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Provider Payment
Alternatives for Latin
America: Concepts and
Stakeholder Strategies

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Alexander Telyukov, Ph.D.
Abt Associates Inc.

Kathleen Novak, Ph.D.
Abt Associates Inc.

Christopher Bross
Abt Associates Inc.

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ACRONYMS

ALOS	Average length of stay
ARS	<i>Administraciones del Régimen Subsidiado</i> (subsidized regime administration – Colombia)
CCSS	<i>Caja Costarricense de Seguro Social</i> (Costa Rican Social Security Fund)
DDM	Data for Decision Making
DRG	Diagnostic-related Group
EPS	<i>Entidades prestadoras de salud</i> (health care provision entities – Perú)
FAP	<i>Facturación por Atención Prestada</i> (billing for provided service)
FONASA	National Health Fund (Chile)
FPMD	Family Planning Management Development
FTE	Full-time employee
GB	Global budgeting
HMO	Health Maintenance Organization
HPU	Hospital Production Unit
HRG	Health resource group
HSN	Health Service Network
IDS	Integrated Delivery Systems
IMSS	Mexican Social Security Institute
LAC	Latin America and the Caribbean
LOS	Length of stay
MCO	Managed Care Organizations
MOH	Ministry of Health
OS	<i>Obras Sociales</i> (Argentina)
PAD	<i>Pago Asociado a Diagnóstico</i> (diagnosis-related payment)
PAHO	Pan American Health Organization
PHR	Partnerships for Health Reform Project (USAID)
POS	Point-of-Service plan
PPC	<i>Pago por prestaciones complejas</i> (payment for complex services)
PPO	Preferred Provider Organization
PPP	<i>Pago prospectivo de prestaciones</i> (prospective payment for provided service)
UPC	Capitated payment unit
USAID	United States Agency for International Development

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1. INTRODUCTION

Given increasingly constrained resources, the entire world seems to be united in its quest for more efficient health care. Indeed, no country, rich or poor, is boasting about the abundance of funds in its health care budget. Industrialized nations, although relatively affluent in health resources, have had to face health costs that are rising faster than the nations' ability to pay for them. Aging populations, ever-growing costs of biomedical research, and the increased supply of expensive high-tech treatments are all factors that bear heavily on the national medical bill. Many developing countries have to run their health care systems on a fraction of the funding available in the industrialized world. Their efficiency agenda is centered on making the most productive use of very limited resources in order to: extend basic services to disadvantaged populations; address newer health risks and diseases that often involve a disproportionately high treatment cost; and ensure more sustainable funding and cost recovery potential for the health sector. This paucity of funding is all the more problematic given that the health sector, along with other social service sectors, continues to be the most vulnerable to economic shrinkage and fiscal instability.

Experience from around the world suggests, however, that health system performance is no less sensitive to *how* funds are allocated to providers than the total amount of funding available for health services. Provider payment reforms that create performance incentives for health care providers play an important role. This paper concentrates on prospective global budgeting (GB), including its key features, prerequisites for planning, institutional framework, and implementation agenda.

Within the past ten years, prospective global budgeting (GB), has become the locus of international efforts to control the costs of health care. Given the multitude of international experiences with GB however, it is no wonder that this payment mechanism continues to mean very different things to different countries, institutions, and groups of professionals. Global budgeting can serve as a shield to protect the *status quo* if implemented through the familiar, centrally controlled, historical budgets utilized in many developing countries. Conversely, the concept and strategies of global budgeting may also serve as critical drivers of health sector reform. Innovative provider payment tools, e.g., prospective case-based reimbursement of hospitals and prospective capitation of integrated health care systems both fit under the umbrella of prospective global budgeting.

A singular focus on the technical aspects of provider payment reform, however, ignores a major element required to achieve results, i.e., the ability to manage the political environment surrounding payment reform efforts and develop strategies within the reform context to deal with anticipated resistance. As with most other economic innovations, provider payment reforms are perceived to have positive outcomes for some key actors and institutional interests, and adverse outcomes for others. For these reforms to be successful, it is important for policy makers and technical reform teams to identify those key stakeholders who perceive themselves to be “winners” and those who perceive themselves to be “losers” under any given payment reform plan. Advocacy strategies and communication campaigns can then be targeted to offset concerns and minimize/neutralize opposition from the perceived losers and solidify the support of the perceived winners. (See the Policy Toolkit for Strengthening Health Sector Reform, Guidelines for Developing an Advocacy Strategy, Partnerships for Health Reform Project, 2000).

This article defines prospective global budgeting and its key features, describes the prerequisites needed to plan global budgets and institutional arrangements that support global budgeting, and provides general recommendations to help ensure the successful implementation of global budgets. This paper also presents strategies to address key stakeholders affected by the introduction of global budgets that are tied to productivity rather than solely based on historical capacity. Strategies are presented for both purchasers' and providers' to successfully navigate the new playing field that is created when performance based prospective global budgets are introduced. Two additional provider payment tools, i.e., prospective case based reimbursement of hospitals and prospective capitation of integrated health care systems, are discussed within the context of regional experiences from Latin America and the Caribbean.

