

## For Policymakers

References for  
International  
Development

Health Policies,  
Incentives,  
Financing,  
Organization  
and Management

### Alternative Provider Payment Methods: Incentives for Improving Health Care Delivery

**P**rovider payment methods are important to consider any time a government or a payor wants to improve the efficiency and the quality of health services with the use of its funds. Changes in provider payment methods are often pivotal to broader health reform measures to contain costs and use existing resources effectively, and also to improve quality of care and equitable financial access to care. *Provider payment method* refers to the way in which money is distributed from a source of funds, such as the government, an insurance company or other payor (all also referred to as *fundholders*), to a health care facility (including a laboratory or a pharmacy), or to an individual provider, such as a physician, a nurse, a physical or psychotherapist.

Each provider payment method carries a set of *incentives* that encourage providers to behave in specific ways in terms of the types, amounts, and quality of services they offer. Health sector reform often requires policymakers to rethink the incentives they wish to set for providers. For example, provider payment reform is linked to government efforts to improve the efficacy of a health system through various means, among others:

- ▲ decentralizing the management of the health system
- ▲ separating health financing functions from the institution providing care
- ▲ contracting for public health services with private sector providers and non-governmental organizations
- ▲ developing or reforming public or private health insurance to expand coverage of the population
- ▲ promoting primary and preventive care over reliance on expensive curative and hospital-based care
- ▲ improving hospital management and quality of care.



Still, changes in provider payment methods can be considered without undertaking any of these broader reforms.

This primer describes the alternative payment methods developed over the course of the last 25 years—their advantages and disadvantages, the incentives they create for providers, payors, and consumers, how they operate—and offers policy guidance gathered from experiences in diverse countries and health systems. There is a selected bibliography for readers who wish more information or technical references.

#### ***Provider Payment Incentives***

*Each provider payment mechanism carries a set of **incentives** that encourage providers to behave in specific ways in terms of the types, amounts, and quality of services they offer.*



## Importance of Payment Reform

Provider payment methods vary around the world. In many developing countries, where health services are funded and organized by a central health ministry or related government agency, payment usually is set by a line item budget with resources allocated according to personnel and non-personnel budget categories such as salaries, drugs, supplies, utilities and fuel. The resources providers receive under such budgets typically depend on political considerations or historical trends, rather than on the quality and quantity of services delivered. In the private sector, fee-for-service payment is prevalent. While line item budgets cap government expenditure for public providers, fee-for-service payments may lead to cost escalation as providers face incentives to deliver more services, whether or not they are medically necessary.

Experience from around the world shows that, while many health care systems do suffer from underfunding, system performance is generally more sensitive to *how* funds are allocated to health care providers than to the *amount* of funds. Policymakers and health managers who seek to improve the cost effectiveness of the health system can do so by adopting new payment methods that introduce the risk of financial loss for health providers (see page 3 regarding financial risk incentives). Risk provides incentives to restructure and reorganize health care delivery to be more effective, efficient, and responsive to patients. However, these incentives work only if managers of health facilities and services have autonomy and

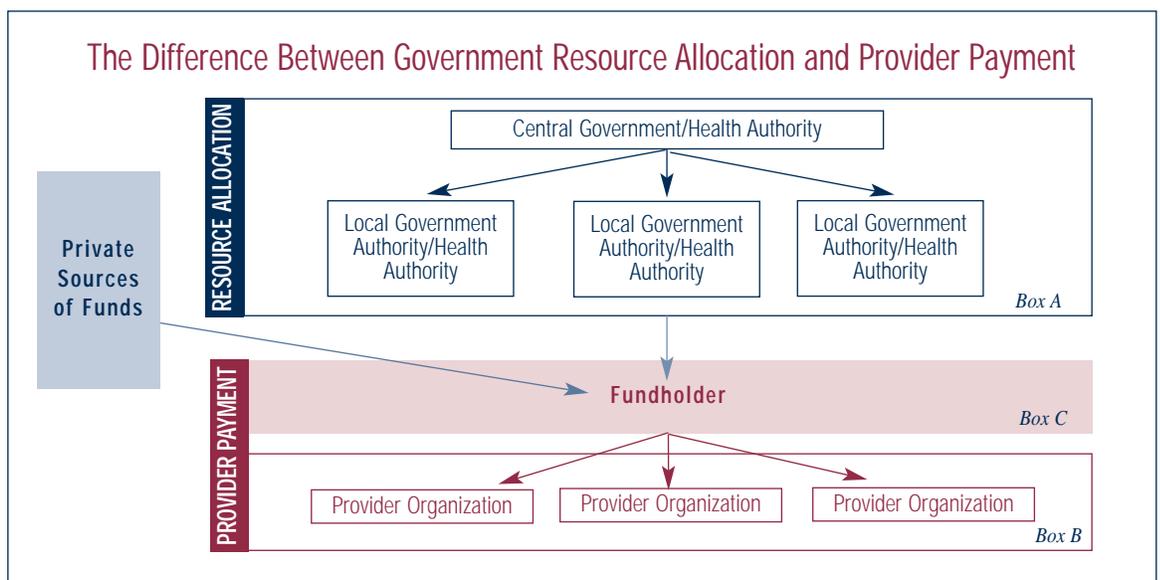
flexibility to reallocate resources, such as adding or removing certain types of services, changing treatment settings from inpatient to outpatient, or altering personnel size and mix.

