WEEK 10 SUPPLY SIDE REFORM AND REIMBURSEMENT

Activity-based funding versus block grants

The cost containment thesis was outlined in the previous lecture. In this lecture we examine proffered solutions. The main components of reform policy have been the injection of competition or outright privatization of service management, funding and provision. These measures are known as 'supply-side' and 'demand-side' reform. Supply-side reforms target arrangements for health care production or supply. Demand-side reforms target the source of health care funding. Supply side reform is critically examined in this lecture.

Objectives/learning outcomes

Recognise and understand funding and reimbursement methods, including, global budgets and block grants, case payment, capitation, copayments and cost sharing and user charges;

Analyse the equity effects of different funding and payment mechanisms.

Seminar: How reimbursement mechanisms are used to move financial risk around the system

Take an example of a capitated or an activity-based payment mechanism and critically examine its effects on financial risk allocation and service integration. Short presentations for class discussion. Data should be drawn from the WHO or Health Systems in Transition database (summaries only).

You should consider: the extent to which these types of payment mechanisms affect needs-based planning; the extent to which the financial constraints are 'hard' or 'soft'; and how facilities might try to manage the financial risk.

Set reading

Figueras J et al (2005) *Purchasing to improve health system performance*. Maidenhead: Open University Press, chapter 11.

Kutzin J (2008) *Health financing policy: a guide for decision-maker*. Geneva: WHO, paragraphs 46 and 47.

Lecture summary

Supply side reform

In non-market systems financial risks of ill-health are borne by the funder or government, not by the hospital or clinic, and allocation is based on historical costs plus estimates of need. In market systems, such as those in which a purchasing function has been developed, payment or purchasing mechanisms are deliberately designed to devolve varying degrees of financial risk on to the provider and are based on some calculation of sales value. Provider reimbursement or payment is one of the main focuses of health system reform because payment methods are linked in economic theory to cost efficiency. We will be concerned in this lecture with the extent to which financial risk is

devolved by the system of remuneration on to health care providers and through them on to patients.

We saw in an earlier lecture that new public management (NPM) ideas have been influential in health system reform. Two reforms, semi-independently managed public firms and contracting out, have been widely adopted in Europe (Figueras, 2008:39). Independent public firms are created when a purchaser-provider split is introduced to integrated systems (e.g. Estonia, Norway, Portugal, United Kingdom, Spain and Italy). European countries with SHI systems have concentrated largely on financing reforms (see previous lecture).

The introduction of 'firms' as providers introduces purchasing as a function and health systems throughout the world have been experimenting with different systems of provider payment (see introductory course, lecture 5). Purchasing is 'the allocation of pooled revenue to health service providers' (Figueras, 2008: 40). According to Figueras (2008: 41), 'an increasing number of countries have experimented with ways of specifying in contracts what care is to be delivered, as a means of improving the efficiency of hospital care. Typically, there has been a move away from retrospective reimbursement, based solely on numbers of cases and from (prospective) line-item budgets that defined financial flows but not service specifications. Instead, case-based payments were introduced (mainly variants of diagnosis related groups), or some combination of case-based reimbursement within a global budget cap.'

Reforms of this type are concerned with supply-side controls and often complement the demand side controls dealt with in the previous lecture. They often involve "commercialization", defined as 'the provision of health services through market relationships […]; investment in, and production of, those services and of inputs to them, for cash, income or profit, including private contracting and supply to publicly financed health care…' (Macintosh and Koivusalo, 2005: 3). This type of health system reform is found in health systems such as the UK's (replacing or diluting integration where the public sector is both payer and provider) and also in health systems such as America's where commercialization is being extended to public insurance plans such as Medicare and Medicaid.

The basic intuition behind supply side market reform has been well described by Roberts et al (2004, pp225-35):

> 'Incentive strategies take advantage of the fact that every organization has to acquire financial resources to continue to operate. To change the behaviour of organizations, therefore, reformers can change what must be done to obtain such resources.'
>
> 'Competition is desirable because it pushes sellers to keep down costs and prices and responds to customers in order to attract additional business. The managers of firms that might not survive have a powerful incentive to work hard and take risks. Indeed, firms managed by their owners are often more successful … exactly because managers have so much to lose, and gain, from their company's success.

