, how and from whom" (WHO 2000)

Purchasing process: essentials

- Effective stewardship
  - Defining priorities and plans
  - Ensuring accountability of purchasers and providers
  - Establishing an integrated regulatory framework
    - → Defining roles, responsibilities and rules
- Ensuring cost effective contracting
  - Establishing population health need
  - Planning a provider network
  - Linking contracting with planning
  - Evidence based contracts
  - Promote quality through contracts

However, many countries are struggling to do these things

Purchasing primary care

Effective stewardship

- Priorities and plans
  - Primary care a priority in National Health Plan but not clear (on targets)
- Accountability of purchasers and providers
  - Not clear how HIIS is made accountable for primary care services purchased
  - Not clear how primary care providers are monitored (
- Establishing an integrated regulatory fram
  - How should population health ... what data, methodology, et
  - Should HIIS define a p ... mary care providers? Or should this be done by ... regional governments?
  - Should HIIS/government/other institutions define standard contracts/treatment guidelines/quality standards
  - Responsibilities for developing the payment system?

Exact set-up is not important…
Important are clear roles and responsibilities

Purchasing primary care

Cost effective contracting

- Population health need
  - Debate concerning need for primary care physicians (number of patients/capitation points per primary care team)
- Provider network
  - No centralized/rational planning: concessions awarded by mayors
- Contracting in line with plans
  - General Agreement (and contract) negotiations
- Evidence based contracts
  - Contracts are relatively unspecific (co
    treatment in line with evidence/guide
- Quality
  - Contracts could be used more to ensu
  - Weak control and monitoring systems

However, many preconditions missing that need developing:
- planning criteria
- clinical guidelines
- process and outcome indicators

Improving purchasing: summary

1. Assess institutional set-up/capacities → Clearly define roles, responsibilities, lines of accountability
2. Improve National Health Plan → concrete prioriti… and targets
3. Improve efficiency of negotiati… …nd contracts) + include …
4. Strengthen the pu… …g role of the HIIS → reducing government intervention + better budget control
5. Improve contracts → more specific about indicators, quality, targets

Comprehensive approach best, but each point is a step in the right direction

Payment for primary care

Mixed remuneration system:

- Budgets for primary care teams (different for GPs, pediatricians, gynaecologists):
  - Calculated based on 2400 capitation points
- Within budget (reached relatively easily):
  - Capitation: about 50%
  - Fee-for-service: about 50%

  \+ preventive program payment
- 60% of GPs are employees, 40% self-employed

Primary care payment

Challenge 1: Inadequate age weighting of capitation payments

England:

- age and sex s[...] population
- proportion of populatio[...]ntial homes
- additional care needs of the popula[...] data)
- [...]new patients [...]
- [...]viders, e.g. higher wage co[...] rurality

Impossible to adequately adjust capitation payments without cost and utilization data

BUT very different weightings exist across countries
→ Even Scotland is very different!

Age-sex workload index (males aged 5-14 = 1) for UK except Scotland

	0–4	5–14	15–44	45–64	65–74	75–84	85+
Male	3.97	1	1.02	2.15	4.19	5.18	6.27
Female	3.64	1.04	2.19	3.36	4.9	6.56	6.72

Source: (BMA/NHS Employers, 2007)

Primary care payment

Challenge 2: Malfunctioning institutional arrangements for revising and updating the FFS system

		Responsible institutions	Regularity of updates
France	FFS catalogue	French National Health Insurance Fund (NHIF) in collaboration wit	irregular, 10 amendments between 4
	Base value	Negotiated betw	
Germany	FFS Catalogue	Valu deadlock prevent members, federal government has the right to intervene	FFS nor adjustments since then
	Base value	Negotiated between SHI Funds and Associations of SHI Physicians	Annually
Switzerland	FFS catalogue	A joint company (TARMED Suisse), intervene	in 4
	Base value	Ne providers	
USA (Medicare)	FFS catalogue	Cente basis	
	Base value	Parlia	

Physicians important for defining fees and relativities (within specialties) – but payers/government may overrule

Negotiated between payers and providers

Alternative: Include outpatient (secondary ambulatory) care in DRG system – maintained by DRG institution

Primary care payment

Challenge 3: Limited incentives for service provision and qualit

Netherlands | E

Objective	Payment	Netherlands	E	
Objective: appropriateness & outcomes	Quality payment		Q (25-30%)	(ma 0%)
Objective: productivity & patient needs	Extra service payment	FFS (per visit & out-of-hours), (40-45%)	FFS ("enhanced services"), (<10%)	FFS (per visit), 10-20%, Stockholm 60%)
Objective: admin. simplicity & cost-containment (& geogr. equity)	Basic service payment	Capitation (55-60%)	Capitation (65%)	Capitation (80-90%, Stockholm 40%)