Payment methods may be used to change how resources are allocated from one level of government to another (box A in figure below), or they may be used to allocate health care funds from a fundholder, receiving funds from public and/or private sources, to a specific health care provider (boxes B and C). Although reform of resource allocation methods between central and local governments is often an essential part of reform programs (particularly decentralization reforms), the desired changes in service delivery cannot be achieved unless the means of channeling these funds to providers are also reformed. This primer focuses on the latter issue, namely payment of providers. However several of the payment methods discussed here can also be used to transfer resources between different levels of government.

## Relevance of Provider Payment Methods to Health Care Reform

Alternative provider payment methods can be applied to a variety of health care reform situations:

- ▲ *Reallocating resources to improve efficiency of the health system and creating appropriate incentives for consumers and insurers:* For example, new payment methods can redirect funding and utilization among primary, secondary, and tertiary care facilities. This reallocation is critical to improving the



efficiency and effectiveness of the health care delivery system as well as increasing access to it. Both providers and patients need incentives to make maximum use of preventive and primary care and to use more costly, curative secondary and tertiary care only when appropriate.

- ▲ *Transferring funds among regions:* Payment reforms can be used to set inter-regional payment transfers when patients who receive care in a local health facility are not residents of the region.
- ▲ *Allowing public hospitals to bill for services to improve quality and efficiency:* New methods for government to pay hospitals are important components of reforms that grant management autonomy to public hospitals and authorize them to charge and retain fees including insurance reimbursements for services to covered patients. Some hospital reform initiatives replace the line item budget method with a combination of per capita payments, contracts for specified services, or fee-for-service payments.

Provider payment reforms may encompass national health care service delivery, sub-national regions, or segments of a system, such as individual purchaser-provider relationships between an enterprise and local health providers.

## Attributes of Provider Payment Methods

Each provider payment method can be defined through a number of different attributes — namely the *unit of payment*, whether the method is *prospective or retrospective*, and the degree of *financial risk* borne by the provider and the payor respectively. The first two attributes (unit of

payment and prospective or retrospective) directly affect the distribution of financial risk. The table on pages four and five describes these attributes for six major payment methods.

Payment methods can set prices for an aggregate *unit of payment* (a fixed payment for all services required by one person during the course of a year, as in capitation payment) or for disaggregated units (specific services such as X-ray, consultation, drug item, as in fee-for-service payment). Other payment methods fall between these two extremes, for example case-based payment sets the price for all services needed to treat a defined case of illness, classified by a diagnostic related group (DRG).

The terms *prospective and retrospective* refer to *when* the payment rates for a package of health services is set. When the rate for a clearly defined package of services is set *before* the treatment takes place, it is referred to as *prospective* payment. Prospective payment methods, such as case-based and capitation payment, increase incentives for efficiency because the health care provider faces higher financial risk. When the payment rate is established *during or after* the service has been rendered, it is *retrospective* payment (or cost-based reimbursement). Retrospective payment tends to be cost-enhancing rather than cost-reducing.

A health care provider is at *financial risk* when the provider bears the consequences of the cost of service turning out higher than anticipated (due to unexpectedly complex cases or provider inefficiency). At the same time the provider stands to gain from the cost of service turning out lower than anticipated (due to skimping on service delivery or healthier patients than anticipated or provider efficiency). Different payment methods distribute financial risk differently between provider and payor. The provider tends to bear more risk the more aggregated unit of payment is. Also prospective forms of payment place the provider at more financial risk than retrospective payment.

