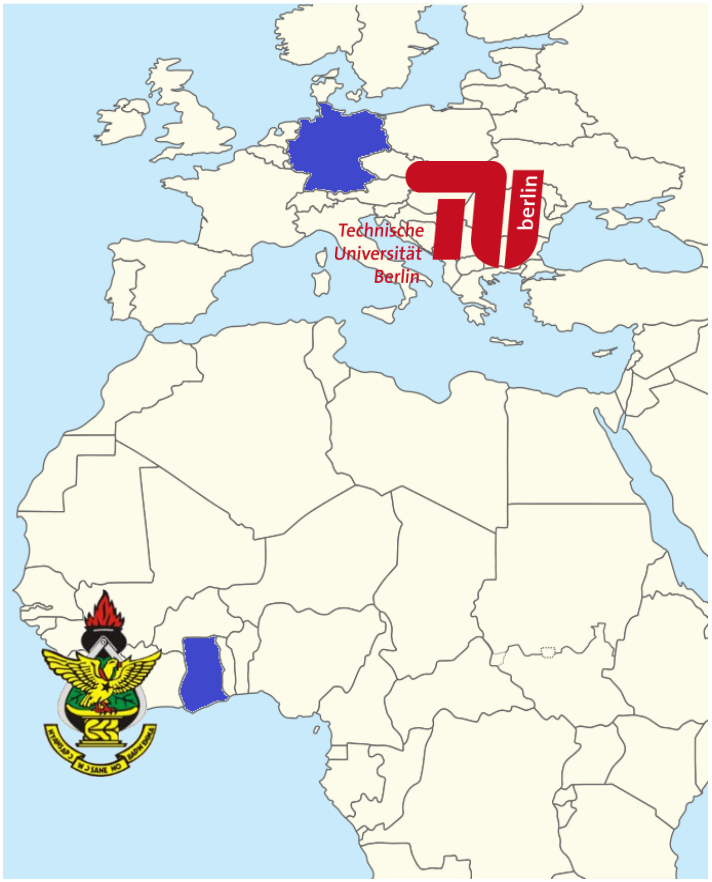
HSRM
Capacity-building in Health Systems Research and Management

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Health Systems: Goals, Functions, Actors
Financing 2



Wilm Quentin

Department of Health Care Management,
Technische Universität Berlin

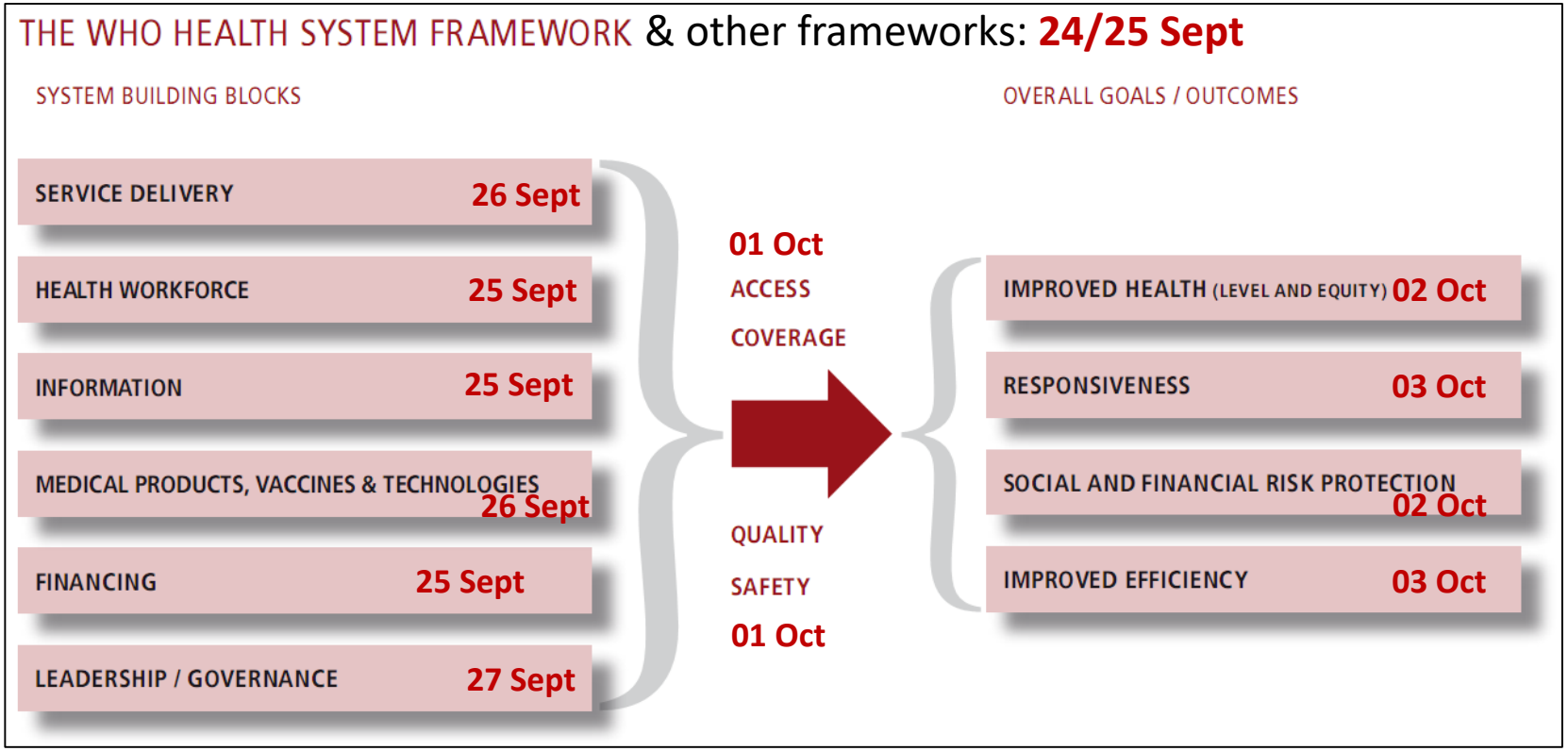
European Observatory on Health Systems and Policies
WHO Collaborating Centre for Health Systems Research and Management