In this lecture we review the concepts and processes involved in commercialization and consider research findings about their effects.

Stages of supply side reform

Corporatisation

In order for organisations to become autonomous they must be given separate legal status. This process is known as 'corporatisation'. Corporatisation involves delegating power to providers by transforming services so that they are no longer integrated under geographic planning tiers serving the population on the basis of need. Instead services are reconfigured as stand alone delivery units or firms with private sector disciplines and separated from direct government control. Relations with government are now largely (but not necessarily entirely) via legal contracts containing financial incentives (or penalties) for poor performance. Separate legal status means organizations can enter legal contracts, borrow money, and form joint ventures with other businesses.

The primary goal of corporatisation is to provide a publicly administered body with a business structure and new legal entity in order to strengthen its commercial objectives and/or facilitate privatisation.

Corporatisation is a tool of public sector re-engineering. It is often accompanied by funding reforms and service unbundling:

- Capitation: The UK is leading the way in re-engineering its public sector services. One example of this is the switch in the funding arrangements for public services. In the NHS, for example, budgets were previously allocated on the basis of geographic areas' needs and health services received block budgets on an annual basis.

  Now funding is allocated as a payment per patient so that it follows the patient to the point of delivery. The capitation payment allows funds to be diverted from public to private service providers.

- Service unbundling: The private sector can only enter into previously integrated services through a process known as 'service unbundling' where services are split off for separate provision. There is a variety of unbundling mechanisms. They will differ from health system to health system. (The following UK policies are currently breaking up the integrated health service:

  PFI, LIFT , HUB

  New GP contract (out of hours, child health surveillance, cervical screening)

  UnitedHealth – Evercare pilots

  Disease management clinics - e.g. statins

  Independent treatment centres - elective surgery)

Privatisation - the transfer of ownership and/or control from the public to the private sector.

Basic principles of market-based reimbursement

Insurers and providers with fixed budgets use financial incentives and reimbursement systems to reduce the risks and change the behaviour of providers, doctors and patients. Doctors are seen as the gatekeepers to care and resource use. Government or the insurer seeks to manage both financial and utilisation risk in various ways through the contracts they make with providers and staff. The contract determines how the supplier, provider or doctor is to be paid and in turn the sort of behaviour that results.

Payment systems to competing providers are designed to manage supply and demand by shifting responsibility for the financial of risks of care. In these systems efforts are made to devolve risk down to individual services, doctors and ultimately to the patient. These systems are sometimes called risk sharing especially where they involve user charges or co-payments or cost sharing arrangements. Universal systems based on needs based planning are increasingly incorporating market mechanisms. Some universal systems have always had elements of the market in their reimbursement structures e.g. Belgium, and France, and these are being increasingly exploited.

Institutional framework - Who pays providers?

In health systems with a purchasing function, third parties (or 'payers') purchase care on behalf of patients. There may be single or multiple payers. A variety of purchasing bodies is found among health systems. Kutzin (2008) provides the following list of third party payers:

Ministry of Health – central or decentralized units (e.g. provincial or district health departments)

Local government health authority

Area Health Boards

Social health insurance fund(s)

Private insurance funds

Health "plans"

Employers

Member-owned "mutual" insurers

Fundholding providers

The risks borne by third party payers may differ. For example, a payer may operate in a poorer part of the country or with a sicker and older membership. Methods have been developed to tackle differences in risk by pooling resources to third party payers.

Measures can be taken to equalise risks among different social insurance funds or competing health insurers by transferring funds among them. For example, in 1994 a risk equalisation mechanism was introduced to German sickness funds. (See finance lecture)

Conceptual framework for reimbursement methods

1. Block or global budgets

Block or global budgets are allocations of a fixed amount for a given period where the provider has discretion over the use of the budget. (Liu, 2003, 34)

Global budgeting for hospitals has been adopted in all countries with national health services (Liu, 2003, 35), although it is often combined with 'case-mix adjustment' where the hospital is paid on the basis of the number of admissions adjusted according to a case-mix index. GP or physician payment schemes tend to be more varied.