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## Incentives Created by Payment Methods

Each payment method has different impacts on efficiency, quality, equity and patient satisfaction. Although often the main goal of alternative payment methods is to improve efficiency in resource use, they may all have other impacts, both intended and unintended. For example, if incentives to promote efficiency are taken to the extreme, they may create incentives to reduce quality, equity, and consumer satisfaction. Policymakers must carefully identify the full set of incentives created under each payment method and decide what trade-offs are acceptable. Sometimes the payment methods can be adjusted to introduce more appropriate

incentives for quality, equity and consumer satisfaction. Otherwise, separate systems such as quality assurance or utilization management are necessary to avoid undesirable effects. At all times, allowing patients to choose providers and insurance alternatives creates the opportunity for the consumer of healthcare to have a direct voice in what tradeoffs are acceptable.

Where there is a third party payor—such as an insurance agency that contracts with hospitals and providers to pay for the care of covered patients—it is common for each of the payment methods presented in the table on the next pages to be

## Six Major Payment Methods: Advantages and Disadvantages

Payment method	Unit of Payment	Prospective or Retrospective	Description
Line item Budget	Functional budget categories, usually on an annual basis	Either	Budget is allocated according to specific categories of resources or functions, usually on an annual basis. Budget categories include: salaries, medicines, equipment, food, overhead, administration.
Global Budget	Health facility: hospital, clinic, health centre	Prospective	Total payment fixed in advance to cover a specified period of time. Some end-of-year adjustments may be allowed. Various formulas can be used: historical budgets, per capita rates with various adjustments (age, sex), utilization rates for the previous year.
Capitation	Per person per year	Prospective	A payment made directly to health care providers for each individual enrolled with that provider. The payment covers the costs of a defined package of services for a specified period of time. In some instances, the provider may then purchase services which it cannot (or chooses not to) provide itself from other providers.
Case-based payment	Per case or episode	Prospective	A fixed payment covering all services for a specified case or illness. Patient classification systems (such as Diagnosis Related Groups - DRGs) group patients according to diagnoses and major procedures performed. Most frequently applied to inpatient services, although outpatient groups are being developed.
Per diem	Per day for different hospital departments	Prospective	An aggregate payment covering all expenses incurred during one inpatient day.
Fee-for-service	Per unit of service	Retrospective	Separate fees for different service item eg. medicines, consultation, tests.

Efficiency	Quality and Equity	Management and Information systems	Financial risk
<ul style="list-style-type: none"> <li>- Little flexibility in resource use</li> <li>- Tendency to spend entire budget even if unnecessary, to ensure that level of budget support is maintained</li> </ul>	<ul style="list-style-type: none"> <li>- Rationing may occur if budget is too low</li> <li>- If rationing occurs more complex cases may be referred elsewhere</li> </ul>	Relatively simple	Provider = LOW Payor = LOW
<ul style="list-style-type: none"> <li>+ Flexibility in resource use</li> <li>- Spending set artificially rather than through market forces</li> <li>- Not always linked to performance indicators (e.g. volume, quality, case-mix)</li> <li>- Cost-shifting possible if global budget covers limited services; one provider may refer patient to another who is outside purview of global budget to minimize expenditures under global budget</li> </ul>	<ul style="list-style-type: none"> <li>- Rationing may occur if budget is too low</li> <li>- If rationing occurs more complex cases may be referred elsewhere</li> <li>+ Case-mix adjustments in global formulas link budget amounts to complexity of cases; other adjustors may be used to adjust payment for special population groups.</li> </ul>	Requires ability to track efficiency and effectiveness of resource use in different departments, and mechanisms to switch resources to most effective uses.	Provider = HIGH Payor = LOW
<ul style="list-style-type: none"> <li>+ Flexibility in resource use</li> <li>+ The more services included in the package the less the scope for cost shifting</li> <li>+ Resources closely linked to size of population served and their health needs</li> </ul>	<ul style="list-style-type: none"> <li>- Providers may sacrifice quality in order to contain costs</li> <li>- Rationing may occur if capitation is too low</li> <li>- Capitation may encourage providers to enroll healthier patients</li> <li>- Patient choice of provider is generally restricted</li> <li>+ Adjusters in capitation formula can adjust payment to special population groups</li> </ul>	Management system required to ensure that each beneficiary registers with one provider and primarily uses that provider. Utilization management and quality assurance programs essential to prevent under-servicing. If payment covers primary and secondary services, providers at different levels of the system must establish contractual links with each other.	Provider = HIGH Payor = LOW
<ul style="list-style-type: none"> <li>+ Flexibility in resource use</li> <li>- Tendency for hospitals to increase cases (through increasing admissions or double-counting admissions) to increase revenue</li> <li>+ Patient classification systems can be used to monitor performance</li> </ul>	<ul style="list-style-type: none"> <li>+ Case based payment links payment directly to the complexity of cases.</li> </ul>	Providers need ability to record and bill by defined case, this generally entails collecting a large volume of reliable information on patient characteristics, diagnoses and procedures.	Provider = MODERATE Payor = MODERATE
<ul style="list-style-type: none"> <li>+ Flexibility in resource use</li> <li>- Tendency for hospitals to increase length of stay to increase revenue</li> </ul>	<ul style="list-style-type: none"> <li>+ Per diem rates allow longer stays for more complex cases.</li> </ul>	Need to track inpatient days by department and ensure costs are covered.	Provider = LOW Payor = HIGH
<ul style="list-style-type: none"> <li>+ Flexibility in resource use</li> <li>- Tendency for provider to increase number of services to increase revenue</li> </ul>	<ul style="list-style-type: none"> <li>+ Payment is directly related to intensity of service required.</li> <li>- There is a tendency to over-service or provide unnecessary interventions.</li> </ul>	Providers must record and bill for each medical service transaction.	Provider = LOW Payor = HIGH

