PAYMENT INNOVATION IN OECD COUNTRIES

Michael Müller
OECD Health Division

Strategic Purchasing for Universal Health Coverage
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Limitations of traditional modes of payment led to innovations

- Payment reform high on agenda in OECD countries
- Main aims pursued with payment reform
  - improving **quality of care**
  - generating **efficiency** gains
  - enabling **coordination** across providers
- Reform trends
  - More blended mix of payment systems (increased use of P4P)
  - Developing innovative models (new ways of 'bundling')
    - Bundling for chronic conditions or acute care episodes
    - 'Population-based bundling' (across providers)

PPS in OECD countries

	Provider payment		
	Primary care	Outpatient specialist care	Inpatient[1]
Australia	FFS/P4P	FFS	DRG
Austria	FFS	FFS	DRG
Belgium	CAP/FFS	FFS	Global budget
Canada	CAP/FFS/P4P	FFS/Global Budget/Other	Global budget
Chile	CAP/FFS	FFS/Global Budget	Procedure service
Czech Republic	CAP/FFS/P4P	FFS	DRG
Denmark	CAP/FFS	Other	Global budget
Estonia	CAP/FFS/P4P/Global	FFS	DRG
Finland	Global Budget	FFS	DRG
France	FFS/P4P/Other	FFS/P4P/Other	DRG
Germany	FFS	FFS	DRG
Greece	FFS	FFS	DRG
Hungary	CAP/P4P/Global Budg	FFS	DRG
Iceland	Global Budget	FFS	Global budget
Ireland	CAP/FFS	Global Budget	Global budget
Israel	CAP/Global Budget	Global Budget	Procedure service
Italy	CAP	FFS/Global Budget	Global budget
Japan[2]	FFS	FFS	DRG/Procedure service
Korea[3]	FFS/P4P	FFS/P4P	Procedure service
Luxembourg	FFS	FFS	Global budget
Mexico	CAP/Global Budget	FFS/Global Budget	Global budget
Netherlands	CAP/FFS/P4P/Global	FFS/P4P	DRG
New Zealand	CAP/FFS/P4P	Global Budget	Global budget
Norway	CAP/FFS	FFS/Global Budget/Other	Global budget
Poland	CAP	Other	DRG
Portugal	CAP/P4P/Global Budg	P4P/Global Budget	Global budget
Slovak Republic	CAP/FFS	FFS	Procedure service
Slovenia	CAP/FFS	FFS	DRG
Spain	CAP/P4P	FFS/Global Budget	Line-item remuneration
Sweden	CAP/FFS/P4P	FFS/P4P/Global Budget	Global budget
Switzerland	CAP/FFS	FFS	DRG
Turkey	CAP/P4P	Global Budget	Global budget
United Kingdom	CAP/FFS/P4P/Other	P4P/Global Budget/Other	DRG
United States[4]	CAP/FFS/P4P/Other	FFS/P4P/Global Budget	DRG

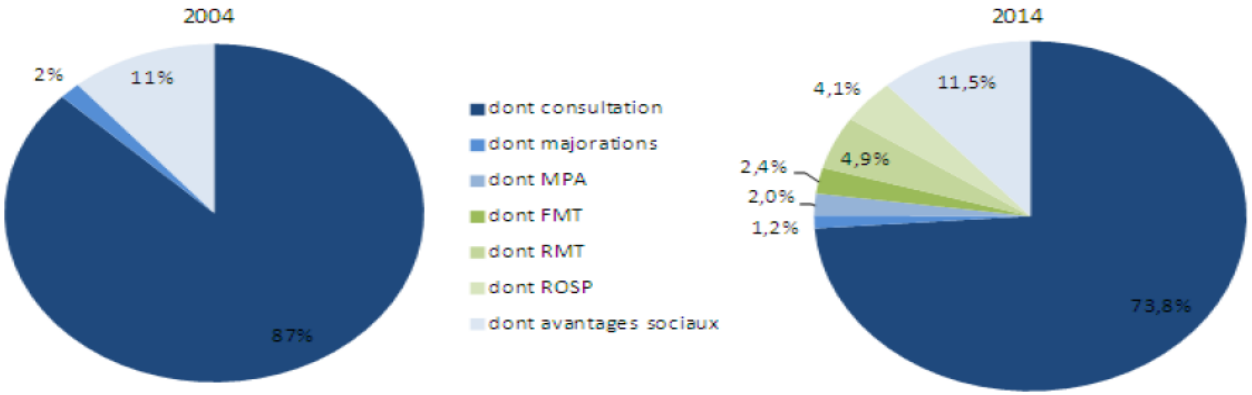
Source: OECD (2016)