PAGEL
Partnerschaften für den Gesundheitssektor in Entwicklungsländern
DAAD

KNUST-SPH
SCHOOL OF PUBLIC HEALTH

MiG
Management im Gesundheitswesen

Guiding framework for the module

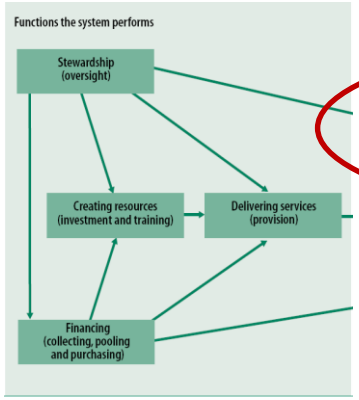


Summary: **27 Sept**

Performance assessment: **03 Oct**

WHO 2007

Functions



Financing II: Resource pooling & allocation

Collector of resources → **Third-party Payer**

Financing III: Purchasing/ contracting/ paying providers

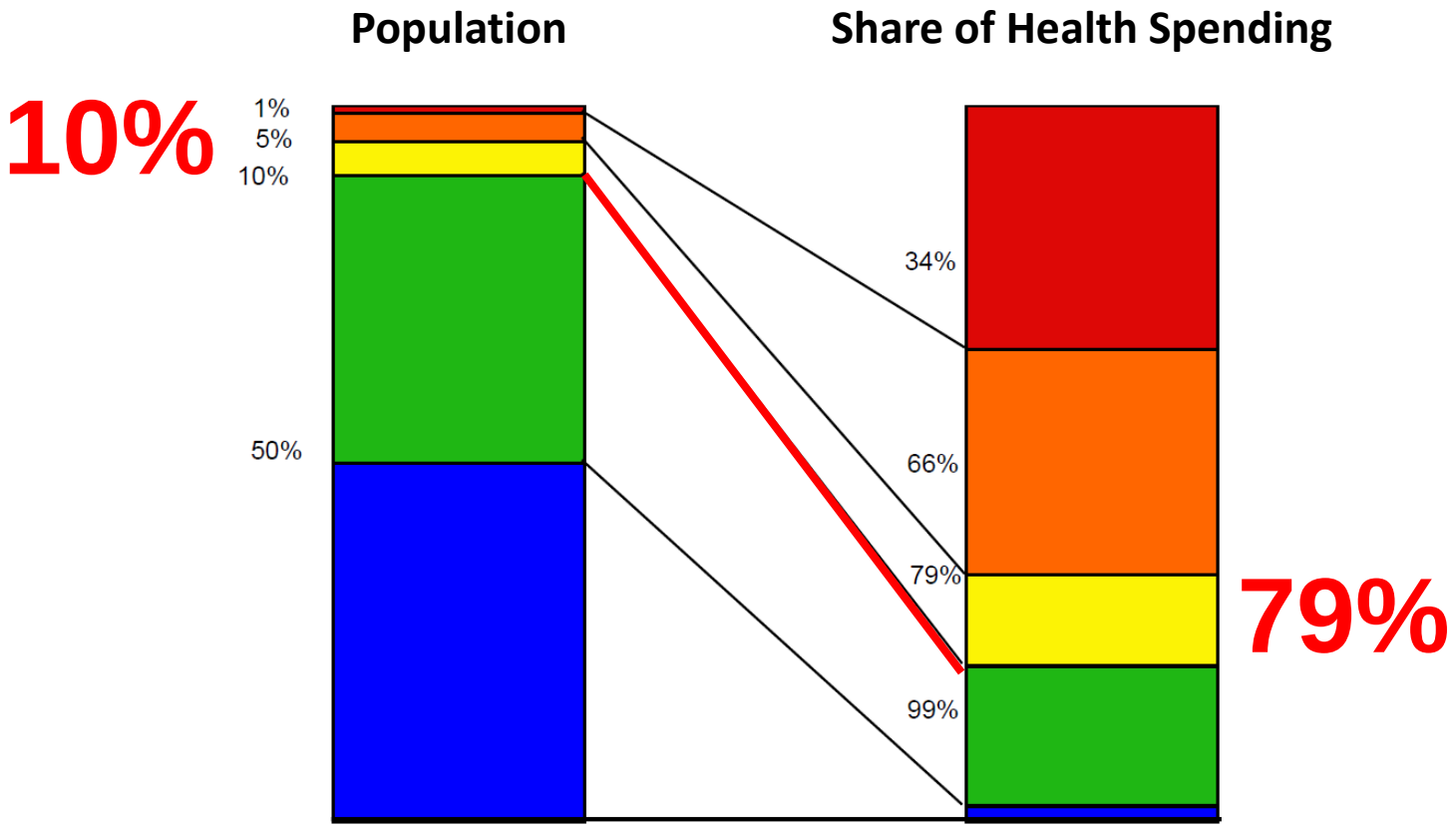
Steward/ Regulator

Population

Providers

Expenditure is highly skewed I

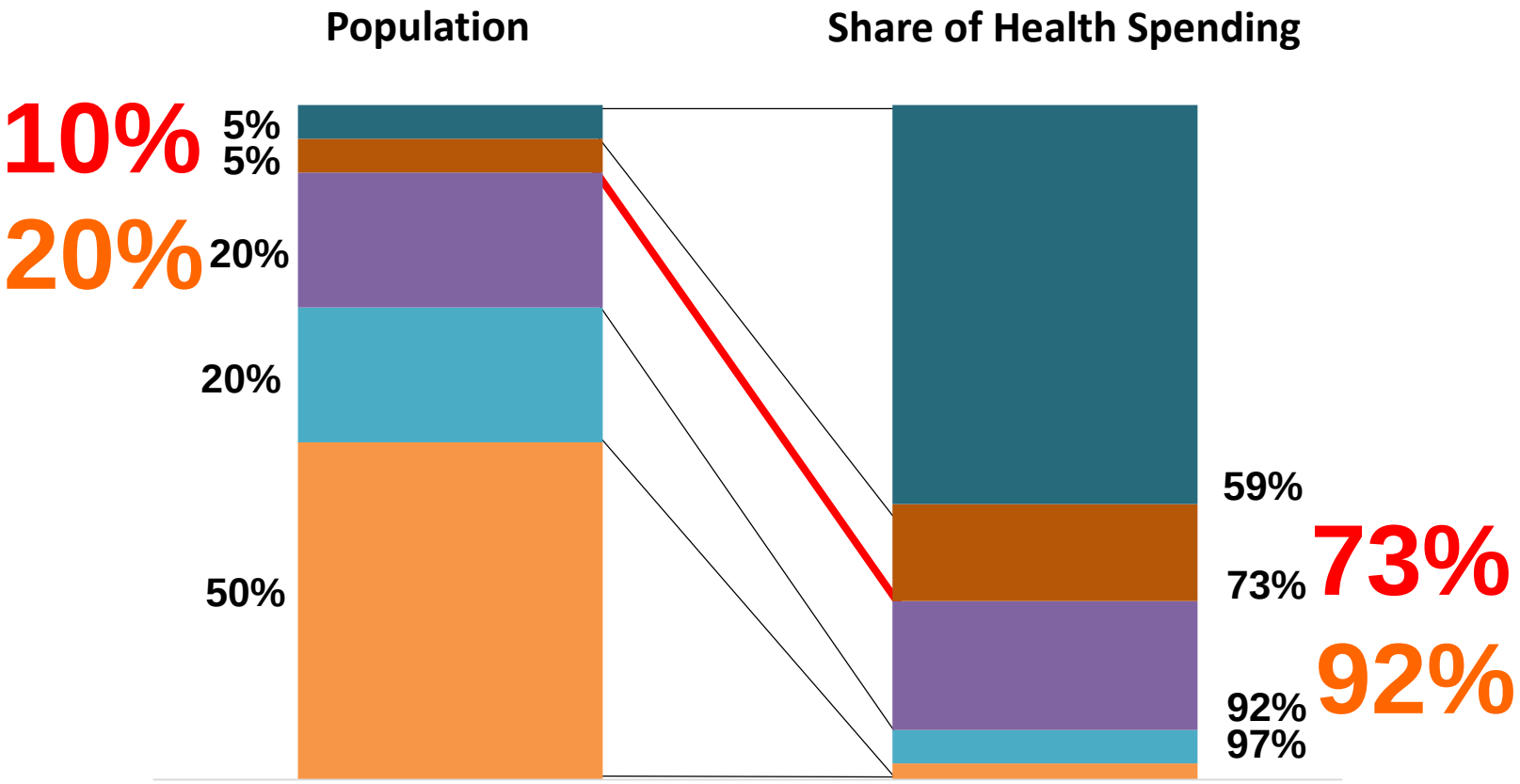
Ontario, Canada (2008)