accompanied by some payment on the part of the patient. The form of payment by the patient will not necessarily be determined by the payment method used by the payor. For example, fee-for-service payment by the patient could be combined with the payor using any of the payment methods listed in the table on pages four and five. This primer does not discuss fully the range of possible patient payment methods or their incentives, however it should be noted that:

- ▲ For all payment methods, financial risk to the *patient* is determined by what services are covered by the third party payor under the payment method and by whether the payor requires the patient to make a co-payment or pay a deductible.
- ▲ With respect to equity, the strongest influence upon financial accessibility is the payment incurred by the patient, *not* the payor.
- ▲ Ensuring efficient use of different types of health care services entails creating appropriate incentives for *both* providers and patients.

## Efficiency

Efficiency generally refers to providing the maximum amount of services, at an acceptable level of quality, for the least amount of cost. Incentives for efficiency increase when payment rates:

- ▲ increase financial risk to providers
- ▲ allow flexibility in use of resources
- ▲ link to performance indicators
- ▲ cover relatively comprehensive services to minimize cost-shifting to other providers
- ▲ combine with patient choice of provider so that providers compete to attract patients.

The level of financial risk assumed by health care providers differs under each payment method defined in the table. Implementation rules also affect risk. A prospective payment system that allows adjustments to the set price at the end of the year affects risk. If health institutions must bear a loss then the incentives associated with financial risk are stronger.

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## *Preparing for New Payment Systems*

*Working out the local design and management infrastructure to support a new payment method is a lengthy, detailed, but necessary process to ensure that the right incentives are in place and that facility managers have the skills and systems to deal with these new incentives.*

## Quality

Quality of health service delivery means providing care that is expected to achieve the most favorable balance of medical risks and health benefits. It also means performing interventions that are known to be safe and effective according to accepted standards of practice. Lastly, quality of care also refers to the patient's perception of quality as described below under "consumer satisfaction." Incentives for quality increase when payment methods encourage physicians, patients and insurers to choose those treatments which are found to be more cost-effective, of higher technical quality and properly implemented. Incentives for cost containment and efficiency can compete against incentives for quality. Incentives for efficiency should not be so stringent as to encourage providers and insurers to underserve patients. Quality assurance programs, provider ethics, and ability of patients to choose and switch providers are important and complementary aspects of payment systems that can provide an appropriate balance to incentives for efficiency.