2. GLOBAL BUDGETING

2.1 DEFINITION

As noted above, global budgeting continues to mean different things to different people. Below is the basic definition of global budgeting that emphasizes its generic, constant elements:

With respect to a health care provider or group of providers, global budgeting is a system in which providers receive financing from a third-party payer on the basis of a pooled prospective budget as opposed to a claim-by-claim reimbursement through itemized charges. [Glazer, 1987] Global budgets imply that limits are set in advance on the total expenditure for health services to keep them within a predetermined amount over a specified period of time.

When the prospective budget is linked to performance (e.g. volume, quality, clinical complexity or case-mix) the financial risk for the provider is potentially high, while that for the purchaser is low. Global budgeting encourages flexibility in resource use and requires that providers be able to measure and track their own use of resources in terms of efficiency and effectiveness. This ongoing monitoring and evaluation will allow providers to make informed decisions when redistributing resources from less to more effective use.

2.2 KEY FEATURES OF GLOBAL BUDGETS

Global budgets invariably contain the following key features:

- ? *Financing is fixed.* Synonymous with global budget are “fixed budget” and “expenditure cap.”
- ? *Funding is established on a prospective basis.* Budgets are negotiated and set forth in a provider/payer contract on an annual basis.
- ? *A global budget is related to a certain amount of clinical activity.* If there is no linkage between the global budget and workload (defined through caseload or enrollment), there will be no productivity incentives created by this method of provider financing.
- ? *Global budgeting may be applied to a region, a provider network, a medical facility, a type of care, or a particular service.* If applied on a regional or network-wide level, the global budget would be established in population-related terms, i.e., payment to provider organizations is based on the number of persons served by the organization. The payment would be adjusted for demographic characteristics of the enrollment pool, such as age, sex and social profile, used as proxies of need for medical care. In the case of a hospital budget, prospective funding would be established in patient-related terms, e.g., per patient discharge. Population- and

patient-based financing are inter-linked: a global budget for an integrated health system caps the total amount of hospital spending which, under a given case-based reimbursement schedule, also caps the admission rate within the enrollment pool. Service-related budgeting is limited to costly and/or socially relevant programs of care. The purpose is dual: (1) to ration expenditure on particularly costly services; (2) to assure that the amount of clinical activity in certain areas of public health is not reduced below a minimally required level.

- ? *To arrive at a global budget, the core element is multiplied by the population, enrollment, or discharged patients, respectively.* In the regional global budget, the core element is a per capita health care expenditure adjusted for need. In a managed care plan, it is a per capita amount of funding per enrollee. In a hospital, it is an average rate per discharge.
- ? *Decisions on care rationing, potentially a concern under global budgeting, are shifted from the payer to the provider of services.* The administrators of the global budget on the provider side are expected to allocate limited resources among their patients, types of care, and kinds of interventions, using their best ethical, clinical and managerial judgment.
- ? *Management autonomy is inherent to the concept and practice of global budgeting.* The global budget is allocated in block and should not be subject to micro-management by the payer. The increased responsibility of the provider for efficient internal allocation of resources under global budgeting, however, must also be matched by adequate authority over the use of funds. Ideally, global budgeting should allow the provider the requisite flexibility to: maximize net revenue within the global budget, minimize the risks of overspending, and provide appropriate, quality care to its patients.

Autonomy consists of the provider's right to:

- ↔ Expend the budget on a 'non-itemized' basis. Decisions on how to allocate the prospectively determined budget by production input would be left to the provider's discretion. This would put the hospitals at the helm of their resource management process, an important prerequisite for building their management capacity and increasing their viability in anticipation of increased competition for funds. As a matter of general principle, budgeting rules should be simplified and streamlined to enable more decision-making power at the provider level.
- ↔ Adjust the facility size and reassign bed capacity and human resources across clinical specialties in response to changing supply and demand conditions. The purchasing authority can regulate the direction and intensity of structural change by establishing market quotas and percent caps on the annual change, to ensure that minimal requirements on production capacity are met by specialty and geographic location. The purchaser, at the same time, can withdraw its support for redundant capacity.
- ↔ Diversify, beyond traditional inpatient services, e.g. into home care, ambulatory surgeries, outpatient consultations, hospices, long-term nursing care. Such diversification will require removal of legal obstacles and

introduction of a licensing mechanism to ascertain the organizational and clinical capacity of a facility to provide new services with adequate quality.

- ↔ Retain surplus of revenue over cost, whenever such surplus is generated within a prospectively allocated budget by providing the planned volume of care with good quality and at a lower than planned cost. Hospitals should be allowed to keep the savings, provided those are reinvested in the production of medical services. There may be specific regulations relating to the allocation of cost savings, e.g., to ensure that all operating needs of the facility are addressed in a balanced way, instead of paying out all or most of the savings in bonuses.

2.3 PREREQUISITES FOR PLANNING GLOBAL BUDGETS

Baseline information (historical) on the level of costs, utilization and enrollment is the required starting point in planning a global budget. External financial constraints must be considered, e.g., if a regional health budget is projected to decline, case reimbursement and capitation rates may be scaled down proportionately as will the global budget.

Existing regulatory requirements must be understood and, depending on circumstances, adjusted to meet the new demands resulting from provider competition and other aspects of global budgeting. Since global budgets grow out of the prices of services (per procedure, episode of care, discharged case) and projected utilization rates for these services, prices must be predetermined in reimbursement rate schedules. The rates may or may not be negotiable for individual providers. In any event, provider-specific costs influence the rate-setting process statistically since payment rates are linked to the weighted average costs of all participating facilities.