BUT
- Requires a functioning FFS system, and
- Unintended incentives have to be monitored

Payment of physicians

Challenge 1: Rigidity of the civil servant pay scale

	How are salaries set (for specialists in hospitals)?		Which criteria define different income levels?
	Responsible entities	Frequency of revision	
England			
Germany			
Sweden			
The Netherlands			

Specific contracts and salary scales for physicians:

Options for flexibility

1. Bonuses – England
2. Individual negotiations – Sweden, Germany, Netherlands
3. (Right to) FFS income

Payment of physicians

Challenge 2: Insufficient incentives for productivity and quality

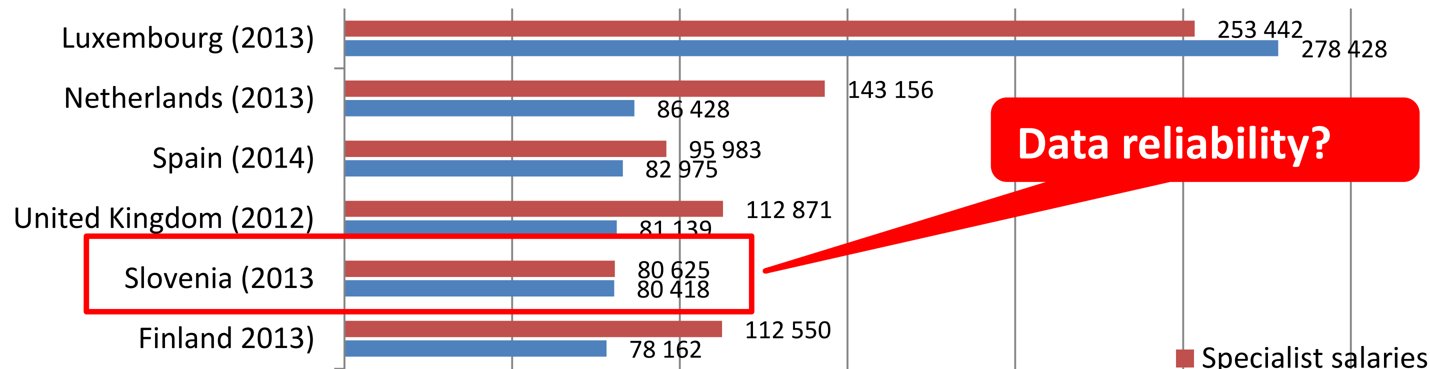
England – most systematic system for bonuses

- Clinical Excellence Awards for employed specialists
- Quality and Outcomes Framework for GPs

Other countries: bonuses linked to FFS income, quality bonuses (e.g. Latvia)

Payment of physicians

Challenge 3: Insufficient remuneration of primary care physicians?



Maybe payment is not the main reason why family medicine is an unattractive specialty?

→ Improving working conditions
→ Increasing training capacity – number of training places
→ Increasing status: Academic positions for family medicine
→ Aligning training requirements with those of other specialists

Summary: Main challenges

1. **Institutional/regulatory challenges:** capitation/FFS system updates, rigidity of civil servant pay scale.
2. **Inadequate payment levels:** lack of cost data for calculation/adjustment of capitation/FFS payments.
3. **Weak incentives for efficiency and productivity:** budgets are easily reached, pay scale does not reward performance (in terms of productivity).

Lessons from other countries

- Clearly assigned institutional responsibilities are essential
  - for developing payment systems and
  - for maintaining systems up-to-date
- Payment adequacy can be improved by
  - increasing availability of data for calculation of capitation rates
  - improving mechanisms for updating FFS weights, and
  - Reforming the salary scale
- Providing stronger incentives for efficiency (and quality) can be achieved by
  - Changing the relative importance of different payment mechanisms (FFS, capitation … and potentially P4P)

Thank you!

For more information:

www.euro.who.int/observatory

www.mig.tu-berlin.de

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Potential for P4P?

Quality can be promoted through other (less contentious) mechanisms

- P4P provides financial incentives to promote quality (sometimes more broadly: other performance)
- P4P requires:
  1. Clearly assigned ins[...] y management
  2. Valid indicators (structure[...] and accepted by stakehol[...]
  3. Reliable measurement and reporting of indicators
  4. Strong mechanisms for monitoring data quality and provider behaviour (to prevent unintended effects – in non-measured areas)
  5. Mechanism for risk-adjustment
  6. Appropriately designed incentives

A well functioning purchasing process

Improved functioning of existing payment systems

Often introduction of P4P requires many years, starts in pilot-projects