Source: BMC Health Services Research 2014

Expenditure is highly skewed II

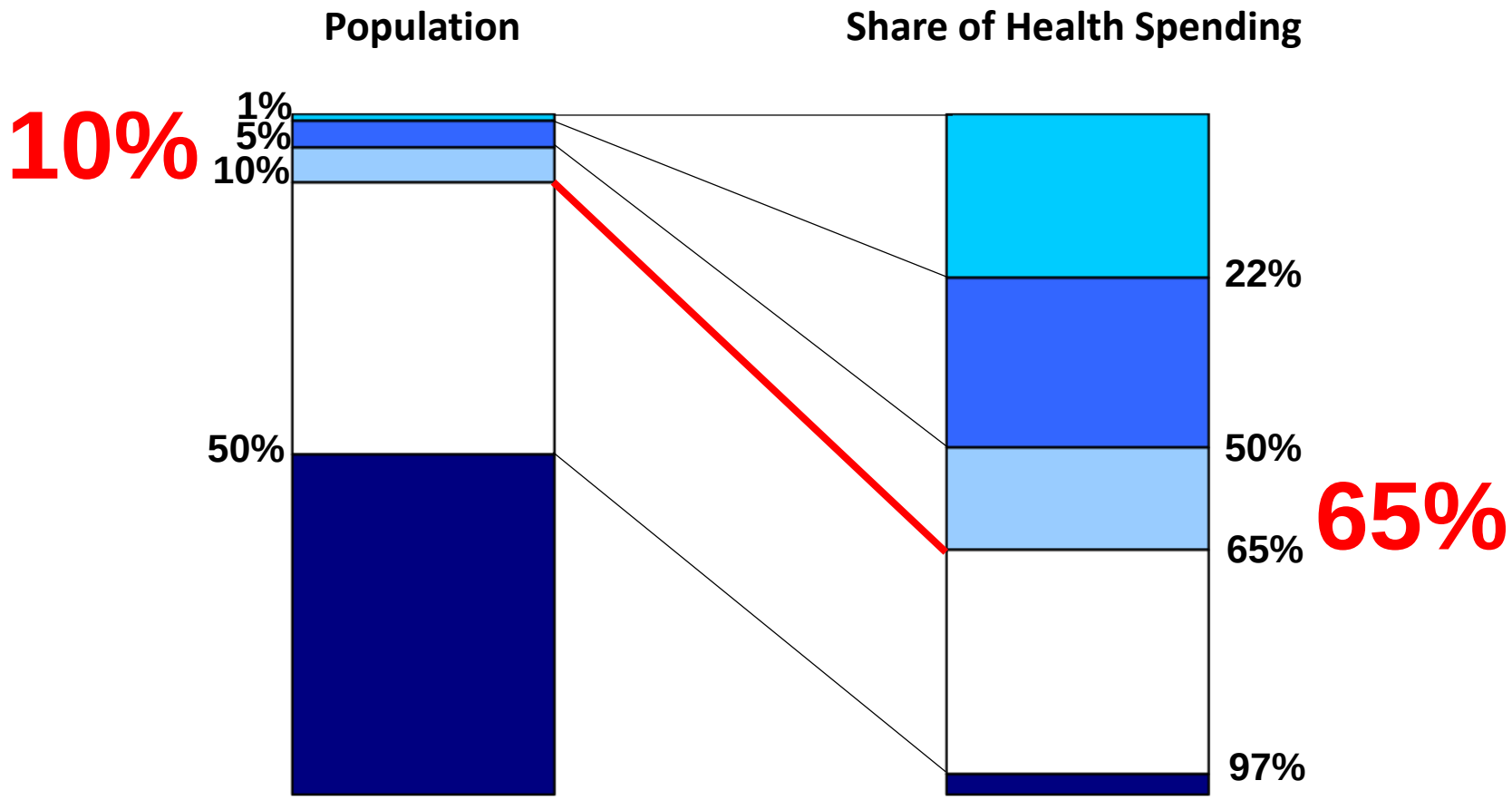
Denmark (2012)



Source: Institute for Fiscal Studies 2016

Expenditure is highly skewed III

USA (2014)

