

# Quality care & costs

(in the context of Optimal Provider-Payment Mix)

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# Painting the big picture

- Universal & quality healthcare is an ideal towards which all countries strive.
- Achieving & sustaining universal care is a constant balancing act between revenue & expenditure.
- Revenue generation is important for coverage expansion, but so is expenditure management & provider payment early on, or at key junctures, of system refinement.
- The most successful countries make choices that are coverage-enhancing, learn from past challenges & continuously adjust & adapt.
- Learning from other countries can help make better technical decisions & navigate implementation challenges.



# The idea

- Effective resource management is key.
- Consider the optimal provider payment mix, as proposed by the US-based non-profit Results for Development Institute (R4D) (<http://r4d.org>).



# Revenue & expenditure: two sides of the universal coverage coin

**Revenue:**  
the resources  
available to expand  
& sustain effective  
coverage



## **Expenditure:**

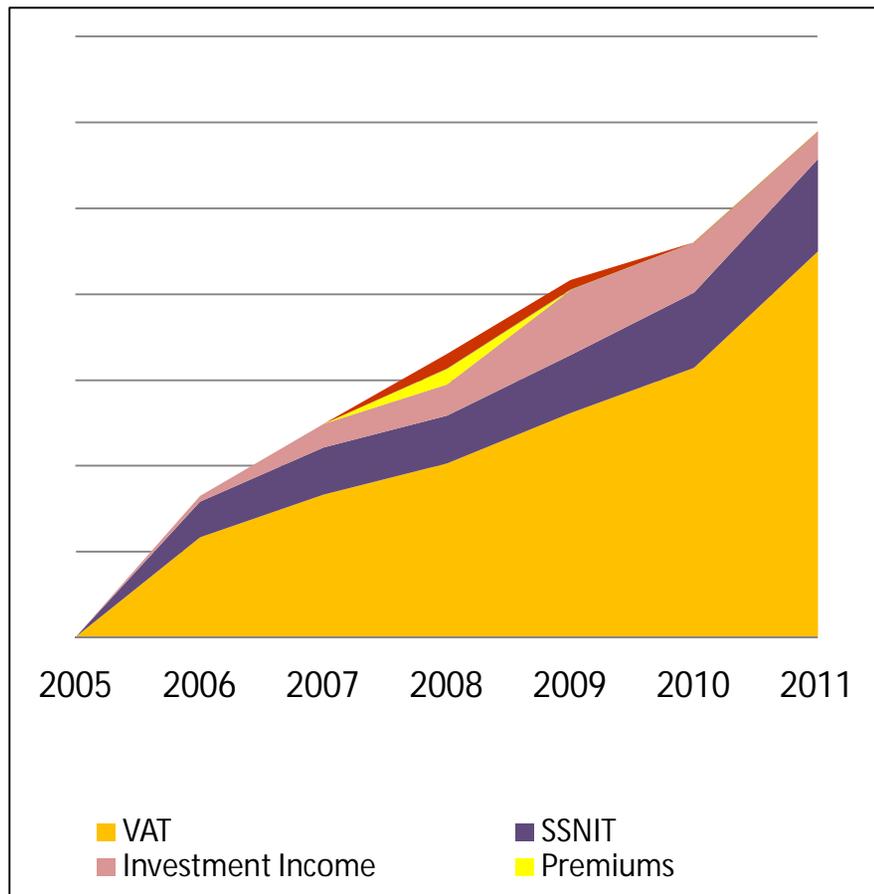
- Benefits package (services & medicines guaranteed)
- Subsidies
- Payment to providers

# **Revenue & expenditure: two sides of the universal coverage coin cont.**

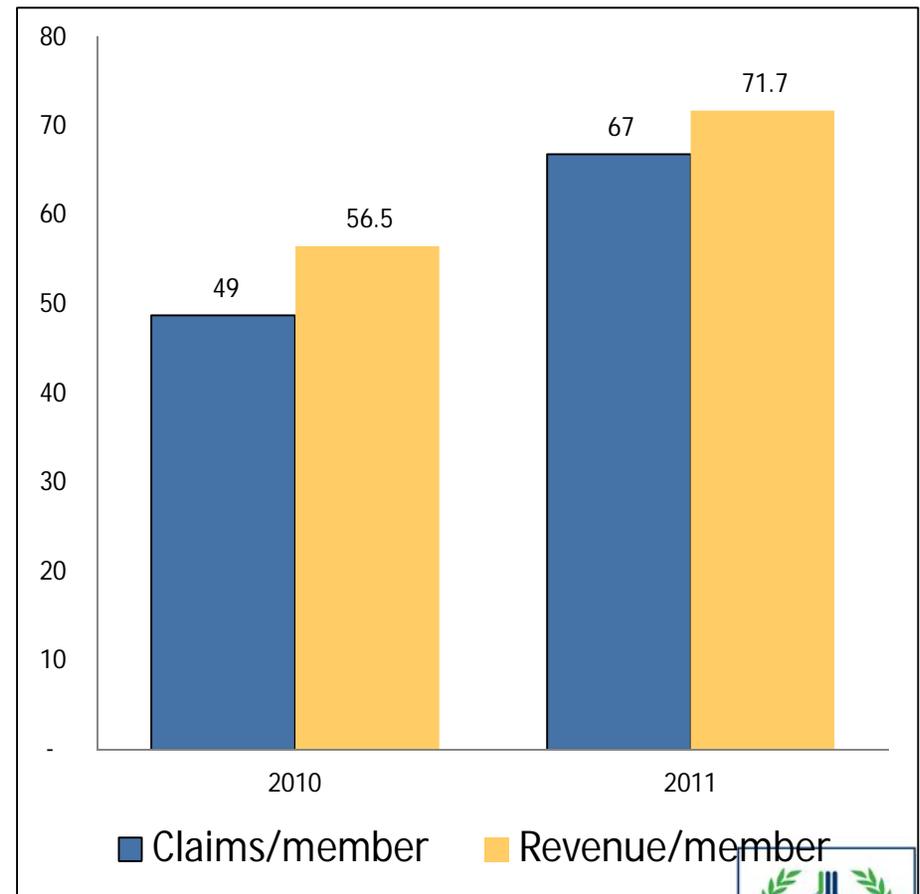
**The question is:  
does revenue generation get  
more attention than  
expenditure management?**