Market quotas and caps on cost reimbursement also need to be negotiated. Rational health care financing implies that a global budget will always be somewhat smaller than it would need to be in order to accommodate every patient with every intervention judged by a clinician to be effective and desired by the patient at the time of medical need. [Veatch, 1994: 292]

2.4 INSTITUTIONAL ARRANGEMENTS THAT SUPPORT GLOBAL BUDGETING

Monopsony, a market dominated by one payer that controls resource allocation and payment through a single purchasing authority, is a setting ideally suited to demonstrate the cost-efficiency potential of global budgeting. National or regional monopsonies are common in countries with a high public stake in health financing, be it funding from general revenue from the budget or through nationally mandated health insurance programs with universal coverage. Government-funded and owned hospitals are also good targets for global budgeting.

In highly integrated health care sectors, both regulatory and purchasing functions are entrusted to the Ministry of Health and/or the National Institute of Social Insurance. There is no distinction between a regulatory center and a purchasing authority. The authors wish to emphasize an increasingly important institutional step for successful global budgeting, the

decentralization of purchasing authority to regional health authorities. Subdividing strategies and mechanisms between the regulatory and the purchasing authorities usually implies that control over the regulatory process would remain in the hands of a national health agency, while purchasing of services would shift to regional health authorities. Decentralization of regulatory powers, if at all pursued as a health policy goal, would usually lag behind the decentralization of purchasing of care.

A health care sector with the national and/or regional health authorities in charge of both financing and provision of services is known as an integrated health care system (not to be confused with an IDS, or integrated delivery system, that is basically a network of provider facilities). The evolution of such a system into one that embodies a purchaser/provider split, i.e. where a public agency purchases health care from autonomous providers, would offer the benefit of creating competition among providers for public contracts, grants, and funds. With such an institutional arrangement, the purchasing authority can choose providers who are the most competitive on the quality/efficiency scale, thus, improving the performance of the health care sector. In order to separate purchasing from provision, the following steps need to be taken:

- (1) Decentralize health care administration, entrusting the purchasing function to a regional health administration rather than the national MOH;
- (2) Set up clinical and cost reporting in a fully comparable way for all the providers seeking to compete for public contracts;
- (3) Introduce contractual practice and provider payment methods enabling transparency, accountability, and a symmetric increase in financial risks and incentives for providers;
- (4) Establish intermediate resource allocation mechanisms, such as fund-holding general practices, which in turn would become purchasers of care on behalf of its enrollees.

2.5 CONSIDERATIONS FOR SUCCESSFUL IMPLEMENTATION

The following are elements to be considered and recommendations for successful implementation of global budgets.

Staged management: The evolution of provider financing towards a prospective global budget based on workload characteristics (caseload, enrollment) can be managed sequentially. In the hospital sector, for example, introduction of case-mix groups may precede introduction of fixed budgets, may follow it, and may be managed in parallel.

A sensible methodology of price calculation. Viability of a global budget will depend on the soundness of the underlying service prices. Such price calculation involves the following:

- (1) Payment level for a particular service or set of interrelated services should be established at a uniform level for a given geographic area or a given category of provider facilities.
- (2) Uniform rates should be coordinated with historical costs.

- (3) Transition from provider-specific to network cost-based rates should be gradual, allowing time for providers to adjust their individual costs to the average levels built in the rates.

Physicians should be part of hospital salaried staff to allow effective spending control, so important for the facility to survive on a predetermined amount of funding. With the financial targets derived from the global budget, it is easier to get salaried doctors to coordinate their referral decisions and prescription behavior. Vertically integrated delivery systems set an even better stage for financial and clinical management under global budgeting.

Regulating supply of health care resources. The government should decide whether it wants to regulate bed-to-population ratios, specialist-to-population ratios, and other resource supply ratios. Such ratios can be helpful when considering the extension of the service provider networks or when setting out the structural adjustment targets that may lead to the reduction in production capacity. Nationwide ratios need to be brought up to date in many countries and, if necessary, differentiated by region, based on the baseline supply of and a reevaluated need for resources, and the anticipated changes in population and demand for care.

Regulating supply of care. This is linked to the regulation of resource supply. Supply of health care and resources may be monitored through estimation of waiting times for outpatient appointments and admissions for elective surgeries, assuming urgent admissions are not held back by the lack of hospital capacity. Waiting periods should be evaluated in conjunction with provider productivity, vacant capacity margins, and consumer satisfaction. Resource shortage is present if waiting times are growing despite improved productivity and/or high capacity utilization rates, and amid consumer complaints. Resources are adequate and, perhaps, even redundant, if waiting periods are reduced and acceptable for the patients, while a visible part of capacity remains vacant.

Strengthened population-based information that serves as the base for informed decisions on the optimal mix of services, skills and care settings. Policy guidelines should be developed from international panels of experts that provide generic and country-specific recommendations on the optimum numbers and mixes of facilities, technology, and professional personnel to respond effectively, compassionately, and efficiently to the needs of the individuals and populations served. [White, 1997]

Output/outcome measurements as an anchor for GB projection and control. Among the recommended indicators are: (1) hospital caseload, i.e. number of admitted or discharged inpatients adjusted for their case mix intensity; (2) number, status (planned or emergency), and clinical profiles of readmitted cases; (3) number of diagnostic and surgical procedures performed in the day admission mode; (4) enrollment numbers for primary physician practices and integrated health networks; and (5) standardized disease incidence rates for integrated delivery systems or provider networks. We do not recommend more ambiguous units of output, e.g., the finished consultant episode, given their susceptibility for inaccurate reporting.