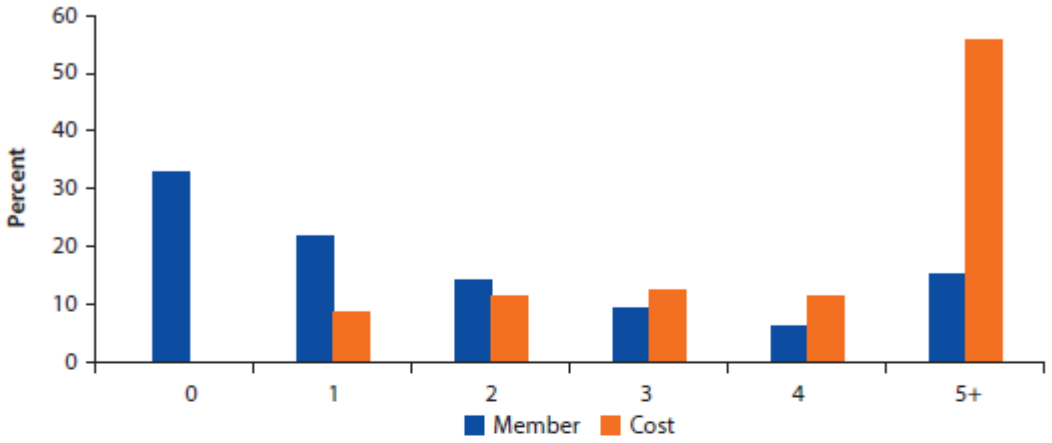


Source: Agency for Healthcare Research and Quality analysis of 2014 Medical Expenditure Panel Survey

Expenditure is highly skewed IV

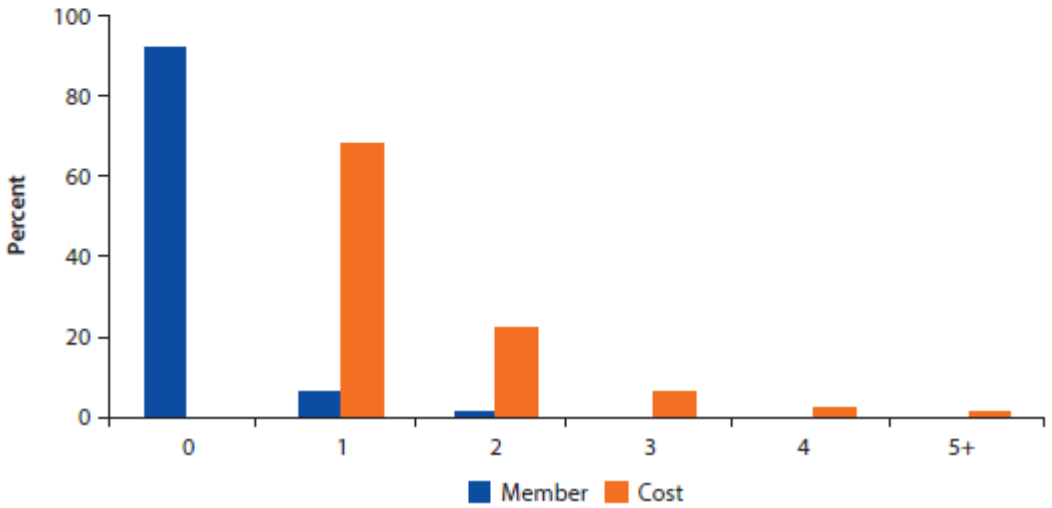
Ghana (2014)

Figure 4.13 NHIS Members and Claims Expenditures, by Number of Outpatient Visits, Volta, 2014

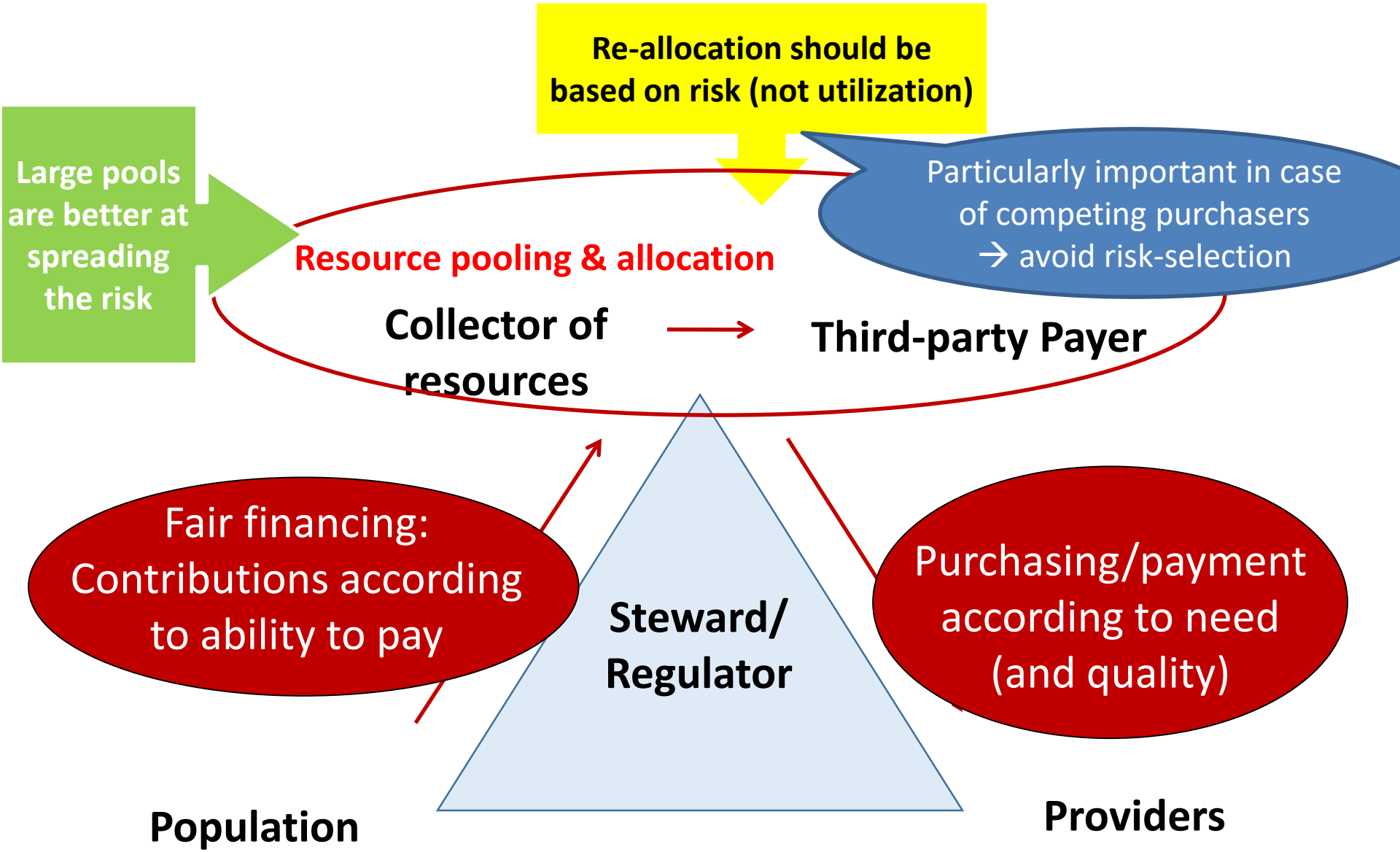


Source: Ghana NHIS claims expenditure in Volta region.

