Incentives for quality and efficiency at primary care providers:

The role of output-based payment methods and inancial autonomy

28 August 2024
Provider autonomy country workshop
Mauritious

Inke Mathauer, MSc., PhD
Senior Health Financing Advisor
WHO Geneva

Certain payment methods **require a certain degree of financial autonomy** to respond to incentives set by the payment methods

A complex theory of change:

\+

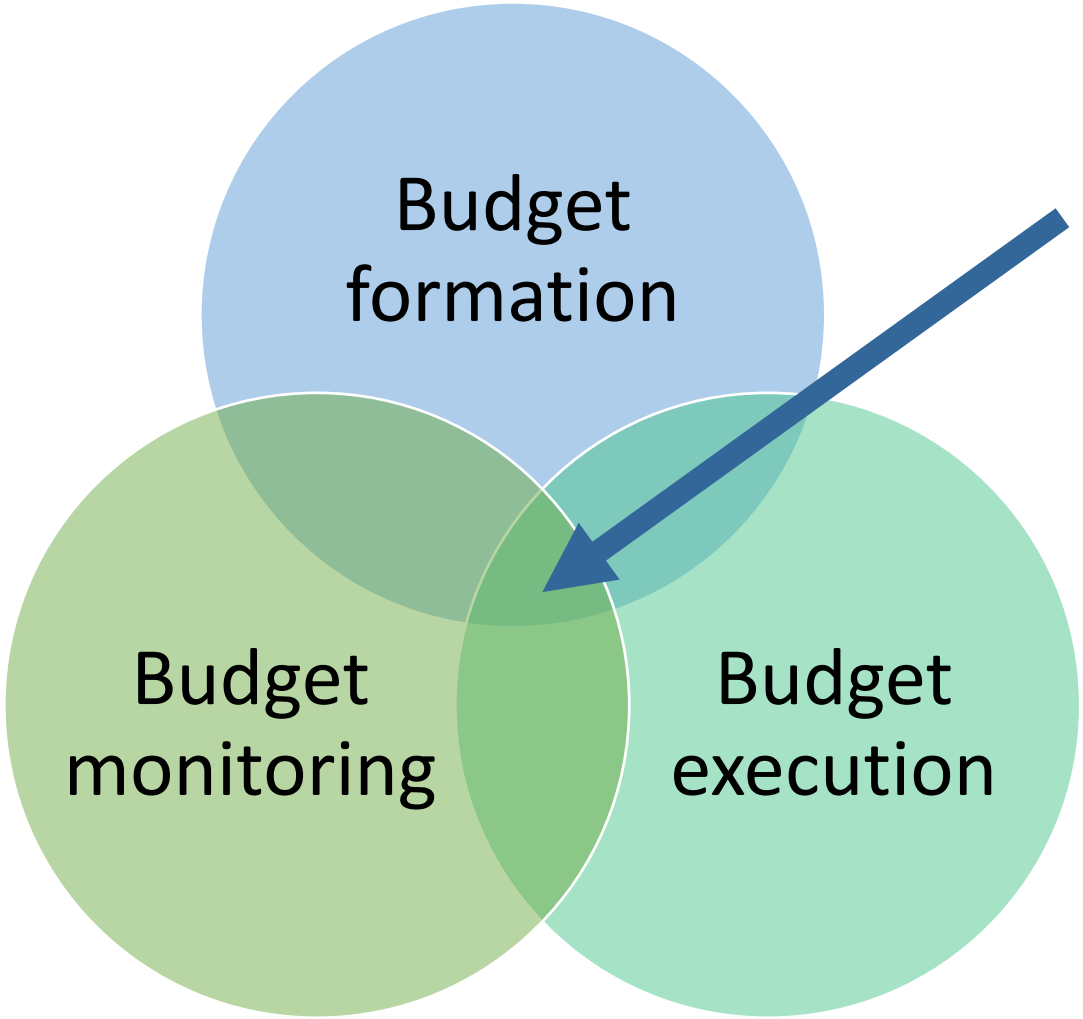
- Financial autonomy would make **resources flow smoothly** to service delivery units.
- This would **improve efficiency and outcomes** (e.g. quality of care, equity in access, responsiveness).
- With **responsibility and flexibility over funds**, providers would purchase services strategically and respond to incentives.

