PROVIDER PAYMENT MECHANISMS

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Health Financing challenges in Kenya

- Low efficiency
- Inequity
- Poor Quality
- Poor Access
- Low Risk Pooling
- High OOP
- Poor financial and management systems
- Poor Regulatory environment
Types of Provider Payment
Types of provider payment methods

**Prospective vs. retrospective:**
- Prospective - rate for a defined set of services is set before treatment takes place
- Retrospective: rate determined during or after the service has been given

**Aggregate vs. disaggregated units**
- Aggregate unit payment – payment is made for a set of services
- Disaggregated units: payment is made for specific items such as consultation, X-rays, drugs. typical of fee-for-service.
Prospective payment methods

• fee is set before the procedure, e.g. case – based and capitation methods

• Healthcare provider carries some degree of financial risk. If costs turn out to be higher than anticipated, provider bears the consequence.

• there is an incentive for efficiency to reduce costs on the part of the provider but quality may be compromised
Retrospective payment methods

- Financial risk rests with the payor
- No incentive for provider to reduce costs
- Tends to be a cost enhancer and may promote over servicing
Common provider payment mechanisms

- **To individuals:**
  - Budget
  - Capitation
  - Fee-for-Service
  - Pay for Performance
  - Salary

- **To Facilities**
  - Budget
  - Capitation
  - Diagnosis Related Groups
  - Fee-for-Service
  - Pay for Performance
  - Salary
Budget

- Commonly used in the public sector
- Could be prospective or retrospective
- Line item budget – allocated to specific functions such as food, salaries, medicines. Limits flexibility in resource use
- Global budget; advance payment to a health facility to cover a specified period. Allows flexibility in resource use
- Tendency to spend entire budget to ensure continued level of support
Capitation

• A prospective payment
• fixed amount paid based on number of patients enrolled
• Controls costs by transferring risk to the health care provider
• Low administrative burden
• method is favourable to the provider, because it guarantees revenue over a defined period.
• Management systems required to register each beneficiary with one provider and to monitor utilisation to curb under servicing
• Has more incentive to stimulate efficiency
• Riskier populations may be excluded – the aged and those with chronic illnesses
• Quality may be sacrificed to contain costs
Diagnosis Related Groups

- Most frequently applied to in patients
- Prospective system
- the provider is paid a fixed and predetermined amount for treating a case rather than for each treatment,
- Uses a patient classification system such as diagnosis related groups (DRGs)
- Links payment to complexity of case and therefore may be complicated
- Reliable data and information recording system required;
- The development of a case-based system of payment is a complex and time consuming task
Fee-for-Service

- Payment is per unit of service – provider paid according to number of service items delivered.
- Financial risk rests with payor, low risk for provider
- May encourage over servicing and unnecessary interventions
- Has very high administrative costs for both the provider and payor.
- For the providers, billing procedures are costly.
- For the insurer, the cost of processing claims is high.
- The payor/insurer must establish expensive monitoring procedures to minimize false claims.
Pay for Performance

- Administrative burden for providers and insurers
- P4P programs can be costly and require substantial additional investment in information-technology to monitor performance
- Providers may Increase number of services that lead to improved performance indicator
- Gaining acceptance from providers
Per Diem

- Mostly for in patient services
- Pays daily aggregate fee for all expenses
- Low financial risk to provider, high risk on payor
- May encourage increase in the number of admissions and longer lengths of stay.
- Case coordination required to monitor length of stay
Salary

- Objective is to make doctors focus on core business of service provision
- Salaries often lag behind especially in the public sector
- Consequently low morale, frequent industrial actions, low productivity, high turnover of professionals → reduced quality of service
- NGOs tend to offer more attractive packages
- Tendency for medical personnel to move from public institutions to donor funded facilities
## Incentives in Different PPMs – Primary Health Facilities

<table>
<thead>
<tr>
<th>Health facility</th>
<th>Payment method</th>
<th>Financial incentive set to provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health care</td>
<td>Capitation adjusted by age and gender</td>
<td>Treat patient within budget, or in worst case, provide sub-standard care and exclude high-risk patients; Refer patients to specialist and hospitals</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>Increase number of services per patient</td>
</tr>
<tr>
<td>line item budget</td>
<td></td>
<td>Increase input factors (bed, staff, etc) and use full budget</td>
</tr>
<tr>
<td>P4P</td>
<td></td>
<td>Increase number of services that lead to improved performance indicator</td>
</tr>
<tr>
<td>Capitation – Fee-for-service mix</td>
<td></td>
<td>Treat within budget and increase number of fee-based services</td>
</tr>
</tbody>
</table>
# Incentives

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>Incentive to increase activity</th>
<th>Incentive to decrease activity</th>
<th>Incentive to shift patients' costs to others</th>
<th>Incentive to target the poor</th>
<th>Controls cost of doctor employment</th>
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</thead>
<tbody>
<tr>
<td>Fee-for-service</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>May be</td>
<td>No</td>
</tr>
<tr>
<td>Salary</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Capitation</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Diagnosis Related Group</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>May be</td>
<td>No</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Budget</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
### PPMs- Policy Trade-Offs

<table>
<thead>
<tr>
<th>Capitation</th>
<th>Capitation</th>
<th>DRG</th>
<th>FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG</td>
<td>DRG</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td>Salary, Per Diem</td>
<td>Per Diem</td>
<td>Per Diem</td>
<td>Per Diem</td>
</tr>
<tr>
<td>FFS</td>
<td>FFS, Salary</td>
<td>Capitation</td>
<td>Capitation</td>
</tr>
</tbody>
</table>

- **Lower Efficiency**
- **Less Patient Risk Selection**
- **Lower Quality**
- **Cost Control**
Need for Balance

- Efficient provider payment systems allow providers to earn a reasonable income, but maintain good quality of care while preventing waste and unnecessary service provision.
- This is a difficult balance to achieve.
Conclusion

• A well designed PPM should be able to meet the three objectives of quality, efficiency and accessibility.

• Design of PPM must also take into consideration the management capacity and systems of both the financier and health providers.

• Each payment method has different impact on efficiency, quality and access.

• Complex payment methods require more financial and clinical information and therefore have higher administrative costs.

• Competition among providers tends to promote quality and consumer satisfaction.

• No single provider payment method provides all the right incentives; a combination of payment methods may be necessary.
“Ignorance on fire is better than knowledge on ice”

Burke Hedges (You Inc.)