Under this system the government bears financial risk. However, modifications are possible such as the NHS internal market experiment. In these circumstances a global budget can be divided into 'hard' and 'soft', according to who bears the financial risk:

> *A soft budget means that if there is an overrun the purchaser assumes part of the financial responsibility; a hard budget means that the budget is fixed, and if there is an overrun the purchaser does not assume any responsibility, and all the financial risk is shifted to the purchaser. (Liu, 2003:35)*

English hospital reforms can be seen as a progression of attempts to substitute hard budgets for soft budgets.

2. Reimbursement

A basic distinction is made between prospective and retrospective reimbursement (Donaldson, 2005: 59). Retrospective reimbursement 'involves the insuring agency paying the provider for all 'reasonable' expenditures incurred on behalf of an insured person or group…' In this case, the funder bears the risk of costs being higher than expected. Prospective reimbursement occurs when funds are allocated on the basis of the resources individual patients or groups of patients are expected to use. In this case, the risk of costs exceeding estimates is borne by the provider. The most commonly used system of prospective payment is the diagnosis related group or DRG system (see below).

Payments systems that devolve risks to providers are known as supply-side controls. For example, prospective payments (payments made before treatment)

operate as supply side controls because they transfer financial and utilisation risk to the provider.[i]

The choice of payment method determines the allocation of financial risk. For example, when the purchaser provides a fixed price per case the risk of variations in treatment costs is transferred to the provider whose corporate policy will have to reflect this commercial reality (Figueras, 2006: 117). Economic analysis treats payment systems as 'incentives' or rewards in a market and asks which system is most cost efficient.

Payment systems are frequently linked to demand side controls such as user charges, co-payments, and top-up insurance policies or 'deductibles'. There are two main forms of co-payment: a percentage payment and deductibles (or co-insurance). With deductibles the insured bears a fixed amount and the excess is borne by government or the insurer. Sweden and the Netherlands apply deductibles. In other countries charges are means-tested. (Mossialos, 2002)

The payment system in managed care is designed to protect health maintenance organisations from financial risk by passing it on to providers, patients or both. Managed care systems use a range of devices to manage risks including 'capitation' (per-head payments), payments per case (the DRG system), salaried staff, fee for service and user charges. These arrangements reflect the existence of competing private providers in a health care market. However, they are not limited to managed care systems; in Bismarckian systems arrangements can be mixed, involving elements of public and private provision, whilst in 2001 a DRG-type mechanism was introduced to the NHS as a prelude to privatising provision.

Payment mechanisms

i) Fee for service:

Fee for service is the specific amount paid by a funder or patient to a provider for specific services rendered. when fee for service is the main route to income generation there is an incentive to do more regardless of need and to lower thresholds for treatment and care. Under a fee for service system, the funder retains the financial and utilisation risk . In some systems doctors and providers are paid on a fee for service basis. Fee for service can encourage over-servicing because every encounter results in income for the provider. For similar reasons, fee for service can encourage under-referring. Fee for service encourages curative care rather than preventative care because providers are paid when they treat patients i.e. care is not seen a holistic. The funder retains total risk under a fee for service system. Fee for service systems can be complicated to administer as they require a large number of tariff codes and very expensive.

ii) Case payment (cost per case):

The third party payer pays a fixed amount per case 'regardless of the actual types and quantities of services provided.' (Liu, 2003, 29) The diagnosis related groups (DRGs) is a 'risk adjusted' cost per case payment system. This is a fee for service

but complex since it bundles together a range of services and groups conditions under diagnostic codes known as diagnostic related groups or DRGs. The price is set but adjusted to take into account case mix and different needs (this is what risk adjustment means). This in turn of course results in 'gaming' or fraud (see ref) as providers try to ensure that they carry out fewer services than they say they do, or that they re-categorise patients into a higher level of need. This is also known as 'DRG creep'. Another concern described by Liu is the effect on non-insured patients in the US system:

> Traditionally, hospitals and other providers used revenues from insured patients to cross-subsidize uninsured patients… With case payment, hospitals' profit margin from Medicare patients reduced, and hospitals are thus less willing to provide care to the uninsured poor. Studies showed that cross-subsidization was no longer effective for covering the cost of care fort the uninsured. (Liu, 2003, 31)

The key to the DRG is that it does not spell out what levels of care should be provided either in terms of staff or investigations (i.e. the appropriateness of the care); it simply groups patients on resource use rather than needs. Quality of care may therefore become a major concern.

iii) Capitation:

Capitation is the regular annual or monthly payment by a funder to a provider of a fixed amount per enrollee for the provision of specified services to an enrolled population, i.e. unlike the universal system it is not built an assumption of universality of entitlement. From the funder's point of view, capitation passes the short-term risk on to providers as the latter receive a fixed amount regardless of the services they provide. Capitation encourages preventative care since healthy patients result in fewer visits (and hence higher fees per visit).

