

# *Technical Briefs for Policy-Makers*

**Number 2  
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**PROVIDER PAYMENTS  
AND  
COST-CONTAINMENT  
LESSONS FROM OECD COUNTRIES**



*Department of Health Systems Financing  
Health Financing Policy*

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## PROVIDER PAYMENTS AND COST-CONTAINMENT LESSONS FROM OECD COUNTRIES

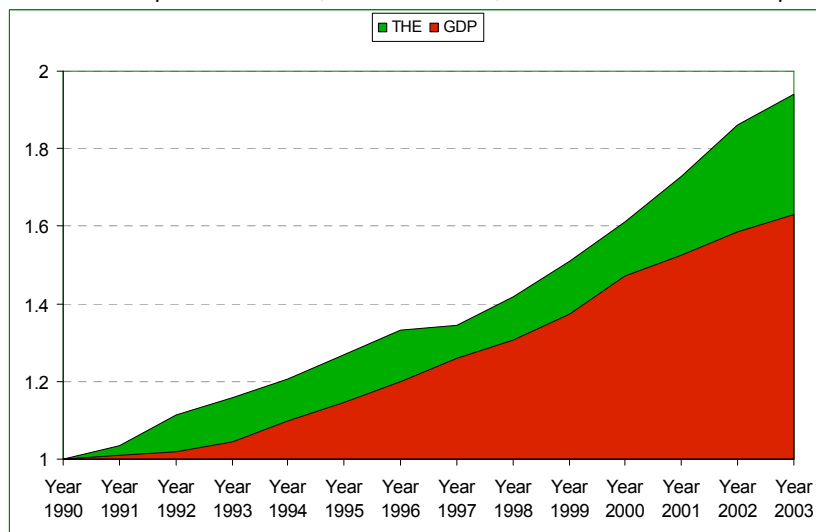
Historically the OECD countries have struggled to curb their public spending on health care through the use of both demand-oriented and supply side regulations. Empirical evidence suggests that the simultaneous use of different provider payment methods can restrain expenditure on health while maintaining good quality care and fair access to services. Regulatory commitment is necessary to maximize the efficiency of these tools.

### *The need for health care cost-containment*

To a large extent, the pressures for cost-containment are attributable to the higher growth rate of health spending compared to aggregate income. One reason is that because of aging more medical services are needed. Further medical technology advanced remarkable in the last years, so treatments often have become more expensive. Intervention for cost-containment is deemed necessary when 'capacity to pay' of the economy as a whole is lower than the costs of the population's health care requirement; generally the latter relates to budget constraints in the public sector as well as to limits on what households can afford to allocate to health from their incomes.

Figure 1 shows that both GDP and total expenditure on health care (THE) have increased in the OECD<sup>1</sup> countries, with the rate of growth of THE systematically being higher. The red area indicates the gap from the disproportional increase in health spending. Since 1997 this gap has widened: illustrated by THE accounting for 8.8 % of GDP in 2003 compared to 7.8% in 1997.

Figure 1. Nominal average growth rate of GDP and THE in the OECD countries (1990 as reference point: GDP =16,033 and THE=1,205 at international dollar per capita).



<sup>1</sup> The OECD refers to Organization for Economic Cooperation Development and has 30 member countries: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Japan, Republic of Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak, Spain, Sweden, Switzerland, Turkey, UK, and USA.

### ***Overview of cost-containment instruments***

The introduction of cost containment instruments dates back to the 1970s during the global economic recession but its pervasive use in the OECD countries has only been apparent since 1990 due to the occurrence of public deficits in several OECD-countries, especially in the period 1990-95. Cost-containment instruments can be classified into four groups, on the basis of whether they are monetary or non monetary and designed to target providers or consumers.

Currently the OECD countries widely use monetary incentives to restrain consumer demand in the form of co-payments: consumers have to meet part of the cost of services out-of-pocket and health insurance and/or government pays the rest. They also use many non-monetary incentives to regulate provider behavior, including clinical guidelines, clinical pathway management or the use of standardized evidence-based treatments. However, attention has focused increasingly on the use of monetary incentives targeting providers.

### ***Provider payment schemes and their impacts***

Most would agree that the level and structure of provider payments are a core element for influencing providers' behavior. To pay providers has been an area of contention among policy makers. The most prevalent provider payment methods among OECD members are salaries, fee-for-service payments, diagnosis related groups, capitation or per-diem payments. Another way of paying providers is via a budget remunerating a set of pre-defined health-related activities in a lump-sum fashion. For the sake of this technical brief, we focus on individual doctors and hospitals as providers.