Provider licensing may be utilized to restrict market entry for, and control the volume of care associated with ‘catastrophic cost.’ This implies tighter regulation of expensive care that requires highly specialized knowledge, or is ethically controversial. Renal dialysis, kidney

transplantation, radiotherapy, neurosurgery, heart surgery, angioplasty, neonatology, clinical genetic research, in-vitro fertilization, bone marrow transplantation, and liver, lung, and pancreas transplantation may be subject to special licensing procedures to control public spending on these services. The amount of service-specific control and regulation should be balanced against the cost of such control. A principal deficiency of licensing can be its bureaucratic and time-consuming character and inflexibility.

Quality Control. To optimize the impact of global budgeting on health care performance, it is critically important to counterbalance increased financial incentives with reinforced mechanisms for quality control. The latter may include: the introduction of practice guidelines; monitoring of health status indicators for peri-operative and total death rates, and in-house infection rates for hospitals; observance of clinical and management standards; tying redesign of hospitals to mandatory development of compensatory services. E.g., extensive investments must be made in home and other hospital-substitute care in order to avoid a revolving-door phenomenon where earlier patient discharges lead to unintended patient re-admissions.

Regionalization of the health care system. This restructuring will reduce inefficiencies by consolidating service delivery at the regional level. Provinces are better placed than the federal center to phase out inefficiencies and set their own restructuring policies and targets, customized to local needs and institutional capacity.

Changing hospital status and roles – This means incorporating hospitals into integrated health systems and community care networks and moving away from the concept of the hospital as the pillar of the community medical and social services, with the potential (not always realized) to strengthen primary care and lead in the development of home and hospice care. This line of evolution would lead to a partial loss of the hospital's dominance over local providers of care, health care budgets, and service delivery strategies. Financial viability of such an integrated delivery system would require that patient and resource flows be spread across levels of care more evenly than at present, implying redistribution of some resources away from hospitals.

Channeling service, patient and resource flows away from the hospital sector. This would include reductions in the length of stay (LOS), changes in the number and type of patient admissions, and shifting services to out-of-hospital settings. Shifting resources toward primary care is one indisputable direction of structural change in the health care sector. 'It has been known for decades that more than 95% of health problems experienced by a general population can be managed successfully by an appropriately trained primary care practitioner' [HMSO, 1979]

Changing the market structure. Concentration and de-concentration should be continuously weighed for their potential to optimize effectiveness, efficiency and accessibility of care. Concentration of production capacity, through mergers and/or elimination of redundant facilities, promotes the reduction of perceived over-capacity, and facilitates the adoption of the modern medical technologies, since larger health care institutions may be better suited to utilize high-tech medicine. Quality, effectiveness, and efficiency of care may be promoted in larger facilities through economies of scale and better managerial capacity to optimize clinical decisions and resource flows. The downside of concentration is the threat of monopolization of the local health care markets and limited accessibility of services for the local population due to reduced number of provider facilities.

De-concentration in the form of small, freestanding, public or private health care centers may be an important alternative in some local settings in order to foster competition, reduce commute time for the patient, and diversify the local health care delivery system into new services not readily available from large provider institutions. Concentration and de-concentration may also coexist under the same roof to ensure the best of both options.

Deregulating fixed investment. Access to investment resources should become more competitive for providers and more transparent for all the stakeholders in the health care financing. At the regulatory level, the capital investment budget may be divided into several fund pools according to the method of their allocation to providers of services:

- (1) Depreciation funds that would be paid to medical facilities as part of the service reimbursement rates. These funds would be inherent in the providers' global budget.
- (2) Regional grant funds to be allocated by a regional health administration in: (a) response to provider's demonstrated needs or (b) its commitment to meet the regional demand for certain services. Such grants would be awarded through competitive tenders and coordinated with the list of regional health care priorities.
- (3) National grant funds would be assigned by the MOH to the regions or directly to providers of services, with earmarks for certain types of care and target populations.
- (4) Donations. These funds may be used at a provider's discretion or as directed by a donor. A provider's decision on the use of its investment funds may affect its access to public grant funds. Also, a public purchasing agency may reduce provider-specific reimbursement rates and global budget for a disproportionately high share of depreciation, if the involved equipment does not contribute productively to the quality and/or volume of contracted care. Investment grants may be awarded or denied dependent on the past equipment utilization rates. Equipment sharing requirements may be set out by a grant-awarding agency for grant applicants to secure its efficient use.

3. DISTRIBUTION OF RISK AND STAKEHOLDER STRATEGIES

By promoting global budgeting, the purchaser of services generally seeks to shift onto the provider the risk of budget overruns and, eventually, the burden of provider inefficiency. The relative risk for purchaser and provider varies depending on the type of prospective payment involved. With prospective global budgets that have the total payment fixed in advance to cover a specified period of time, the risk for providers is high while the risk for purchasers is low. The same is true of prospective capitation where a payment is made directly to health care providers for each individual enrolled with that provider. With prospective, cased based payment that is determined on a per case or per episode basis however, the financial risk to both provider and purchaser is moderate.