–

•But this may not work, if financial autonomy is **not accompanied by flexible budget structures**, timely disbursements/agile spending, and **accountability mechanisms**.

•Autonomy could also lead to misuse of funds, or pursuit of profit-seeking (income-generating activities).

PFM and (strategic) purchasing are two sides of the same coin



Strategic purchasing

=> need for alignment

I.

Provider payment methods and incentives for efficiency and quality

Payment methods and its incentives

Payment method	Definition	Potential incentives that the payment method may create and that have positive or negative impacts on quality of care
Prospective		
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g. staff, medicines), with limited flexibility to move funds across these budget lines.	- Under-provision, no focus on quality or outputs unless specified and held accountable; no means to align resource inputs to service outputs
Global budget	Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. The budget is flexible and is not tied to line-items.	- Under-provision, also in terms of quality or outputs, unless specified and held accountable; + More potential for efficiency due to budget flexibility, for aligning resource inputs to service outputs, and for care integration
Capitation	Providers are paid a fixed amount in advance to provide a defined set of services for each person enrolled for a fixed period of time.	- Under-provision, over-referral (if unit of payment does not include some referral services), unless specified and held accountable; + Greater potential to align resource inputs to service outputs and to have an enabling environment for care integration
Retrospective		
Fee-for-service	Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.	- Over-provision of services, including of unnecessary, inappropriate and potentially unsafe services, unless controls are in place and effectively implemented; + Alignment of resource inputs to service outputs
Case-based (DRG)	Hospitals are paid a fixed amount per admission depending on patient and clinical characteristics.	- Reduction of costs per case (skimping, under provision), avoidance of severe cases; + Alignment of resource inputs to service outputs
Per diem	Hospitals are paid a fixed amount per day so that an admitted patient is treated in the hospital.	- Extended length of stay, reduction of costs per day (under-provision); cream-skimming; + Alignment of resource inputs to service outputs

Source: WHO (2022), further adapted from Cashin et al. 2015

Payment methods and its incentives

Payment method	Definition	Potential incentives that the payment method may create and that have positive or negative impacts on quality of care
Prospective		
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g. staff	- Under-provision, no focus on quality or outputs unless specified and held accountable; no means to align resource inputs to service outputs
Global budget		ecified ning
Capitation		lude nd to
Retrospec		
Fee-for-service		riate and ctively
Case-based (DRG)		ance of
Per diem	Hospitals are paid a fixed amount per day so that an admitted patient is treated in the hospital.	- Extended length of stay, reduction of costs per day (under-provision); cream-skimming; + Alignment of resource inputs to service outputs

There is no perfect payment method.

Each has its strengths and weaknesses.

Each can create desired incentives and adverse effects.

But depending on the health system objectives, they can be applied in the right context.

Source: WHO 2022, further adapted from Cashin et al. 2015

Payment methods and its incentives

Payment method	Definition	Potential incentives that the payment method may create and that have positive or negative impacts on quality of care
Prospective		
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g. staff,	- Under-provision, no focus on quality or outputs unless specified and held accountable; no means to align resource inputs to service outputs
Global budget		pecified ning
Capitatio		clude and to
Retrosp		
Fee-for-service		priate and ectively
Case-based (DRG)		dance of
Per dien		ovision);

Except line-item budgeting, all these payment methods require a certain degree of financial autonomy for providers to make use of the incentives set by these payment methods.