## Equity

At its most general level, equity means ensuring that all the people in the population have "fair" financial and geographic access to health care, where the term *fair* is determined by societal values. While patient payment may be the primary influence upon the financial accessibility of care, the method of payment by third party payors is also important. In fact, payment methods also can be used to motivate providers to better serve the poor or underserved areas:

- ▲ Health care facilities serving people in remote rural areas, or in poor communities, may be paid at a higher rate than other facilities or using a different payment method. Unless special treatment is given to facilities serving disadvantaged populations, there is a danger that providers (particularly private ones) will not locate in these areas, and the access of the population to health care is limited.
- ▲ *Adjustors* in payment formulas can be used to ensure that patients are not discriminated against due to the complexity of their illness and treatment, by profit-seeking providers. For example under capitation payment, higher amounts can be paid for the elderly or those with chronic illness, in order to insure that providers do not try to exclude these patients from their caseload.



## Consumer Satisfaction

Consumer or client satisfaction refers to meeting patients' perceived needs and concerns. This *satisfaction* includes not only considerations for technical quality of care, but also for aspects related to convenience of service, friendly atmosphere, cleanliness, and attention to the concerns family and friends may have about the care of the patient. Provider payment methods create an incentive for improving client satisfaction in a system where providers compete for patients whom they attract by offering convenient, friendly, and quality services. To improve consumer satisfaction, payment methods ought to link consumer *choice* of provider with payment to the provider.

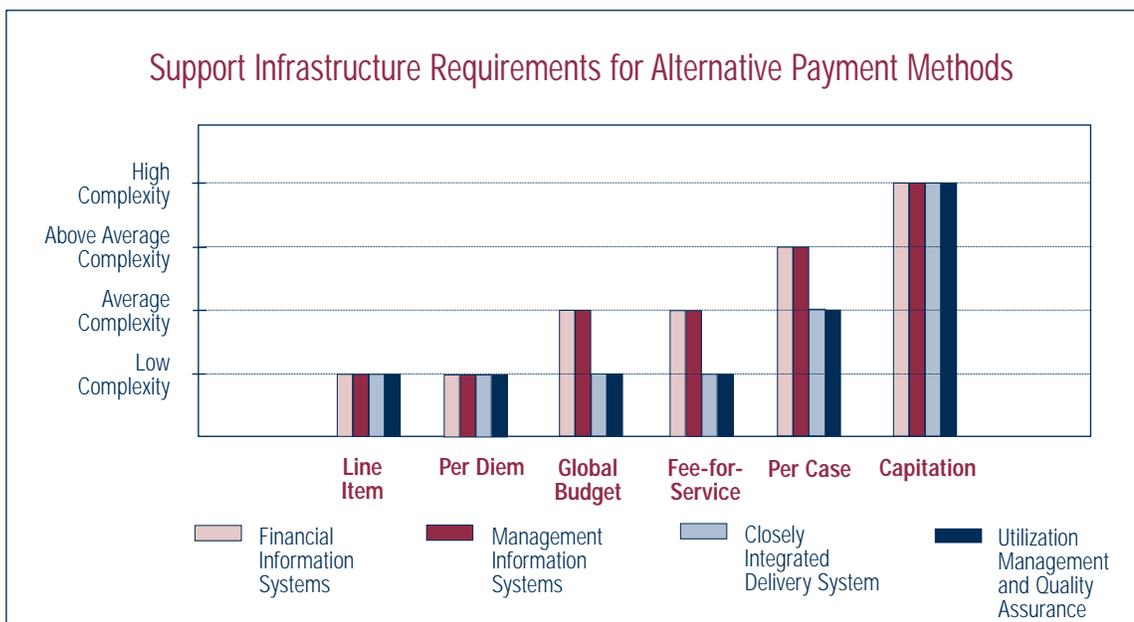
## Support System Design and Implementation

The success of each payment method depends on more than the incentives created. Equally important are the **legal, financial, and management systems**. Each payment method requires a different legal framework and management information system. The success of provider payment reform may also depend upon how effective *referral systems* are between providers at different levels of the health care system, and the presence of *quality assurance* and *utilization management* programs to monitor a patient's care and the

effectiveness of treatment. Payment methods that cover a relatively large package of care, such as capitation, require a well-developed referral system to ensure that the most cost-effective level of care is chosen for a treatment or follow-up. The bar chart below indicates the relative level of complexity for various support components required by each payment method and more detailed examples are given in the table on pages four and five.