#### ***Salary***

All OECD countries make a partial or complete use of salaries for paying doctors, whether they are working as individual doctors or within the context of hospitals. Under salary payment doctors' income is not linked to output such as quantity of items or quality of services. Therefore, salaried doctors in the public sector are often associated with low motivation, low productivity and low quality of services. Recently, however, salaries are also being combined with capitation and performance based components to promote motivation as well as higher productivity and quality.

As personnel costs are only one part of the total treatment costs it is important to see in which context salaries are used as a provider payment method. For example there can be a notable impact from hospital management on hospital doctors' treatment decisions if salaries are paid under strict budgetary limitations, prompting doctors to favour low cost treatments and perhaps tolerating treatments of lower quality.

#### ***Fee-for-service (FFS)***

The FFS method pays providers according to number of services delivered. As it gives them a strong incentive to deliver more and lucrative items, FFS can be a bad instrument for containing costs. Nonetheless, especially in ambulatory care, FFS has been popular in several OECD countries where the majority of physicians are private; for example, it has been an important payment method in Belgium, Germany, Japan, the Republic of Korea, Switzerland and the US. In those countries patients enjoy the freedom to directly choose their physician and generally benefit from an adequate access to health care services. Doctors working within this FFS framework also undertake efforts to improve the quality of health care services in order to attract more patients.

There are situations, however, where FFS can be made coherent with cost-containment policy. For example, in Germany in the last years FFS payments are combined with sectoral budgets for ambulatory care. Each type of service is linked to a specific number of points. The value for each

point is obtained by dividing the sectoral budget for ambulatory care by the total number of points 'produced' by all general practitioners. A doctor's final remuneration (paid on quarterly basis) is then equivalent to the total value of the points he 'earned' through his provision of health services.

### ***Diagnosis Related Groups (DRG)***

The Diagnosis-Related Groups (DRG)-system is a patient classification system developed to classify patients into groups economically and medically similar, expected to have comparable hospital resource use and costs. Under DRGs providers are reimbursed at a fixed rate per discharge based on diagnosis, treatment and type of discharge. Therefore DRGs have a strong incentive for cost containment. As the remuneration refers to diagnoses and procedures, providers are motivated to deliver services as cost-effective as possible with the shortest possible length of stay. On the other hand, concerns about premature discharges, selection of low-cost patients and the increase of admissions should be dealt with. Therefore quality and monitoring measures are essential to avoid negative side effects.

The first DRG payment system was introduced in 1983 for US Medicare. By now a form of DRG-system is adopted by several OECD members. Australia began to pilot the American system in 1985 and has now developed its own DRG-system. As recent examples, since 2003 Germany is developing its own DRG-system based on the Australian system. Switzerland decided to use the German base for the future introduction of Swiss-DRGs.

### ***Capitation***

With capitation scheme providers are paid a fixed amount of money on the basis of number of patients for delivering a range of services. The predominantly tax-based health financing systems in Italy and the UK have adopted this payment method for general practitioners (GPs) to provide primary care to the population.

Underprovision of services within the risk group, for which a particular flat-rate capitation amount is applicable, is a problem to be dealt with. Adjusted capitation payment according to patients' profile such as age and sex can help guaranteeing quality of service and equitable access, by stimulating GPs to accept and treat patients with various characteristics rather than shifting a number of them to specialists or hospitals. In the US, capitation payments are pervasive in both outpatient and inpatient care, especially within the framework of Health Maintenance Organizations (HMOs) or managed care plans.

### ***Per Diem***

Daily payment gives hospitals a strong incentive to increase the number of admissions and to extend the length of stay, thereby enhancing health expenditure. Norway abandoned per diem payments at the beginning of the 1980s and over the past years health reforms in the OECD countries confirm the trend of a limited use of daily payment. For example, an excessively high length of stay under the per diem payment scheme was one main reason for Germany to introduce DRGs for the remuneration of inpatient care.

### ***Budget***

Since 1970s budgets have been introduced as health care cost-containment instruments in a substantial number of OECD countries. One can first distinguish budgets for the whole health care system, and budgets for parts of it such as for ambulatory care, hospital care, pharmaceuticals etc. These are referred to as global and sectoral budgets, respectively. Budgets are also being set for health facilities such as hospitals, as is the case in France. However, this does not preclude hospitals from using other provider payment methods. For example, DRGs may

well be used to remunerate specific hospital departments, all the while respecting a pre-determined budget for the hospital as a whole. In this sense, budgets are different from other provider payment schemes: they are used more to allocate pre-determined amounts of money to providers, thereby setting the framework for the subsequent introduction of other provider payment schemes.

