PROVIDER PAYMENT MECHANISMS

Dr Edward Rukwaro
Group CEO
Mediheal Group of Hospitals

SHOPS is funded by the U.S. Agency for International Development.
Abt Associates leads the project in collaboration with
Banyan Global
Jhpiego
Marie Stopes International
Monitor Group
O'Hanlon Health Consulting

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 of 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

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

Incentives

Payment Type	Incentive Effects				
	Incentive to increase activity	Incentive to decrease activity	Incentive to shift patients' costs to others	Incentive to target the poor	Controls cost of doctor employment
Fee-for-service	Yes	No	No	May be	No
Salary	No	Yes	Yes	No	No
Capitation	No	Yes	Yes	No	Yes
Diagnosis Related Group	Yes	No	No	May be	No
Pay for Performance	No	Yes	Yes	Yes	No
Budget	No	Yes	Yes	No	No

PPMs- Policy Trade-Offs

Capitation DRG Salary, Per Diem FFS	Capitation DRG Per Diem FFS, Salary	DRG FFS Per Diem Capitation	FFS Per Diem DRG Capitation
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 thee 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.)