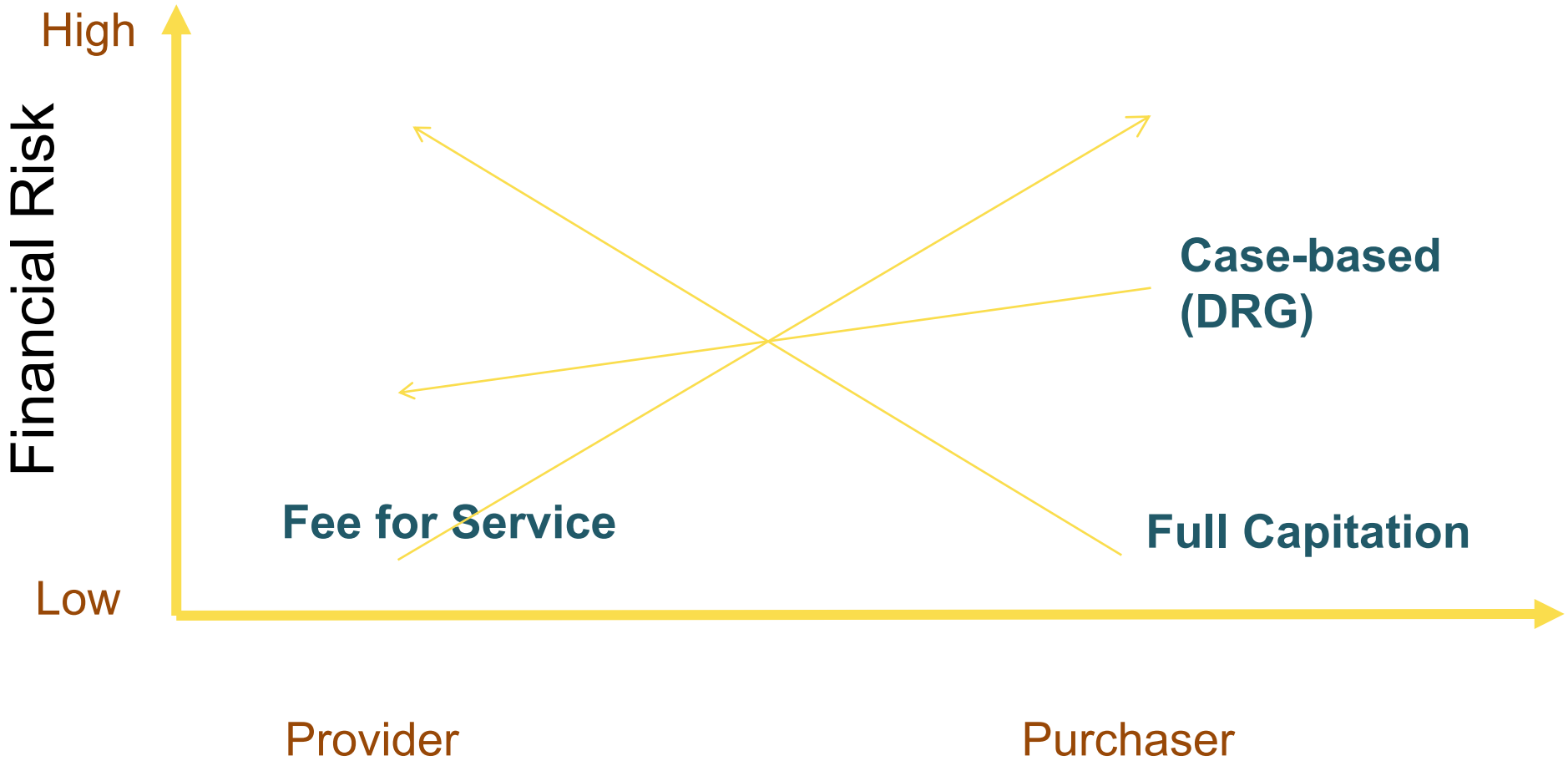
hospital.

+ Alignment of resource inputs to service outputs

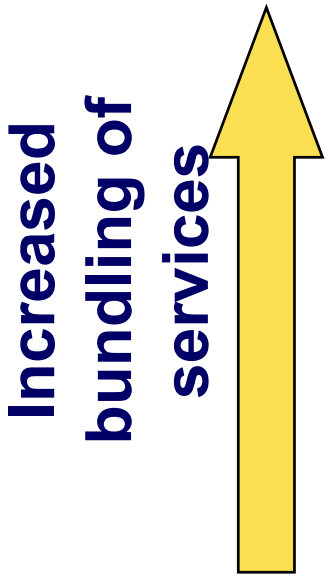
Source: WHO (2022), further adapted from Cashin et al. 2015

I.