Whether cost-containment can be achieved, depends on the type of budget and its rigidity. First, to reflect the degree of rigidity, one can distinguish hard and soft budgets. Under *hard* budgets providers are fully responsible for all profits and losses while *soft* budgets entail a fixed amount of spending but without penalty in case of excess. Therefore, the hard type is more effective for cost-containment but may reduce access and quality of services or produce waiting lists. In terms of cost-containment potential, only hard global and sectoral budgets are effective. With soft budgets, the risk of overspending is large. For example, a system of sectoral budgets may raise overall health expenditure due to shifting of patients and their need for health services to other sectors.

The findings on advantages and disadvantages of different provider payment methods used in OECD countries are summarized in table1.

Table1. Summary of advantages and disadvantages of alternative provider payment methods

<b>Provider payment</b>	<b>Potential Advantages</b>	<b>Possible Disadvantages</b>	<b>Empirical Evidence of a selected country</b>
<b>Salary</b>	Cost containment, equitable provision, easy administration	Low productivity, low quality of service, low moral of providers, informal payment with out -of-pocket money	In Hungary, most medical specialists are public employees and salaried. Physicians receive the bulk of informal payments. Since 2002, the current government has raised the salary by an average of 50% to tackle the problem.
<b>Budget</b>	Cost containment, simple to administrate	Low investment in technologies, selection of patients, patient shifting, substitution costs under sectoral budget	The German hospital care system uses flexible budgets to control expenditures. Every hospital has a budget. In case of exceeding this budget hospitals get only the variable costs of the DRG remuneration inside the budget corresponding to around 35 % of the surplus. Therefore hospitals have a strong incentive to stay inside the budget.
<b>DRG</b>	Cost containment, cost-effective treatment, reduction in unnecessary care	Selection of patients, increase in admission, premature discharge, monitoring cost, under-treatment	In Australia DRG payment is considered to be efficient but criticized for 'quicker but sicker discharge'. Attention now is being paid to developing comparable measures of quality and health outcomes.
<b>FFS</b>	High accessibility, high quality in the presence of competition	Overprovision, high administration cost	The Belgian reforms in 1990s were focused mainly on eliminating abuse, inefficiency, over supply and over consumption resulted from the nature of FFS system.
<b>Capitation (GP based care)</b>	Cost containment, provision of preventive care	Under provision, increase in referral to hospitals and specialists, low quality of care	In Spain general practitioners receive a fixed salary plus a capitation component. This can depend either on the age of patients they treat or the nature of the population in their service area, e.g. the percentage of the population over 65 years of age. The exact kind of capitation component depends on the province as it is responsible for the regional health system.

Provider payment	Potential Advantages	Possible Disadvantages	Empirical Evidence of a selected country
Per diem	Simple administration, more attention given to patients	Increase in number of admission and length of stays, provision of less cost effective treatment	Until 1995, Luxembourgian hospitals were financed mainly on the basis of a uniform per diem payment. Following a financial shortfall the government abolished it and introduced a prospective payment system.

### *Simultaneous use of provider payment schemes*

Generally speaking, salary, budget, and capitation are expected to have a strong effect on cost-containment but cause concerns on low productivity and quality. In contrast DRG, FFS, and Per Diem encourage providers to deliver more and better services but give no incentives for restraining costs, unless these forms of provider payment are applied within the framework of hard budgets or in the case of a competitive environment.

Historically different types of providers in the same country have been paid according to different methods. However, reforms in the OECD countries demonstrate a movement towards the simultaneous use of different provider payment methods, in other words paying the same provider in different ways. For example, the Finnish government remunerates its physicians under the personal doctor system as follows: a basic salary (60%), a capitation amount (20%), FFS (15%) and a local allowance (5%). The rationale behind a mixed payment system is that a combination of alternative methods can compensate for the weakness of a single provider payment scheme.

Some reform experiences with mixed payment methods in the OECD countries are presented in table 2.