Administration for providers is reduced because they do not have to send out accounts nor follow up outstanding debts. Capitation doesn't encourage providers to submit information to the funder since the funder has already been reimbursed in advance. Under a fee for service system, a provider has to submit a claim to receive reimbursement. (This type of capitation should be distinguished from needs-based capitations involving block grants and soft budgets).

iv) cost sharing, co-payments, charges **:**

This usually involves the patients assuming risk through patient charges paid directly to the provider e.g. prescription charges or taking out co-insurance plans (deductibles). There is a large literature on the effects of cost sharing and the way it acts as a barrier to care

SUMMARY TABLE PROVIDER PAYMENT METHODS

Table 5. Provider payment methods and incentives

Payment method type	When price or budget defined	When payment made	Basis or unit for price/budget	Payment 'steered' by	Treatment incentives
Budgets (line item and global)	prospectively	prospectively	inputs or all services of provider for a given period	various criteria, e.g. negotiated contracts, patient volume, physical capacity, etc.	underprovide, shift (refer) patients to other providers
Salaries	prospectively	prospectively	staff time (hours worked)	contract	underprovide, refer to other providers
Capitation without fundholding for referral services	prospectively	prospectively	expected cost of covered services from capitated provider for each person per period	consumer choice or size of population in catchment area	enroll healthy people; under-provide and refer, mitigated by re-enrollment process
Capitation with fundholding	prospectively	prospectively	expected cost of all covered services for each person per period	consumer choice or size of population in catchment area	enroll healthy people
Case-based payment	prospectively	retrospectively	treatment comprising bundle of services, most commonly a hospitalization	fee schedule codified in regulation or contract; patient choice of provider	increase volume of less severe patients in each case category; decrease services per case
Fee-for-service according to fee schedule	prospectively	retrospectively	each agreed service item or input	fee schedule codified in regulation or contract; patient choice of provider	increase patient volume and services per case
Fee-for-service, no fee schedule (or informal)	retrospectively	retrospectively	each item of service provided	patient choice of provider; negotiation between provider and patient	increase total volume of services provided
Mixed, e.g. salary plus fee-for-service	depends on specific mix	depends on specific mix	depends on specific mix	depends on specific mix	depends on specific mix

Source: Kutzin, 2000:14

Reimbursement systems are often analysed in terms of their capacity to control aggregate costs in a health system. Liu has examined payment systems in five countries, the USA, UK, Canada, Germany and Japan.

He found for the USA that 1500 private insurance companies paid multiple providers using a variety of methods (salary, FFS or capitation for physicians, and per diem or DRG for hospitals) with payments coming from a variety of sources (various insurers, cost sharing and full payment by uninsured).

This unmanageable multi-payer system has been criticised for causing the high levels of expenditure in the USA without meeting population health care needs. Explanations vary. For example, Anderson et al (2003) ascribe the high cost to high prices; in other words, the reimbursement system is not constraining prices. Liu on the other hand points out that the USA is unique among developed countries in not having a global budget; so prices will always have a tendency to rise (Liu, 2005).

In the UK, where central government is both insurer and payer and in many cases provider, public hospitals were reimbursed through global budgets (effectively historic funding) until 2004 when the DRG (national tariff) system was introduced.

GPs on the other hand are paid a capitated fee. The interest here now turns on the effects of GP reimbursement on patient care following change to the GP contract. In other words, changes to the legal and regulatory context of reimbursement will make a difference to the effects of financial incentives.

In Canada a further complexity arises because **f**inancing is organised at provincial government level but legally controlled by the national government through the Canada Health Act.

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i In market based systems the assumption is that the patient or doctor will always try to