Figure 4.14 NHIS Members and Claims Expenditures, by Number of Inpatient Admissions, Volta, 2014



Pooling and (re-)allocation is important

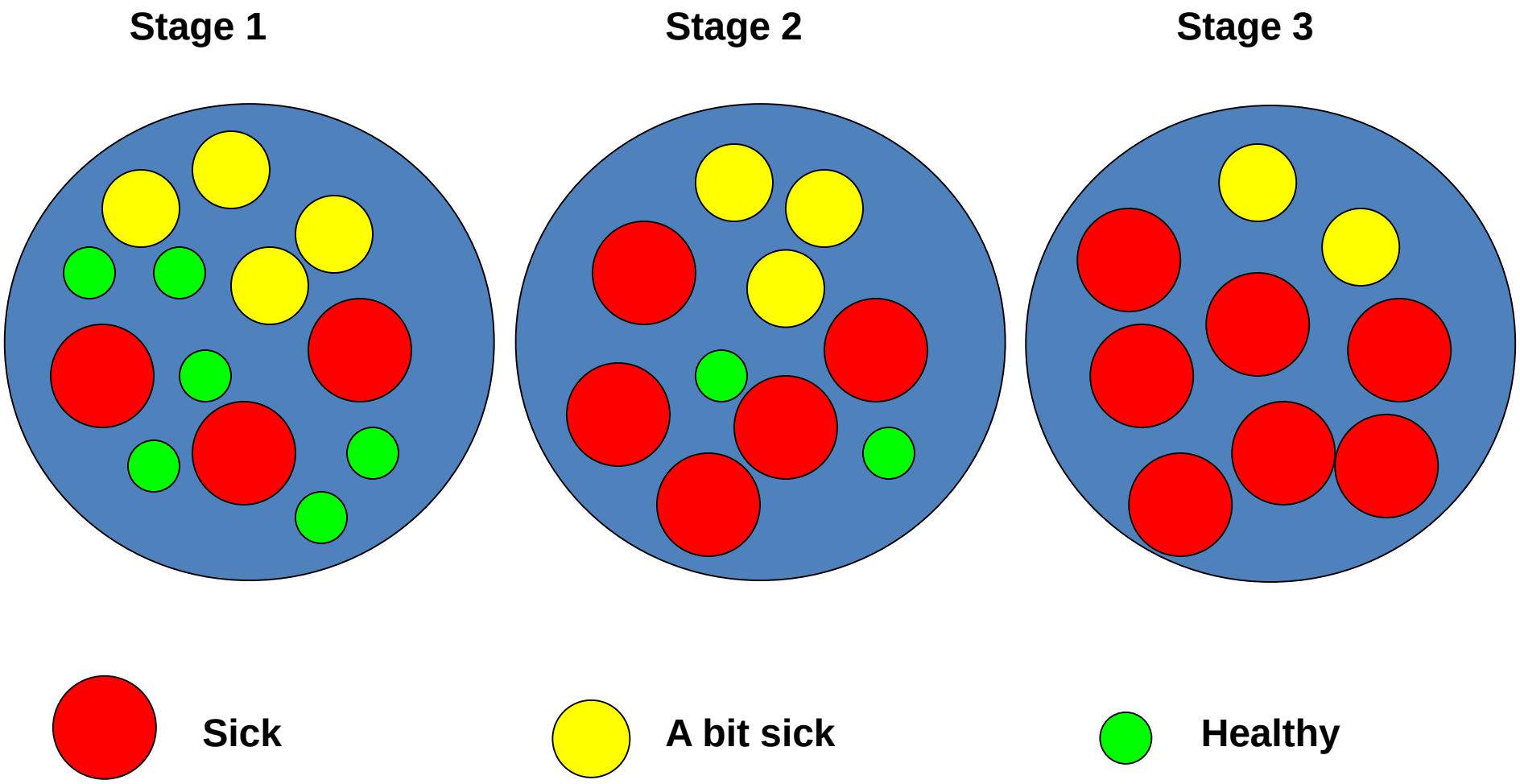


Problems of (limited) pooling

1. Risk selection and adverse selection

Adverse selection

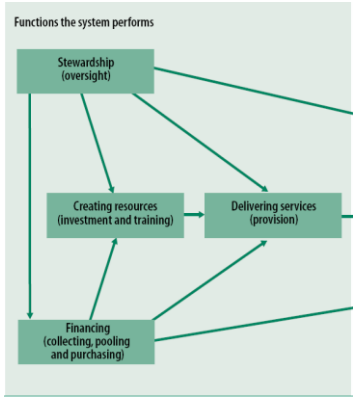
(problem with non-mandatory insurance)



Problems of (limited) pooling

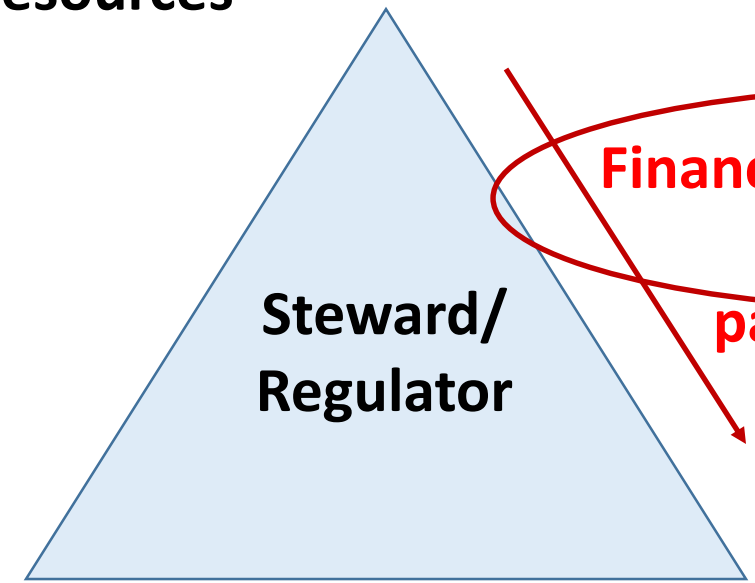
1. Risk selection and adverse selection
2. Vertical inequities (rich – poor):
   insufficient funding for health care of the poor
3. Horizontal inequities:
   differences across regions/ health insurance funds