It would be detrimental for the purchaser's interests, however, to put a provider on a fixed budget and leave it to its own devices. In all likelihood, the provider, without sufficiently developed managerial capacity, would not be able to benefit initially from the potential advantages of global budgeting, nor curb the risks of non-compliance with prospectively determined reimbursement rates, workload, and budget. Effective operation in the environment of competitive contracting and global budgeting needs to be a preoccupation for both purchasers and providers of care who are doing business under this financing approach.

3.1 PURCHASERS' STRATEGIES

Controlling and managing utilization of care. Utilization of care should be driven by demand, not by supply of services. Global budgeting provides an internal incentive for a hospital and an integrated provider network for controlling the volume of their clinical activity. Such control on the part of a provider, however, may not lead to the end result the purchaser is hoping to achieve. If the global budget is linked to case mix parameters of the hospital work, i.e., number of admissions and their distribution by clinically homogeneous groups, assuming rates are set for an average case in each group, hospitals may try to "beat" the system by discouraging the admission of cases with above-average complexity and giving preference to patients with estimated below-average intensity of care. This way the hospital provider complies with the budgeted number of admissions, avoids budget overrun, and may even save some funds from the prospectively determined budget. To preempt such a manipulative admission strategy, a purchaser of care would have to require a fixed caseload along with a fixed budget, i.e., set up the number of cases and the case mix index, i.e., a weighted average complexity of the case mix.

In addition, a purchaser needs to monitor a hospital for indications that care is being denied. Another important purpose of utilization control is to forewarn providers against the practice of premature patient discharge. An important statistic that captures this phenomenon is readmission rate within an established number of days (e.g., 7 or 30) from the date of discharge.

In integrated delivery systems, utilization of care should be monitored and evaluated at three levels: (1) as projected utilization of services based on patient's health status so as to

adjust per capita financing for the health risk level of the group into which a patient is classified; (2) as reported utilization of services to monitor against budget overrun; (3) as the enrollees' health status, waiting times and otherwise expressed level of consumer satisfaction, to ascertain if the health system is illicitly avoiding contacts with patients or limiting care in any other way.

Changing payment principles and pricing techniques in order to establish a closer link between a provider budget and its output (e.g., enrollment size for an integrated delivery system and case load for hospitals). In an integrated provider network, the epidemiological, demographic and environmental situation defines the per capita need for medical care. The severity of illness may be viewed as an aggregate determinant of the intensity of inpatient care. In practice, risk-adjusted per capita funding and hospital rates by case mix group are viable ways to link provider reimbursement to the volume and intensity of clinical work, respectively, in provider networks and hospitals, while at the same time avoiding escalation of the volume of services and expenditures.

Delegation of fund holding functions to general practices (GPs). Primary care doctors or group practices, or a primary care component of an integrated delivery system, receive a capitated budget and use it to compensate the cost of their own services as well as the costs of referring providers. About half of the population of England receives care in fund holding practices. As of April 1997, a number of practices have begun piloting the purchase of all forms of hospital care.

Adjusting methods of labor remuneration to global budgeting. Salaries as a method of worker compensation secure better control over physicians' income and make the labor cost more predictable and, for that reason, more compatible with global budgeting. The opposite of the salary-based compensation is fee-for-service payment to physicians. It is inconsistent with prospectively determined fixed financing of providers: fixed budgets give providers an interest in effective cost control while fee-for-service funding works in the opposite direction, i.e., as an incentive to increase the volume of medical care. Luckily, many LAC health care systems have their physicians working as salaried staff in public provider institutions. A word of caution should be addressed to the Ministries of Health, however, who seek to reverse the status quo by introducing fee-for-service as a mechanism for internal payments within a provider facility financed through a global budget. Fee-for-service payments may very well lead to an unmanageable cost explosion within the capped global budget.

While emphasizing the advantages of salary-based compensation in the global budget context, it is also desirable for purchasers to link salary-based compensation to varying levels of performance among physicians, their skills, responsibilities, and workload. In the hospital sector, the salary may be tied to the number of inpatients treated. If a hospital is paid based on diagnostic-related groups (DRGs), the higher the clinical complexity of a patient, the higher the rate that will be paid by the purchaser of care within the global budget, and the greater will be the salary funds earned by the hospital. A salary markup for operating surgeons is one example of a salary-based system that reflects physician skill and hospital salary funds earned. However, experience in Canada demonstrates that separate funding schemes for hospitals (including nurses and other health care providers) versus physicians have created a growing tension between hospitals and their health care professional employees and physicians. [Shamian et al., 1997]

Salary strategies under capitation In provider networks, a general practitioner's salary should be linked to the number of population enrolled in his/her practice. The salary should also vary based on risk-adjusted capitation rate, thus, reflecting the complexity of maintaining health by population group and geographic area. The general practitioner's salary can also be supplemented with a fee-for-service component to stimulate the provision of preventive and other services of particular importance to the purchaser. Although physician salaries can be quite variable and responsive to the volume and complexity of clinical work, by remaining salaries this main cost of health care production also remains basically predictable, thus, mitigating the risk of budget overrun.