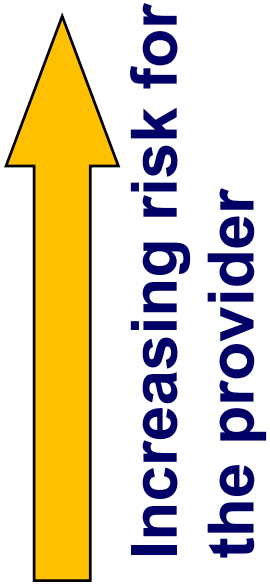
Balance of expenditure risks



I. Who bears the financial risk linked to volume and complexity?



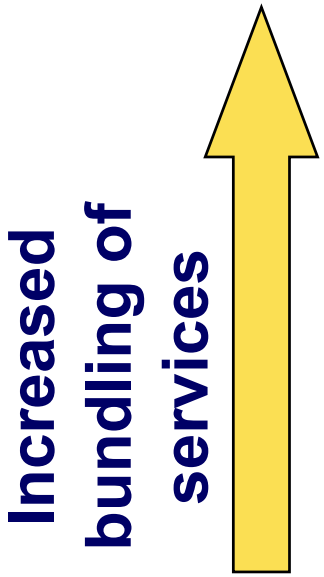
- Capitation
- Global budget
- Case payment (e.g. DRG)
- Bed-day payment
- Fee for service
- Line-item budget



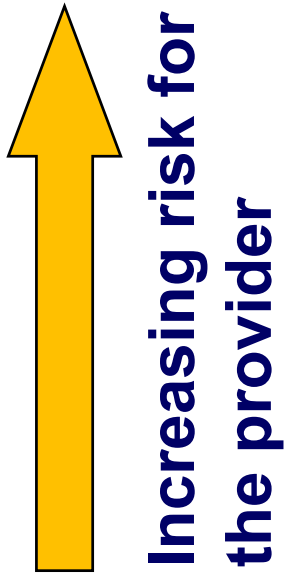
Source of slide: T. Evetovits

I. Some payment methods should be accompanied by a budget or volume cap

A budget or volume cap serves to address overprovision incentives by providers and to control expenditure.