Functions



Financing II:
Resource pooling & allocation

Collector of resources → Third-party Payer



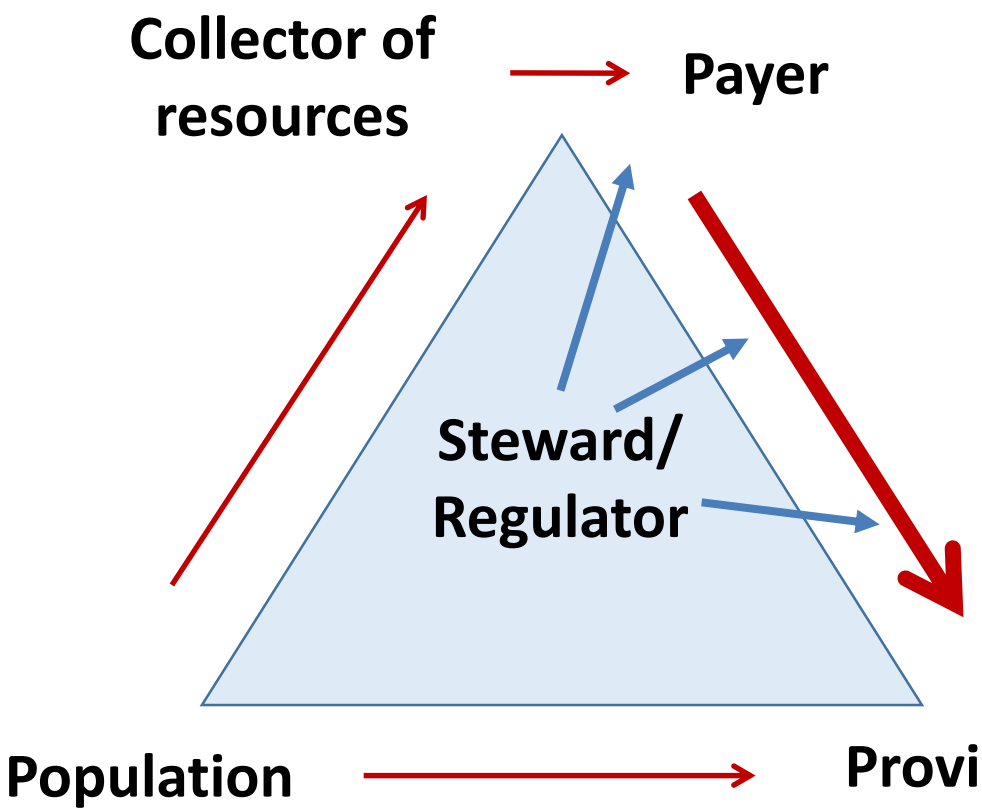
Financing III: Purchasing/ contracting/ paying providers

Population

Providers

What is purchasing?

What is purchasing?



- What services?
- How much?
- From whom?
- How to buy?

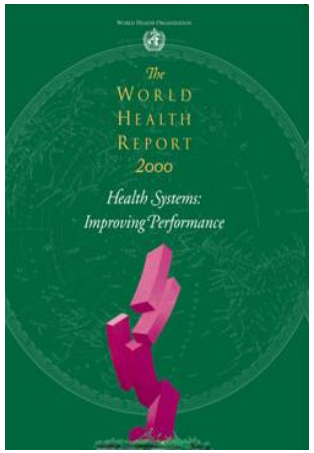
- Who should buy?
- For whom?

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

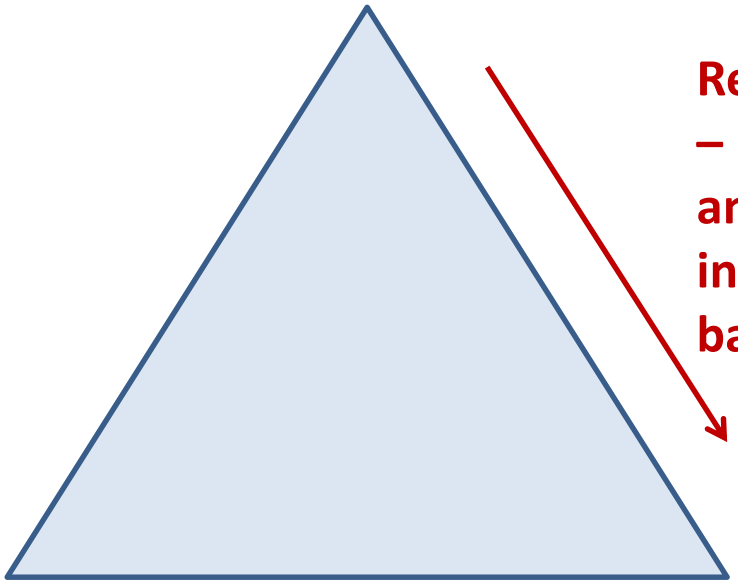
Origins of the idea of strategic purchasing

- Ideological context
  - 1990s: 'New Public Management' ideas influenced public service reforms especially in US, UK, Australia, New Zealand
  - World Bank influential with World Development Report 1993: *"for some services provided by the public sector, the system of provision is so grossly inefficient that it is unlikely to be cost-effective… Such inefficiencies have been criticised so clearly and for so long that it is evident that they will only be overcome by radical changes in the organisation of health care - such as a shift in the government's role from providing care to financing care and stimulating competition between providers"*
- Historical context
  - from traditional integrated systems to new NHS type system

Passive purchasing



Passive Purchasers (MoH, region, sickness funds)



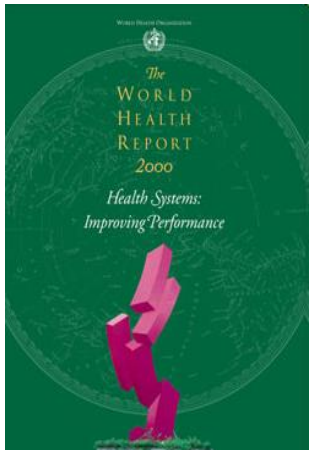
Resource allocation – based on geographical and (more often) institutional/ historical basis/ paying bills