Competitive contracting. Provider competition for public contracts, grants, and funds is a critical purchasers' strategy for successful global budgeting for the following three reasons. First, providers will not agree to the economic self-restraint imposed by prospective fixed budgeting unless they know they will lose business from the main purchaser due to their inefficiency and/or ineffectiveness. Second, periodically renewed contracts provide the main vehicle to inscribe provider rationalization goals in legally binding terms. Finally, tighter conditionality or even cancellation of a contract may result from the purchaser's monitoring of provider costs, quality, and overall performance. Unless such conditionality or cancellation is the predictable outcome for poor provider performance, the cost control objectives of global budgeting will not be achievable.

Steering providers toward gradual organizational change. Purchasers will need to take a critical look at their provider's expenses and performance. Performance and cost targets should be identified and set out, and regional benchmarks should be translated into operational restructuring goals for specific facilities. Incremental change geared toward long-term targets of cost-control and restructuring is a much more viable strategy, however, than abrupt, superimposed change. It should be kept in mind that any radical, punitive action on the part of health care purchasers, albeit based on real provider inefficiencies or breaches of contract, e.g., drastic redistribution of volume quotas, elimination of redundant capacity, or denial of contracts, will stir resistance from politicians, labor unions, and communities. (To anticipate the source and extent of opposition that purchasers may encounter, see Policy Toolkit for Strengthening Health Sector Reform, Guidelines for Conducting a Stakeholder Analysis, Partnerships for Health Reform Project, 2000)

Changes and/or possible reduction in the workforce. If there is a surplus of labor, the global budget financial incentive for containing health care costs may encourage the provider to reduce it. Such action, however, will undoubtedly result in strong opposition from health care personnel and the labor unions that represent them. The purchaser of care, by setting out guidelines on staffing requirements, can provide all parties, the hospitals, provider networks and union representatives, with the basis for consensus building. Since all three groups have a vested interest in securing the purchaser's business, there is an additional incentive for them to come to a mutually acceptable, negotiated agreement regarding the desired changes in the number and/or needed level of health care providers. (See the Policy Toolkit for Strengthening Health Sector Reform, Guidelines for Conflict Negotiation, Partnerships for Health Reform Project, 2000).

Guidelines from the purchaser on staffing requirements might dictate, for example, that the number of full time employees (FTEs) should grow per 100 beds, as may be required by new technologies and higher standards of nursing care, while remaining stable or even declining per 1,000 admissions, as the patients length of stay (LOS) declines. Such

parameters take into consideration the changing technology and higher standards of nursing care required that may increase the need for certain skilled providers while also being responsive to the cost-containment incentives of global budgeting that dictates a static or declining number of FTEs when general medical patient LOSs decline. When estimating the evolving workload per staff member, it is important that purchaser and provider alike take into account the likely shift of care from traditional hospital services to outpatient and other hospital-substituting services. It should be remembered, that labor costs respond to, and may be regulated by, changes in the skills mix, not just in the number of the work force. Selected international data indicates, that the workforce mix of a general hospital remains in a steady state when it consists of at 1/3 physicians and 2/3 nursing and paramedical staff.

Structural change in care delivery. International experience suggests that the traditional three-layer structure in the health care delivery system – a top layer for tertiary care, a medium layer for general hospital and specialty outpatient care, and a bottom layer for primary and general outpatient care – has become obsolete. Purchasers of services may expect global budgeting to precipitate a number of changes in the clinical portfolio of hospitals. The general direction of these changes will be toward divesting the hospital of patients needing medium- and low-skilled care. General practice or health centers will take on additional work to reduce patient hospital admissions altogether, conduct pre-admission tests, and accept convalescents for post-hospital rehabilitative care. Home care organizations, community nurses, and hospital and community based social workers will increase their role in replacing hospital care with more cost-efficient alternatives and in accordance with patients' preferences.

The concept of 'transmural care' appeared in the Netherlands to emphasize such continuity of care and the need for increased vertical cooperation among providers of services. The Netherlands' experience highlighted three major obstacles to such coordinated care: (1) differences in professional styles, goals and interests; (2) hospitals that "cede" sub-acute stage patients to other facilities end up with an increased intensity of inpatient care that is not necessarily reflected in the case mix index and payment rates; (3) alternative care settings are not always reimbursed by health insurance and other major purchasers of care. [Maarse et al., 1997:OS34]

As we conclude with purchaser strategies and begin to consider things from the providers' perspective, it is necessary to remember that global budgeting requires a paradigm shift. The goal is not only to cut or contain the costs of health care, but also to add value for the actual money spent. A legitimate worry among the provider community is that financial incentives will push the health care system towards cost containment with no proper regard for the quality of care. This is known as the "cost/quality tradeoff" issue. Both purchasers and providers need to collaborate closely to improve the productivity in the health care sector while maintaining quality of services. Pilot demonstration projects that can test and adjust innovative attempts at producing cost-efficient, high quality health care provide a laboratory for purchasers, providers, and consumers to explore alternative models and solutions and don't run the risk of prematurely changing major systems before having evidence that supports the change.

Pilot projects can experiment with methods to reduce waiting times and length of hospital stay, streamline hospital admission procedures, schedule tests and operations, improve workforce planning and control, increase the efficiency of nursing (less indirect hours), and strengthen physician's involvement in strategic decision-making at the facility

level. Entrepreneurial efforts of hospital and provider network managers that are expected to increase under competitive contracting and prospective budgeting, also need careful coordination and monitoring to ensure their compliance with sound clinical practice.