Table 2. Combination of provider payment methods

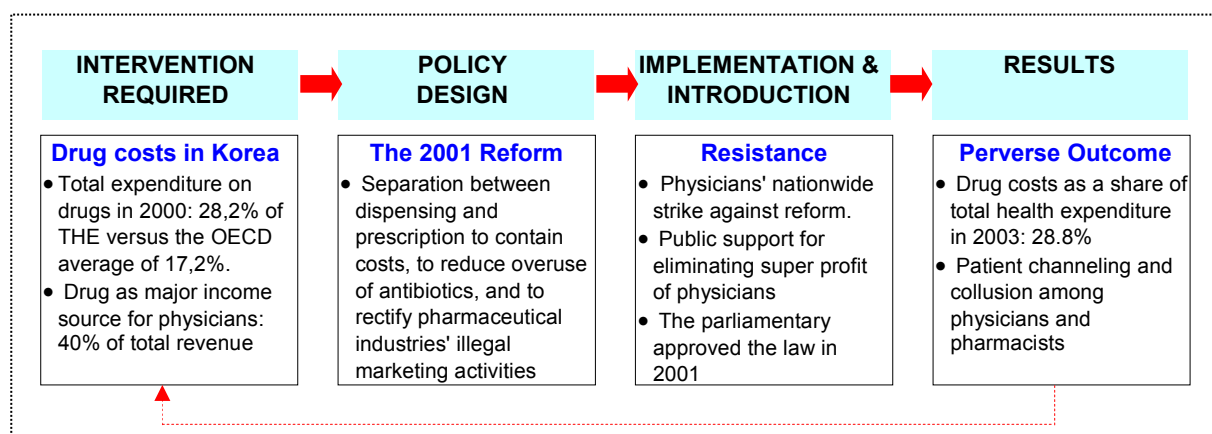
Combination	Countries	Theoretical background	Reform Experience of a selected country
<b>Capitation + FFS</b>	Czech, Denmark, Finland, Italy, New Zealand, Norway, Portugal, Slovakia, UK	FFS encourages providers to reduce number of referrals to hospitals.	The 1992 and 1999 Italian reforms complemented the basic capitation fee given to GPs and pediatricians with additional FFS remuneration for specific treatments (e.g. minor surgery, preventive cares, post surgery follow up).
<b>DRG + Budget</b>	Australia, Czech, Denmark, Germany, Hungary, Italy, New Zealand, Norway	The case mix adjusted budget will improve accessibility of services	In Portugal the case-mix adjusted component of each hospital budget has been increased; the implementation of the model started in 1997 as 10% DRG-based and reached 50% in fiscal year 2002.
<b>FFS + Budget</b>	Czech, Hungary, Netherlands, Poland	The tendency of overprovision of services under FFS can be capped by limits on price or volume.	Since 2000, in Dutch hospital financing efforts have been undertaken to integrate the fee-for-service system for specialists and the hospital budget system into a single integrated budget.

### ***Policy development and regulatory commitment***

The combination of various provider payment methods has been arrived at after evaluating the outcomes of using a single provider payment method. For example, in the Czech Republic since mid-1997 hospital inpatient health care has been remunerated according to a budget. This was the result of some problems with the previous points-based FFS payment system, implemented from 1993 to 1997. Since 2001, in addition to these budgets, DRG payment has been introduced so as to improve productivity in hospitals and stimulate the provision of cost-effective treatments. From the Czech reform experience, a sequence for the development of a particular health policy can be distilled, starting from the need for cost-containment need up to the monitoring of results of that policy. These results may then feed back into the design of an adjusted policy.

Box 1 illustrates the process of undertaking a pharmaceutical reform in the Republic of Korea in the year 2001.

Box 1. Policy development sequence



A health policy that has proved to be effective in a number of countries may not work in all countries, however. For example, the political power shown by doctors' associations in the Republic of Korea against the 2001 pharmaceutical reform had a critical impact on policy development. Still, the separation between prescription and dispensing of drugs has been approved thanks to a strong commitment of the government and to public support. However, the operation has not been successful so far. Physicians attempt to maintain their income by channeling patients to colluding pharmacies nearby their practice offices. One of the lessons from this policy process is that regulatory instruments need to be foreseen so as to ensure that a policy's objectives will be met.

### ***Competition framework***

More competition in health care is a further important factor for cost containment. In the last years most of the OECD-member states have strengthened the influence of competition in their health care system to enhance efficiency and to promote cost-containment. It follows that the impact of provider payment schemes will need to be assessed taking account of the competition framework. In general all provider payment schemes can be used and combined, but some provider payment schemes are more appropriate for competition than others. For example DRGs are based on the principle that patients with a comparable disease, complexity and costs belong to the same DRG. The latter therefore is a good basis to let providers compete for the provision of care to these patients. Important, however, is that all providers fulfill the same quality conditions. Budgets or per diem payments are not ideal provider payment schemes in a competitive environment as it is difficult to relate these to the providers' performance.

### ***Summary and important considerations***

- Every provider payment scheme has advantages and disadvantages. An optimally mixed provider payment system with regulatory commitment can be a powerful 'side-effect free' cost containment instrument but some trade offs will be inevitable. Quality management and the use of monitoring indicators will help to minimize such side effects.
- The choice of the best provider payment scheme depends on a country's framework, especially the competition environment. Another important factor may be the influence of lobby groups on the sustainability of the provider payment scheme.
- The introduction of monetary provider incentives is mandatory for cost-containment but not sufficient for achieving a sustainable health care system. Other important factors include a continuous medical education, professional satisfaction and the human relationship with patients.
- Non monetary consumer incentives such as medical education may lead physicians to provide high quality and cost effective services as well.

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