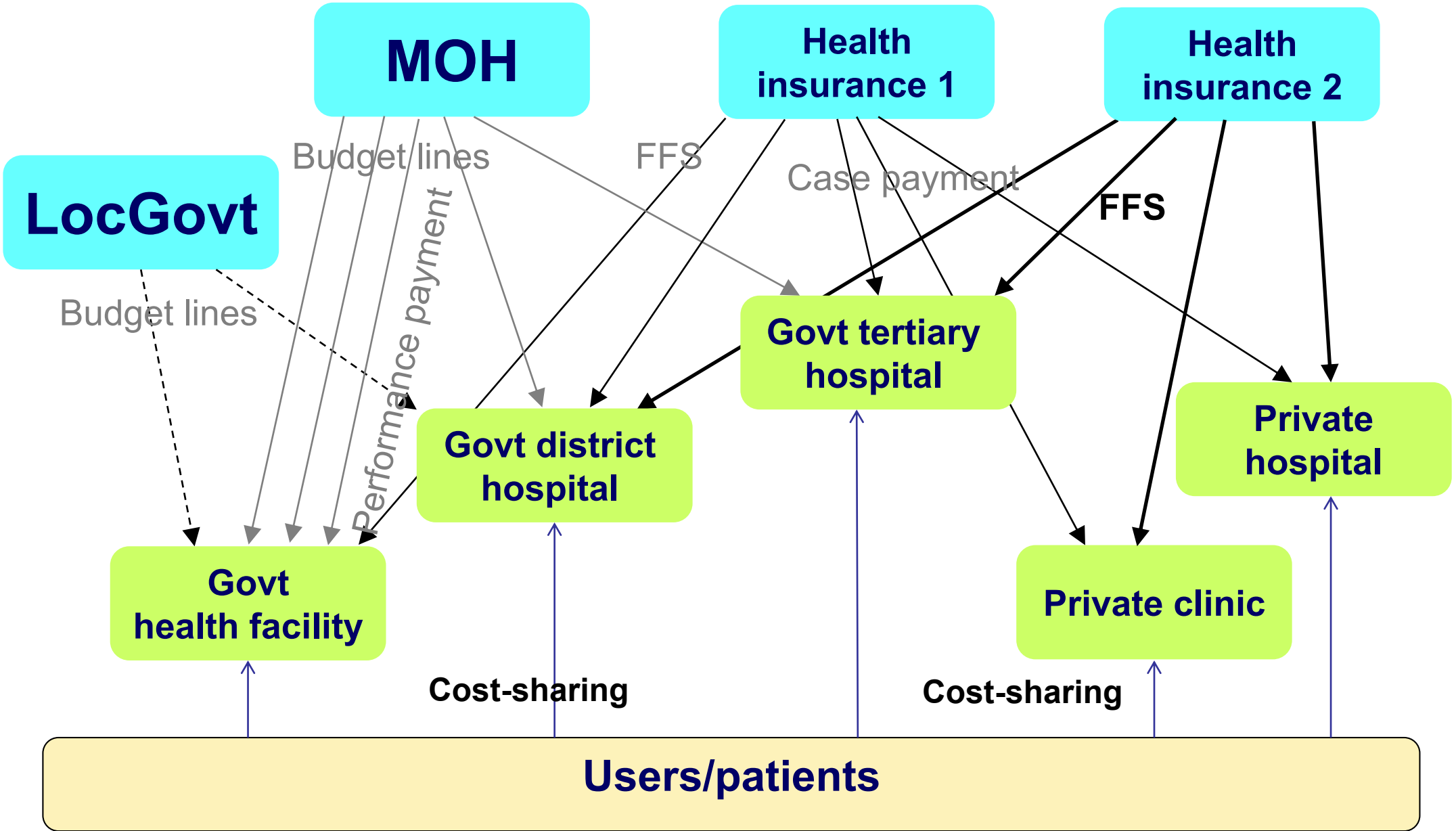


- Capitation
- Global budget
- Case payment (e.g. DRG) – cap needed
- Bed-day payment – max number needed
- Fee for service - cap needed
- Line-item budget



II. Mixed provider payment systems

II. Seeing the 'mix' in multiple provider payment systems



II.

Mixed provider payment systems

- Most countries have a mixed provider payment system due to various reasons:
  - There are multiple purchasers
  - There are different care levels/different service types which are paid for by different payment methods
  - Different payment methods can be applied for one service to address negative incentives of one payment method

- In particular, a mix/combination of (two or more) payment methods is needed for remunerating providers for integrated care and for provider networks

Payment methods and its incentives

Payment method	Definition	Potential incentives that the payment method may create and that have positive or negative impacts on quality of care
Prospective		
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g. staff, medicines), with limited flexibility to move funds across these budget lines.	- Under-provision, no focus on quality or outputs unless specified and held accountable; no means to align resource inputs to service outputs
Global budget	Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. The budget is flexible and is not tied to line-items.	- Under-provision, also in terms of quality or outputs, unless specified and held accountable; + More potential for efficiency due to budget flexibility, for aligning resource inputs to service outputs, and for care integration
Capitation	Providers are paid a fixed amount in advance to provide a defined set of services for each person enrolled for a fixed period of time.	- Under-provision, over-referral (if unit of payment does not include some referral services), unless specified and held accountable; + Greater potential to align resource inputs to service outputs and to have an enabling environment for care integration
Retrospective		
Fee-for-service	Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.	- Over-provision of services, including of unnecessary, inappropriate and potentially unsafe services, unless controls are in place and effectively implemented; + Alignment of resource inputs to service outputs
Case-based (DRG)	Hospitals are paid a fixed amount per admission depending on patient and clinical characteristics.	- Reduction of costs per case (skimping, under provision), avoidance of severe cases; + Alignment of resource inputs to service outputs
Per diem	Hospitals are paid a fixed amount per day so that an admitted patient is treated in the hospital.	- Extended length of stay, reduction of costs per day (under-provision); cream-skimming; + Alignment of resource inputs to service outputs