3.2 PROVIDER STRATEGIES

The list of provider strategies includes innovations that need to be undertaken by providers to respond to the challenges and opportunities of global budgeting and by other stakeholders in order to gain providers' collaboration on the cost-control measures stemming from global budgeting. Such strategies can be implemented jointly by regulatory, purchaser and provider institutions.

Changing referral and utilization patterns. Integrated delivery systems or provider networks and free-standing practices, if they become the fund-holders and, hence, armed with a strong financial incentive to control the utilization of services, will limit referrals to higher levels of care and this will require specialists and hospitals to change their organizational and clinical approach. Fund-holders are likely to be more demanding in their choice of subcontractors than regional health authorities since they are not committed politically to maintaining the entire provider network. Shorter turn-around times for ordered tests, better accessibility of specialists, higher use of day surgeries, and reduced length of hospital stay would be among the fund holders' main expectations.

Hospitals, particularly when in competition with one another, would be trying to win over their competitors, by producing higher levels of activity with lower fixed cost. If paid on a per-case basis, hospitals will undoubtedly increase the number of admissions and will reduce average lengths of stay (ALOS). Day surgeries will become commonplace. Hospitals will focus on diagnostic and treatment of cases where their medical and technical contribution is greatest, and less on recuperation and rehabilitation. These less resource-intensive phases of care can be delegated to facilities with skilled nursing care. Reserve margins (vacant beds) also would decline as care providers at all levels seek reduction in fixed costs. For example, in the United Kingdom, in 1984-94, hospital admissions grew by 1/3 with most of the increase caused by rising intervention rates, particularly in the very young and the elderly. ALOS, however, fell in all age groups, and the total number of inpatient days has declined despite a higher number of admissions. Day case rates have also risen sharply – from 176 to 499 cases per 10,000 population. The number of medical staff and R&D and technical staff rose in the hospitals 26% and 51%, whereas nursing declined 14%. [Harrison, 1997:OS54-OS55]

Improved reporting and research of the cost-quality tradeoff by providers based on quantitative measures of functional results, clinical outcomes, evidence-based interventions, appropriateness of clinical management, staff composition and turnover, managerial, professional, and support staff salaries, patient charges, capital and operating expenditures, and profits and losses, as well as population-based assessments of individual, familial, and community experiences with convenience, timeliness, and accessibility of services and amenities. Informed consumers and health care purchasers will demand no less' [White, 1997]

Benchmarking from 'Magnet Providers', i.e., sharing of best practices from facilities judged by their peers to provide high quality, cost-efficient patient care. In addition to peer

evaluation, the best hospitals, for example, can be ascertained by studying differential hospital mortality and how mortality levels relate to the organizational and management characteristics of the hospitals. Hospitals' teaching status, ownership, size, financial status, location and nurse staffing variables, e.g., nurse-to-patient ratios and nursing skill mix, should be studied and monitored as potentially significant proxies of the quality of inpatient clinical work. Legal protection of key care standards, e.g., mandating minimum requirements on certain hospital stays for maternity and outpatient surgery also need to be maintained.

Reestablishing the role of nursing resources in hospitals and other care giving settings. Hospitals are shifting resources away from nursing care, while, with the increasingly intensive diagnostic and treatment activities within hospitals, nursing care has become more important and intensive. This can be illustrated best by the following evidence from the Canadian city of Winnipeg. In 1991-93, 18% of hospital beds was closed while the number of treated patients remained unchanged. The LOSs, however, declined, reflecting an increased intensity of care per patient day. Concomitantly with this trend, the number of registered nurse hours per patient increased 15%. [Shamian, 1997: OS65] The overall use of resources actually became more efficient: fewer beds, same amount of treated patients, more intensive care, and greater input of nursing resources. Slashing nursing resources or lowering the skill and professionalism of bedside caregivers is certainly not a recommended strategy.

Four decades ago Beecher concluded from a review of 15 studies that the placebo effect (a term for caring) provided, on average, approximately 35% of the outcome benefits from most clinical interventions. [Beecher, 1955: 1602] . Nursing interventions, therefore, need to be considered as cost-effective complementary care to the work done by the more expensive physicians.

Reestablishing job certainty and professional self-esteem of medical staff. This will have a powerful, positive impact on the quality of care, patient satisfaction, and costs. The operations research from the late 60's showed that the attitudes of management and supervisory personnel had a direct impact on the turnover of nurses and other staff and, perhaps of equal importance, on length of hospital stay for six common medical and six common surgical illnesses. [Revans RW, 1982] Nurse autonomy, their control over the practice setting, and nurse relations with physicians have also been shown to be important contributors to lower inpatient mortality rates [Sochalski et al., 1997:OS21]

Shift toward a multidisciplinary management culture. Of paramount importance is the involvement of clinicians in the discussion of practice patterns from the standpoint of appropriateness and efficiency of care. Creation of an atmosphere of collegiality is necessary because a health institution can only achieve its strategic and operational objectives by acting as a collective enterprise. Needless to say, external pressure on the provider, coming from the risks of fixed budgeting and competitive contracting, will exert discipline on all the parties in a participatory management process to adhere to the growing requirements of cost-efficiency.