# Raising revenue for universal care is not enough



Ghana's NHIA has achieved a growing & diversified revenue base.



But the gap between claims/member & revenue/member is closing.

# What role does provider payment play?

Healthcare provider payment systems – the way providers are paid to deliver the covered package of services – are an important strategic lever in universal health coverage.

Balance system revenues & costs. Create incentives for providers to improve quality & deliver services more efficiently.

This ultimately makes it possible to expand coverage within limited funds.



# What are the options?

Payment method	Definition
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g. personnel, drugs, utilities).
Global budget	Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. Budget is flexible & not tied to line items.
Per diem	Hospitals are paid a fixed amount per day that an admitted patient is treated in hospital.
Case-based (DRG)	Hospitals are paid a fixed amount per admission depending on patient & clinical characteristics.
Fee-for-service	Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.
Per capita (capitation)	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.

## Some countries are using coverage-eroding expenditure management approaches

Under-paying for services	Brazil, Peru, Vietnam
Supply-side constraints & implicit access restrictions	Brazil, Peru, Indonesia, Bangladesh
Shifting of financial risk to providers (more than they can manage)	Vietnam
Increasing cost-sharing (higher deductibles)	France
Leakage to private insurance coverage	Brazil, France
Excessive shifting of financial risk to patients (creating access barriers)	Peru, Vietnam, Bangladesh, Ethiopia, Indonesia



# What does coverage-enhancing expenditure management look like?

Japan	<ul style="list-style-type: none"> <li>• Fee schedule revision as a cost-containment tool</li> <li>• Global targets for expenditure increases</li> </ul>
France	<p>A set of "soft" expenditure controls</p> <ul style="list-style-type: none"> <li>• System-level spending targets</li> <li>• Sub-level targets (ambulatory care, hospitals, rehabilitation)</li> <li>• Monitoring &amp; “early warning”</li> </ul>
Thailand	<ul style="list-style-type: none"> <li>• Closed-ended capitation contracting with DRG hospital payment</li> <li>• Strong primary care gate-keeping</li> <li>• Tough negotiation with pharmaceutical companies</li> <li>• Priority-setting for expansion of benefits</li> </ul>
Turkey	<ul style="list-style-type: none"> <li>• Closed-ended payment systems with performance-based component (global budget for hospitals &amp; capitation for primary care)</li> <li>• Expenditure caps at hospital level &amp; on pharmaceuticals</li> </ul>



# Some thoughts

- Need for a reference price list (RPL)
- Create incentives for healthcare providers to improve quality & deliver services more efficiently
- Contracting with service providers & purchasing (strategic & active)
- Cap at some level, usually the provider (e.g. capitation & DRG with global budget-pay for admissions until volume targets are exceeded)
- Pay providers below cost for:
  - some high-cost, low-priority services (e.g. MRIs)
  - higher cost-sharing for self-referral



# Some thoughts cont.

- Balance system revenues & costs
- Strong primary care gate-keeping
- Pay relatively higher rates for primary (preventative) care
- Tough negotiation with pharmaceutical companies



# Some thoughts cont.

- ITAP (Industry Technical Advisory Panel)
  - Discussion forum for industry & the CMS
  - Collaboration on research projects identified by the CMS as having systemic & strategic implications for the entire industry
  - Projects supporting & strengthening the legislative framework to serve the public interest (mandate of the CMS)
  - Four (4) ITAP projects underway:
    - Medical Inflation & the Utilisation of Healthcare Services
    - Impact & Value of Managed Care Interventions
    - SRM (former REF) Data & the Cost of PMBs
    - Composite Risk Index (CRI)



# Concluding remarks

- The big picture requires detailed technical action.
- Technical solutions need to be implemented together with interest groups & politicians.
- Sharing experiences with countries who are facing the same challenges can provide innovative ideas & help avoid pitfalls.



**THANK YOU**