Source: WHO (2022), further adapted from Cashin et al. 2015

II. Provider payment methods and incentives

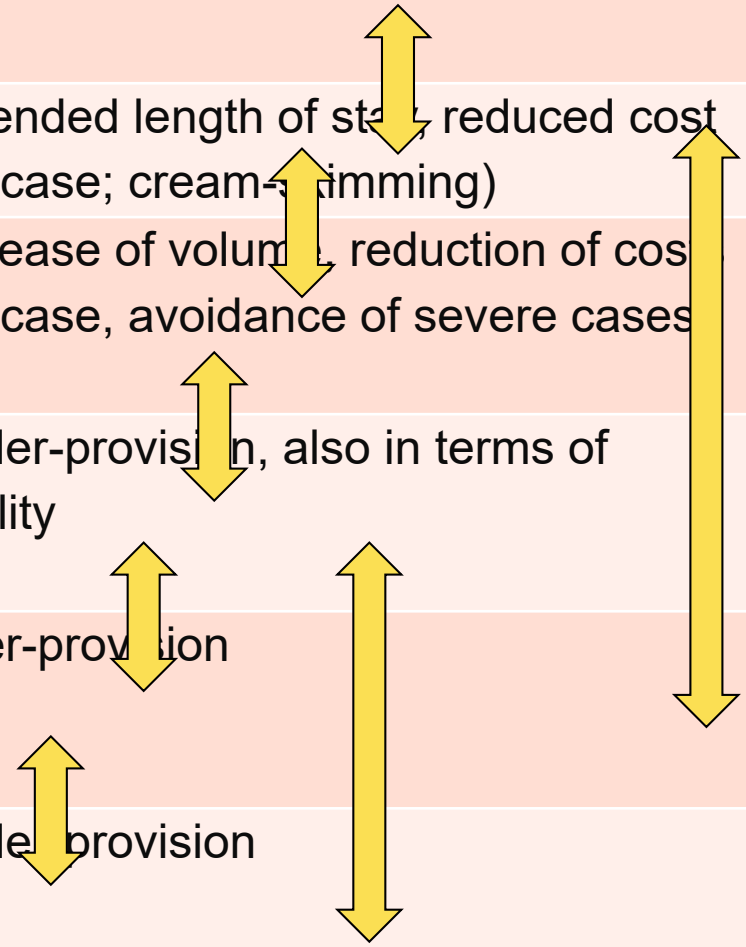
Payment Method	Definition	Incentives
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g., staff, drugs, …).	Under-provision
Per diem	Hospitals are paid a fixed amount per day that an admitted patient is treated in the hospital.	Extended length of stay, reduced cost per case; cream-skimming)
Case-based ("DRG")	Hospitals are paid a fixed amount per admission depending on patient and clinical characteristics.	Increase of volumen reduction of costs per case, avoidance of severe cases
Global budget	Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. Budget is flexible and not tied to line items.	Under-provision, also in terms of quality
Fee-for-service	Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.	Over-provision
Capita-tion	Providers are paid a fixed amount in advance to provide a defined set of services for each individual enrolled for a fixed period of time.	Under-provision

II. From the analysis of one provider payment method and its incentives…

Payment Method	Definition	Incentives
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g., staff, drugs, …).	Under-provision
Per diem	Hospitals are paid a fixed amount per day that an admitted patient is treated in the hospital.	Extended length of stay, reduced cost per case; cream-skimming)
Case-based ("DRG")	Hospitals are paid a fixed amount per characteristics.	Increase of volume, reduction of costs per case, avoidance of severe cases
Global budget	Providers receive a fixed amount of funds for a Budget is flexible and not tied to line items.	Under-provision, also in terms of quality
Fee-for-service	Providers are paid for each individual service service or group of services.	Over-provision
Capita-tion	Providers are paid a fixed amount in advance individual enrolled for a fixed period of time.	Under-provision

… to the analysis of multiple provider payment methods and combined effects on incentives

Payment Method	Definition	Incentives
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g., staff, drugs, …).	Under-provision
Per diem	Hospitals are paid a fixed amount per day that an admitted patient is treated in the hospital.	Extended length of stay, reduced cost per case; cream-skimming)
Case-based (“DRG”)	Hospitals are paid a fixed amount per admission depending on patient and clinical characteristics.	Increase of volume, reduction of cost per case, avoidance of severe cases
Global budget	Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. Budget is flexible and not tied to line items.	Under-provision, also in terms of quality
Fee-for-service	Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.	Over-provision
Capita-tion	Providers are paid a fixed amount in advance to provide a defined set of services for each individual enrolled for a fixed period of time.	Under-provision



… to the analysis of multiple provider payment methods and combined effects on incentives

Payment Method	Definition	Incentives
Line-item budget	Providers receive a fixed amount to cover specifi	Under-provision
Per diem	Hospita an adm	cost
Case-based ("DRG")	Hospita admiss charac	f costs ses
Global budget	Provide certain Budget	
Fee-for-service	Provide provide service	
Capita-tion	Provide to prov individ	

Multiple payment methods can be complementary & compensatory.