Why use mixed payment systems

- Counterbalance weaknesses of individual payment systems
  - e.g. complementing CAP with FFS to incentive activities (prevention, home visits, coordinating activities, etc…)
- Single payment system not possible or inappropriate in some cases
  - Case-based payment limited in hospitals
  - Desire to reward 'performance' (in P4P) but only to complement main payment systems
  - New innovations focus only on specific conditions/patients
    - 'Bundling' for diabetes care, acute care episodes

Blending in practice: slow move away from FFS in France

Graphique 1 • Décomposition du coût de la consultation des généralistes en France, 2004



Sources : DSS/SDEPF/6B

Note de lecture : MPA : majoration pour personnes âgées de 80 ans et plus et le suivi de leur traitement (5 € par consultation ou visite) ; FMT : forfait médecin traitant (5 € par an et par patient) ; RMT : rémunération spécifique annuelle médecin traitant pour la prise en charge des patients souffrant d'affections de longue durée (40 €). Par ailleurs, les avantages sociaux correspondent à la prise en charge par l'assurance maladie d'une partie des cotisations sociales.

- Capitation for patients with 'ALD' (40 EUR p.a.) → purpose: coordination
- P4P: 'ROSP' with 29 indicators from four different areas: organisation of practice, chronic conditions, prevention and efficiency
- Global Budget: 'ENMR' targeted at multi-disciplinary group practice
  - Different modules, frequently coordinating activities in practice
  - ~50 k EUR per structure p.a.

Netherlands: bundling for chronic conditions in primary care

GP practice income

~40% CAP adjusted for age, gender, zip code

~40% FFS for consultation, home visits, examination, vaccination, screening

~20% rest

- Out-of-office care (per hour)
- P4P scheme
- Bundling for chronic conditions

Bundling for Diabetes, COPD, CVD

2007 - Introduction of bundled payment

- Annual capitation payment to care groups with quality stipulations
- Care contracts between insurers and "care groups" for package of negotiated activities
- Care groups legal entity mainly GPs; can provide services themselves or subcontract

Content of diabetes bundled payment in care groups

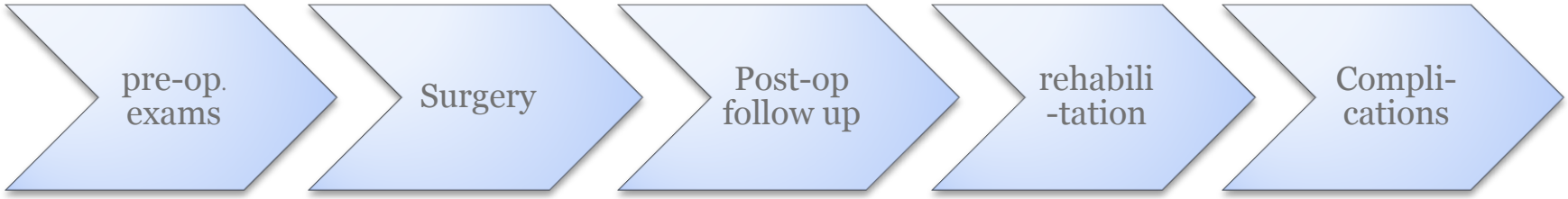
	Provided by care groups
Diagnostic phase	
Formal diagnosis	None
Initial risk assessment	All
Treatment and standard check-ups	
12-month check-ups	All
3-month check-ups	All
Obtaining fundus images	All
Evaluating fundus images	All
Foot examinations	All
Supplementary foot exams	All
Foot care	None
Laboratory testing	Most
Smoking cessation support	None
Exercise counselling	All
Supervised exercising	None
Dietary counselling	All
Prescribing medicines	Some
Insulin initiation	All
Insulin adjustment	All
Psychosocial care	None
Medical aids	None
Additional GP consultations (diabetes-related)	All
Additional GP consultations (non-related)	None
Specialist advice	All

Source: Adapted from Struijs et al. (2012a)

Other ‘bundled’ approaches

Acute care episodes

- Single tariff for range of outpatient and inpatient services
- Ex. Hip and Knee replacement in Sweden



- Tariff can include Patient Reported Outcome Measures (PROMs)

Population-based bundling

- Group of providers that are jointly accountable financially and for quality of care for a population
- Payment frequently shared savings contract with virtual budget embedded in FFS or capitation
- Aim: care strategy across sectors to overcoming fragmentation of care

Conclusions

- Payment reforms remain high on agenda of health policy makers → frequently embedded in broader health reforms
- Trend towards more mixed payment systems with innovative component
- Recent innovations imply more financial risk for providers and require strong IT systems
- Early evaluation show some promise for a number of innovative payment reforms, inconclusive for others

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