For every payment reform a legal and management framework needs to be established with definitive lines of authority and responsibility. For the legal framework, a country would likely have a national law that establishes the new payment method or that allows use of alternative payment methods, or a local waiver that permits a region to experiment with a new payment method. For example, capitation usually requires new laws that allow providers to take on some insurance functions and to form a network of affiliated providers. Fee-for-service may require new laws about who can set the fees, for example, the health care authority, individual providers, and so on.

Management autonomy with respect to both financial and management issues is critical to the success of payment reform. *Financial autonomy* allows a facility manager or program administrator to reallocate resources among functions and programs to improve efficiency. *Management autonomy* allows a manager to hire or fire personnel and restructure or reorganize the facility as needed.



Not all payment methods require all elements of a *financial information system*, but in order for facility managers to respond to incentives inherent in the payment methods, the following would be important: patient-level resource use (encounter) forms, budgets, cost accounting systems, records to track multiple sources of revenue and patient insurance eligibility. Similarly, elements of *management information systems* to consider include: productivity measures, case-mix analysis, and various analyses using an *international minimum basic data set*. By compiling data on patient information, diagnoses, and treatment procedures, collected at hospital admission or discharge, minimum data sets support clinical and financial decisions and greatly facilitate international or regional comparisons. *Case-mix* is a measure of the complexity of patients treated in a health care organization, usually in terms of resource intensity.

Working out the local design and management infrastructure for any new form of provider payment is a lengthy and challenging process, but essential to ensuring that the right incentives are in place and that facility managers have the skills,

systems and authority to adapt to the new incentives. Few countries will implement payment reform with all of the support systems described here fully developed, but some of the support systems are absolutely essential at start-up, and others need to be developed over the mid- to long-term.

## Experiments with Reform and Lessons Learned from International Experience

Health care reform is underway in countries worldwide. The examples on pages eight and nine illustrate diverse experiments in provider payment reform.

Based on experience from around the world, the following lessons about provider payment reform have emerged:

- ▲ ***Financial incentives matter.*** Payment methods are among the most critical aspects of how a country's health financing system is designed, because they can lead to more

*(continued on page 10)*

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## International Experiments in Payment Reforms

### Thailand

In 1990, Thailand passed a Social Security Act which mandated per capita payment to contracted hospitals as a mechanism to enhance efficiency and contain costs. The capitation rate of 700 *baht* (\$28) per year was to cover the cost of care for non-work related sickness. Preliminary evidence suggests that this payment system has increased the use of ambulatory services and decreased the use of inpatient services as expected; however, the system's hospital-focused nature may have limited expansion and utilization of primary care services. It is proposed that primary care medical clinics take a more substantial role in the scheme as subcontractors to the hospital. In addition, consumer choice of provider did not function until recently. In theory, workers register with the hospital of their choice. In practice, the social security scheme's information system was not adequate and employers chose the hospital, rather than the employee. This would often result in a provider that was geographically inaccessible to the worker. (*capitation*)

### Kyrgyzstan

In 1995, the Kyrgyzstan Ministry of Health launched in Issyk-Kul *Oblast* a health insurance experiment with three main components: (1) restructuring of the health care delivery system; (2) introduction of new incentive-based payment systems; and (3) creation of a Mandatory Health Insurance Fund. Restructuring is intended to downsize the hospital sector and shift resources to an improved primary care system. Family group practices were set up as independent entities with their own financial and clinical information systems, managed by a practice manager. For the first time, patients could choose their primary care physician. Payment reforms included development of a case-based payment system for hospitals, a fee schedule for polyclinic services, and a capitation system for family group practices. A simple cost accounting system was developed to support the payment system, and a clinical information system was developed to enter and pay hospital bills. The information systems are being used, but funds are only beginning to flow according to the new payment systems. (*case-based payment, fee-for-service, capitation*)

## Argentina

In Argentina, union-owned health insurance entities, *obras sociales*, insure about 40 percent of the population. PAMI, an *obra social* that covers 3 million retired and disabled Argentines, purchases health care from providers through a variety of contracts, from capitation, to fee-for-service, to case-based payment. Other *obras sociales*, that once provided their own health services, began purchasing in the mid-1980s health services either directly from providers or, and more recently, through intermediary Enterprise Transitory Units; and in many cases capitation has replaced fee-for-service payment. In 1996, a World Bank-financed Ministry of Health project began to promote competition among the existing 300 *obras sociales*, which varied considerably in size and resources, by encouraging reforms to allow beneficiaries to choose among *obras sociales*. Since this reform, several mergers have resulted, dropping the number of *obras sociales* to fewer than 100. Reportedly, the larger ones are developing new relationships with providers including innovative provider payment systems. (*capitation, fee-for-service, case-based payment*)