But if not aligned, they may create contradictory incentives.

This will positively or negatively affect cost containment, efficiency, equity, quality and financial protection.

II. Rather undesired provider reactions and effects through a mixed, non-aligned payment system

Providers change their service provision behaviour to benefit more from financially more attractive payment methods:

- **Resource shifting**
  - Healthcare providers shift *resources* in order to provide services under a particular funding flow
- **Service shifting**
  - A healthcare provider shifts *service provision* under a less favourable funding flow to a more favourable one
- **Cost shifting**
  - A provider shifts *costs* by charging higher rates for the same service to one funding flow, so as to compensate for a lower payment from another funding flow, i.e. one overpays, whereas another one underpays relatively

III. Challenges and key questions in relation to PFM and budget formation/execution

Challenges of implementing output-based PPMs in low-capacity contexts

- Insufficient degree of financial autonomy (need for facility account, ….)
- Existing PFM rules are not made for output-based PPMs
- Lack of data, weak information management system
- Requires changes in budget formulation/ execution/ monitoring
- BUT: we should question simple arguments of low financial management capacity of facilities
  - It is not all or nothing, it can be seen as a learning process
  - Financial autonomy for primary care providers often involves rather small amounts

Challenges of implementing output-based PPMs in low-capacity contexts (cont.)

- Weak or absent governance of purchasing function, requires capacity
- Unclear mandates of purchasing agencies and inadequate levels of autonomy of purchasers
- Introduction of a new PPM mix may often work better through a gradual approach
- PPMs need to be reviewed and adjusted on a regular basis

Which payment methods seem most suitable for primary care providers in low-income settings?

2022 Lancet Commission on

«Financing primary health care: putting people at the centre»

- Incentive for providers and users are inextricably intertwined: PHC provider payment policies must be aligned to policies on the elimination of user fees and informal payments for PHC services.
- Primary care providers should be paid by a **context-specific blended payment model**
  - **capitation at its centre (partial capitation)**
  - other payment methods (e.g., fee-for-service or performance-based bonuses for selected high priority services, and budgets to cover unavoidable fixed costs)

⇒ to maximise beneficial incentives and offsets perverse incentives of each payment method; to meet other service delivery objectives, e.g. access

Why have some health insurance schemes in LMICs been able to introduce output-based payment mechanisms?

- They did not operate through PFM rules
- Selected facilities were given some degree of financial autonomy, with modified PFM rules
  - e.g. Indonesia and Philippines expanded FA for certain types of facilities

How to determine budget estimates with an output-based payment system?

Separate process: determination of payment rates (costing, analysis of utilization data etc.), in line with available budget = this sets the budget cap

- The budget cap is the starting point for the budget estimate

- This needs to be adjusted on a regular basis, due to:
  - Changes in utilization rates
  - Inflation
  - Cost adjustments in the payment methods to finetune incentives

Thank you very much for your attention

Questions? **Comments!**

mathaueri@who.int

References

Slides are based on:

Mathauer I, Dkhimi F. 2019. Analytical Guide to Assess a Mixed Provider Payment System. Geneva, Switzerland: World Health Organization (WHO/UHC/HGF/Guidance/19.5). https://www.who.int/health_financing/documents/analytical-guide-to-assess-mixed-provider-system/en/

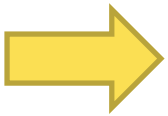
Barasa E, Mathauer I, Kabia E et al. 2021. How do healthcare providers respond to multiple funding flows? A conceptual framework and options to align them, Health Policy and Planning, 1-8. doi: 10.1093/heapol/czab003

Important distinction

Ministry of Finance:

Type of budgeting

- Input based (line item) budgeting, e.g.
  - Inputs
  - Incl. a line for an autonomous hospital

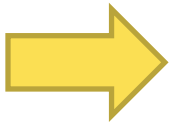


At the level of a provider:

Payment method

e.g. university hospital with financial autonomy:

= global budget



- Program budgeting

Health centre:

= line-item budget allocation