Providers

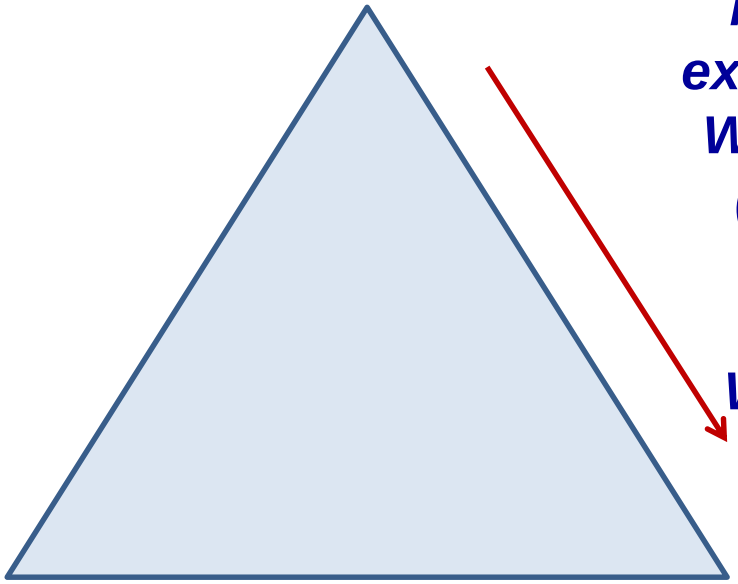
Advantage: providers know budget in advance / can influence their revenues

Disadvantage: not based on actual workloads, outcomes or new technologies

Strategic purchasing



Active Purchasers (MoH, region, sickness funds)

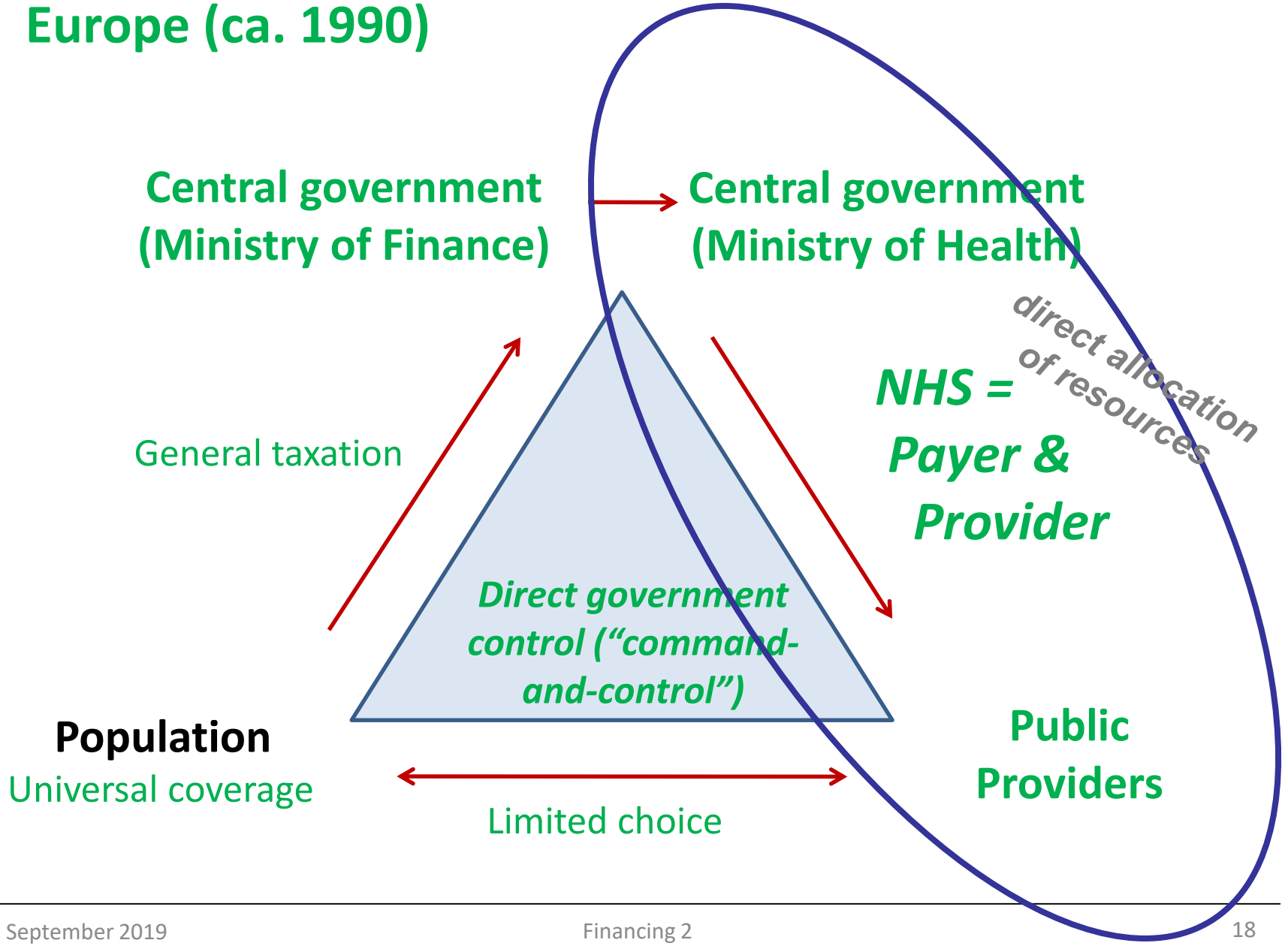


Purchasing based on contracts: explicit decisions about WHICH intereventions (cost-effectiveness, needs), HOW (incentives), FROM WHOM (quality etc.)