## Brazil

In 1985, Brazil's federal Unified Health System (*SUS*) adopted a mixed case-based, fee-for-service payment system to reimburse public and private health care providers nationwide. Reimbursement rates have not been adjusted systematically over time; instead, adjustment is done by negotiation subject to the political power of certain provider groups. There is evidence that *SUS* tariffs offer few, if any, economic incentives for the provision of cost-effective services. Extremely low reimbursement rates for most types of primary and preventive care services may be partly responsible for low quality of care and low utilization rates, especially for maternal and prenatal care. More recently, under the Health Provision Programs (*PAS*) in Sao Paulo, the government has experimented with the use of capitation-based payment. (*case-based payment, fee-for-service*)

## Chile

In 1992, the Chilean Ministry of Health's National Health Fund (*FONASA*) designed a mixed case-based and fee-for-service system to reimburse public hospitals. Realizing that many public hospitals primarily the largest, oldest, more inefficient and complex would be unable to balance their finances through the new fee system, *FONASA* continued historic reimbursement but at the same time recorded how much hospitals would receive if they were reimbursed under the new system. In anticipation of the new system, most hospitals have made various managerial and technical reforms and now track their output and theoretical revenue as if reimbursed exclusively with the new payment method. Gradually, *FONASA* is adjusting what it pays hospitals, in line with the new system. At the primary health care level, *FONASA* finances municipal health centers using a capitation-based payment mechanism. Residents register with their municipality. *FONASA* allocates funds in proportion to enrollment, with adjustments for location and poverty. (*case-based payment, fee-for-service*)

## United States

In 1983, the U.S. Medicare program (government health insurance for the elderly covering 15 percent of the population) replaced traditional fee-for-service cost-based reimbursement to hospitals with case-based inpatient payments as a means to control costs and improve efficiency. The following impacts resulted:

- △ average length of stay fell 14.6 percent between 1982 and 1985
- △ number of hospital days/1000 fell 22 percent by 1985
- △ real growth rate of total hospital expenditures decreased from 5.4 percent (1977-83) to 2.8 percent (1983-87)
- △ hospital payments decreased from 70 percent to 57 percent of total Medicare outlays by 1988
- △ no major reports of declines in quality or customer satisfaction.

(*case-based payment*)

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### *A Key Lesson Learned*

*Experience from around the world suggests that system performance is more sensitive to **how** funds are allocated to providers than to the total amount of funding available for health service.*



(continued from page 8)

efficient systems that promote preventive and primary health care and more judicious use of specialists, diagnostic tests, and referral services.

- ▲ **Experimentation with different methods is an essential step** toward developing optimal payment methods for local conditions. No single method is appropriate for all situations, and none is perfect. Testing reforms in local demonstration sites to determine impacts—positive and negative—allows policymakers to make corrections before launching national-level reforms.
- ▲ **A payment method's defining characteristic is the unit of payment**—per case, per day, per person per year, per service, per visit. Whatever the unit of payment, providers have incentives to increase the number of units while decreasing cost per unit. For example, per case payment encourages providers to decrease the cost per case, but increase the number of cases treated.
- ▲ **As the unit of payment becomes more aggregated, the level of financial risk to the provider rises.** For example, there is more financial risk with per case payments than with fee-for-service.



- ▲ **Payment methods that have stronger incentives for efficiency, equity, consumer satisfaction and quality tend to have higher administrative costs.** Their complexity demands more clinical and financial information, more management skills, and a strong referral system and support infrastructure.
- ▲ **Unnecessarily sophisticated details in the design should be avoided so that providers can easily understand the incentives.** Patients and providers must be able to understand the basic aspects of payment methods in order to respond appropriately to the desired incentives.
- ▲ **Health care systems often use a combination of payment methods.** This combination allows the strength of one payment method to compensate for weakness in other methods.
- ▲ **Competition among providers tends to improve the performance of payment methods.** Competition for clients encourages health institutions to maintain quality and consumer satisfaction. A good regulatory framework would ensure that patients are well informed about the quality of care and other financial and managerial aspects of the providers they are choosing among.
- ▲ **Skilled management and solid information systems are essential under any payment method.** Effective implementation of any payment method depends on the availability of the patient and financial data necessary to assure that payment is made for services actually delivered, for services the payor intended to cover, and for the patients designated to receive the services.
- ▲ **Quality assurance programs are essential.** In order to ensure an appropriate balance between cost efficiency and quality of care, all payment methods must be implemented along with efforts to improve the level of clinical and management performance.

## Three Questions for Policy Research

There has been substantial documentation of the impact of provider payment methods on health systems in industrialized countries but much less so in middle- and lower-income countries. Furthermore, there is only limited understanding of how the observed effects of alternative provider

payment methods are brought about. In the U.S. for example, case-based payment led initially to lower costs. But it is unclear what role the internal management systems of hospitals played in mediating the impact of payment mechanisms to achieve this result versus factors having to do with the broader health market structure, such as economies of scale achieved through mergers of providers.

Reliable information about the effects of provider payment reform in middle- and lower-income countries is a priority need, particularly as the context in which reform takes place is often very different from that in industrialized countries. To help bridge that knowledge gap, Partnerships for Health Reform (PHR) is studying the impact of capitation and case-based provider payment reform in Argentina and Thailand. PHR's Applied Research Program is investigating three key questions:

- ▲ How do the new provider payment mechanisms affect health care services, particularly the allocation of resources between primary/preventive and higher-level care?
- ▲ What new systems do hospitals and other health care providers implement in response to payment reform?
- ▲ How is the structure of the health care market, as measured by variables such as the number, size, and types of providers, affected by provider payment reform?

In 1999, PHR will present and disseminate findings from the studies. The experience in the two study countries can be of great help to others considering or beginning reforms to implement these methods.

## Selected Bibliography and References

Barnum, H, J Kutzin, H Saxenian. 1995. "Incentives and Provider Payment Methods." *International Journal of Health Planning and Management* 10: 23-45.

Bitran, R, W Yip. 1998. "A Review of Health Care Provider Payment Reform in Selected Countries in Asia and Latin America." Bethesda, MD: Partnerships for Health Reform (PHR) Project, Abt Associates Inc.

Bodenheimer, T, K Grumbach. "Reimbursing Physicians and Hospitals." *Journal of the American Medical Association (JAMA)* 272 (12): 971-977.

Coulam, R, G Gaumer. 1991. "Medicare's Prospective Payment System: A Critical Appraisal." *Health Care Financing Review* Annual Supplement: 45-77.

Grumbach, K, J Fry. 1993. "Managing Primary Care in the United States and in the United Kingdom." *New England Journal of Medicine* 328 (13): 940-945.



Leidl, R. 1990. "Diagnostic-related groups: Their introduction and application." WHO/Copenhagen Regional Office for Europe. EUR/ICP/MPN 532.

Maceira, D. 1998. "Provider Payment Mechanisms in Health Care: Incentives, Outcomes and Organizational Impact." Bethesda, MD: Partnerships for Health Reform (PHR) Project, Abt Associates Inc.

Prospective Payment Assessment Commission. July 1993. "Global Budgeting: Introduction and Overview." *Global Budgeting: Design and Implementation Issues*. C-93-01. Washington, D.C.

Purvis, G. 1997. "Health Care Reform in the Issyk-Kul Oblast, Kyrgyzstan, 1994-1997: Restructuring through Payment Reform." Bethesda, MD: ZdravReform Program, Abt Associates Inc.

Rice, JA (ed.). 1996. "Provider Payment Reforms in Russia: The Economic Lever for Health Sector Performance Improvement." *The Journal of Health Administration Education*, Special Issue: 14 (2).

Sulvetta, M. 1991. "Achieving Cost Control in the Hospital Outpatient Department." *Health Care Financing Review*, Annual Supplement: 95-106.

Tangcharoensathien, V, A Supachutikul. January 1997. "Compulsory Health Insurance Development in Thailand." Thailand: Health Systems Research Institute.

Wiley, M. 1992. "Hospital-Financing Reform and Case-Mix Measurement: An International Review." *Health Care Financing Review* 13 (4).

Wouters, A, G Gaumer, K Quinn. 1995. "Alternative Methods of Payment: A One-Week Workshop." Bethesda, MD: ZdravReform Program, Abt Associates Inc.



# PHR

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