Providers

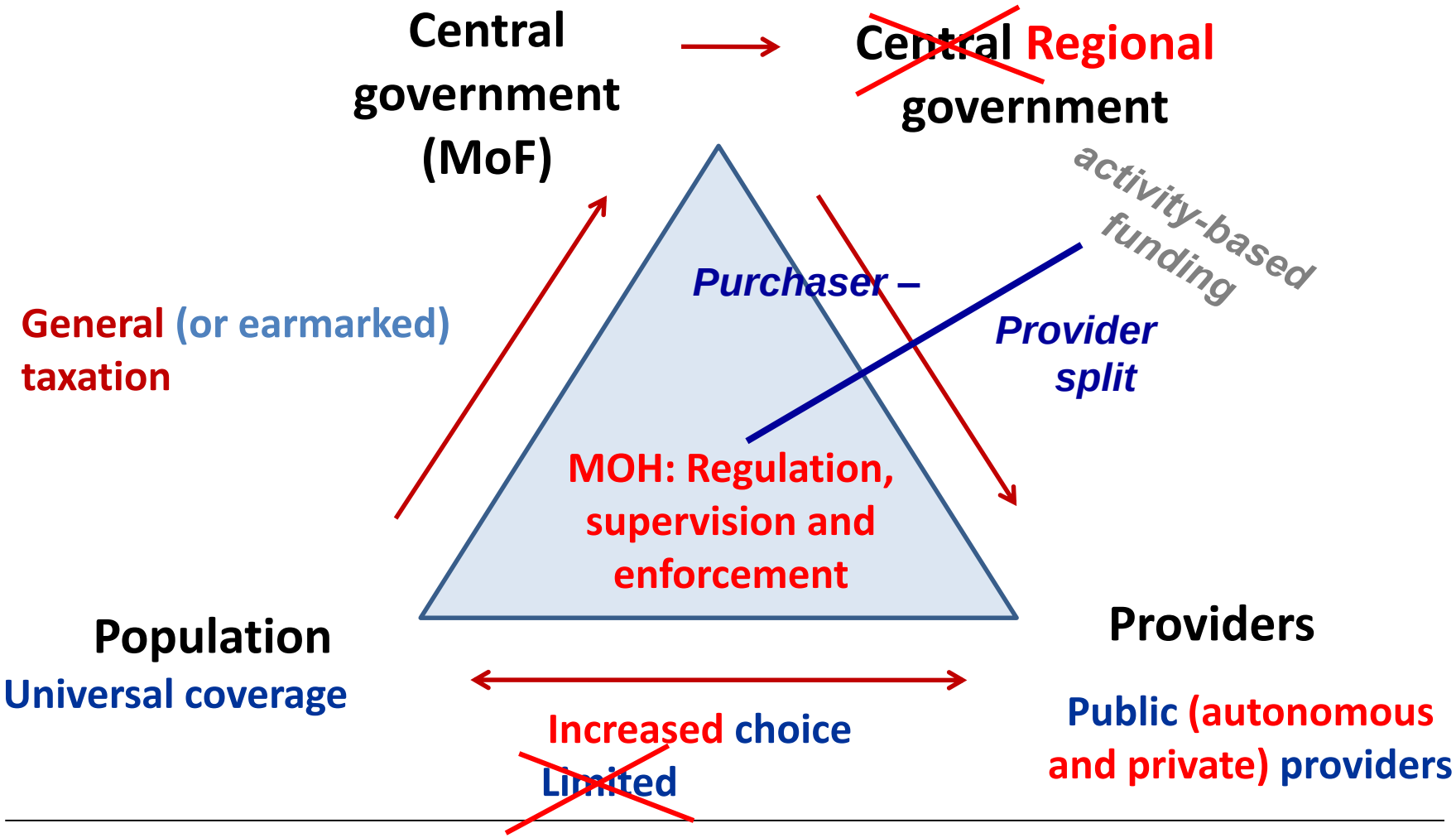
Advantage: services (ideally) financed according to population health needs, cost-effectiveness etc.
Disadvantages: requires information which is often not available or comparable

Traditional integrated NHS-type system in Europe (ca. 1990)



New NHS-type systems in Europe

→Convergence with SHI systems

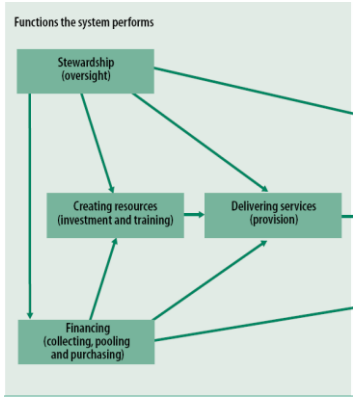


Purchasing in theory... it ought to work!

- Links resource allocation to plans/ priorities
- Gives levers to influence provider behavior
- Encourages management decentralization
- Enables purchaser and provider competition

→ ***Improves performance!***

Functions



Financing II:

Resource pooling & allocation

Collector of resources → **Third-party Payer**

Financing III: Purchasing/ contracting/ paying providers

Steward/ Regulator

Population

Providers

Aims of provider payment: What do we want providers to do? That…

- they care for patients when they need care? … and do not risk-select …
- they provide services? … and are not idle …
- services are provided only if appropriate? … and not unnecessarily …
- expenditure is well controlled? … and not sky-rocketing …
- services are efficiently provided? … and money not wasted …
- service provision is transparent? … and not opaque …
- provided services are of high quality? … and do not endanger patient safety …

Basic forms of payment

- **Fee-for-service (FFS):** every single service is paid separately (each ECG, each physical examination …)
- **Capitation:** a provider (most often a general practitioner) receives a sum of money per patient per year (or 3 months) for all services for that patient during that period
- ***Per diem:*** *an inpatient provider recives a sum of money per patient per day (independent of diagnosis and threatment)*
- **Diagnosis-related group (DRG)** payment: a provider (usually an acute care hospital) receives a sum of money for a patient depending on diagnosis for all services (from admission to discharge including surgery, pharmaceuticals …)
- **Global budget** (for hospitals/ institutions) and **salary** (for physicians): a fixed sum of money for all patients treated within a certain period of time

Advantages and disadvantages of different <u>hospital</u> payment mechanisms

Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number of cases	Number of services/ cases					
Fee-for-service	+	+	+	—	0	0	0	—

Risk of overtreatment

Advantages and disadvantages of different <u>hospital</u> payment mechanisms

Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number of cases	Number of services/ cases					
Fee-for-service	+	+	+	—	0	0	0	—
							Risk of overtreatment	
Global budget	—	—	—	+	0	—	0	+
							Risk of undertreatment	

Advantages and disadvantages of different hospital payment mechanisms

Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number of cases	Number of services/ cases					
Fee-for-service	+	+	+	—	0	0	0	—
DRG based case payment	0	+	—	0	+	+	0	—
Global budget	—	—	—	+	0	—	0	+

Advantages and disadvantages of different physician payment mechanisms

Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number of cases	Number of services/ case					
Fee-for-service	+	+	+	—	0	0	0	—
							Risk of overtreatment	
Salary	0	—	—	+	0	—	0	+
							Risk of undertreatment	

Advantages and disadvantages of different physician payment mechanisms

Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number of cases	Number of services/ case					
Fee-for-service	+	+	+	—	0	0	0	—
Capi-tation	— (if not risk-adjusted)	+	—	+	+	—	0	0
Salary	0	—	—	+	0	—	0	+

Conclusions

- Pooling and (re-)allocation are important to ensure purchasing and service provision according to need and – in case of purchaser competition – to avoid risk-selection.
- Resource allocation should be based on risk, i.e. health needs of the population covered by purchaser
- Strategic purchasing can – in theory – contribute to improving performance… but difficult to implement.
- Payment systems have far reaching consequences for efficiency and quality of care. Blended payment systems (combining basic mechanisms) can reduce unintended incentives of basic payment mechanisms

Thank you very much!

Health System Financing will be further explored in the Financing module 4 Nov – 15 Nov.