Strategic alliances Inter-organizational arrangements that strive for efficiency and quality of care, goals not possible for individual providers to achieve alone, can be achieved through strategic alliances. Optimal care requires involvement of various providers in treating and maintaining the health of a specific patient. To strengthen collaborative effort, providers of services may enter into long-term agreements with various options for integrating care. The following represent some possible strategic alliances:

- (1) Shared services: providers share services to improve efficiency and effectiveness, e.g., logistical functions such as housekeeping, laundry, security, transportation means.
- (2) Joint programs, e.g., radiology, pharmacy, or laboratory services, share the management, clinical, and equipment resources of more than two facilities in order to minimize unit costs.
- (3) Management contracts: to manage a community hospital, nursing home, and community health center as part of one provider complex.
- (4) Umbrella organizations: Two or more providers join and are managed by a common governance structure that has the authority to transfer resources between the organizations as appropriate. Each affiliated organization retains considerable autonomy and independent identity.
- (5) Networking: Horizontal networking establishes contractual links among facilities of the same kind and among providers of end services and their subcontractors, e.g., between a hospital and a laboratory. Creation of health care provider networks that are vertically structured, i.e. a long-term alliance among providers of different levels of care. Networks may or may not have a formal governance structure.
- (6) Mergers: An alliance in which two organizations join to form a new organization.

Organizational adjustment. Providers will need to adjust to and adapt standard techniques for clinical coding, cost accounting and utilization control to enable full comparability of information for the purchaser of care. A master modernization plan may need to be developed under the auspices of a regulatory/purchasing agency for each major type of provider. This would allow managers and staff in a specific hospital or health center to pick out their choices from a standardized menu of restructuring options and develop those choices into a customized action plan. It is recommended that medium-term modernization targets are included in purchaser-provider contracts.

Leveraging the revenue flow. Public providers may seek direct contracts with alternative payers for their services, such as has been done by managed care organizations that have emerged in several Latin America and Caribbean (LAC) countries. Multiple sources of financing available for a given facility allow providers to compensate for income lost to increased cost-containment pressure in the public sector. A regulatory framework will be an important element to have in place to secure that waiting lists and times are not increased for patients reimbursed under the public contract.

3.3 CONSUMER CONSIDERATIONS

Consumers of health care services are increasingly recognized as important stakeholders that merit attention and deserve some voice when changes are being considered in the delivery of their health care. Although rarely organized as advocates on their own behalf, end users in developing countries do communicate indirectly with purchasers, providers and health planners through their care seeking behavior, i.e., their choice and utilization of

services at varying levels of cost and complexity. The following are additional considerations for those who wish to gain “buy-in” from consumers:

Community participation. To gain consumer support, providers of care should appoint community representatives to sit on their advisory board. Focus groups and other forms of information exchange can also provide a vehicle for consumers to communicate their needs and preferences to purchasers and providers. This consumer input is particularly important in situations where the culture, gender, and/or socioeconomic status of consumers may create unseen but very real obstacles to seeking health care.

Referral options. To facilitate consumer buy-in, the freedom of patient choice should be set, on the one hand, to somewhat restrict self-referrals, in order to make cost and utilization predictable and, on the other hand, to give the patient an opportunity to choose his or her provider of services. Two features secure this balance: (1) more than one provider option within the network (e.g., the right to choose a primary care doctor within a health center or an independent group practice); and (2) access to out-of-network providers at an additional charge, e.g., for example, with reimbursement of 80% of customary and usual costs. In either case, patients should be clearly informed of their referral and treatment options.

Consumer-oriented marketing. Annual reports may be published for the public on provider resources, performance, and development plans. Open house events should be part of the open enrollment campaigns to inform patients of the conditions of care giving, staff competence, and patient logistics of a physician practice or an integrated delivery system. Consumer satisfaction should be measured continuously by the purchaser of care through exit and household surveys. Procedures for consumers to address their complaints with their physician and/or management should also be an inherent part of the purchaser-provider contract.

4. LATIN AMERICA AND THE CARIBBEAN (LAC) REGIONAL REVIEW

Two provider payment tools with a strong potential for raising system-wide efficiency, prospective case based reimbursement of hospitals and prospective capitation of integrated health care systems, fit under the umbrella term of prospective global budgeting discussed above. These tools will be discussed within the context of LAC regional experience. To date, evidence suggests that provider payment systems in LAC are increasingly characterized by pre-negotiated fee-for-service reimbursement in the outpatient sector, and historical allocations to hospitals related, primarily, to their production base rather than their performance.

4.1 PROSPECTIVE, CASE-BASED PAYMENT FOR HOSPITALS

Prospective, case-based payment is a hospital payment system whereby a hospital is reimbursed per discharged inpatient according to rates prospectively established. These rates are based on case-mix groupings, i.e., groups of cases with similar clinical profiles and resource requirements. Each case mix group rate is determined as the product of the multiplication of the group cost weight and the hospital base rate. The latter is calculated as the blended rate, i.e., the weighted average of network-wide and hospital specific historical average costs per case.

Of the closely reviewed 5-7 countries of the region, and limited evidence from several others, only Brazil and Chile appear to make use, albeit limited, of prospective case-based methods of payment. In Brazil, the Unified Health System (*Sistema Unico de Saude*) reportedly reimburses public and private hospitals through a case-based schedule. In the public hospital sector of Chile, experimentation with case mix payments has been underway for a number of years. Inside observers, nevertheless, emphasize that the National Health Fund (*FONASA*), the public health financing agency, does not really reimburse hospitals on the basis of these rates, and allocations remain essentially a process that is based on adjusted historical budgets.

In Argentina, the British Hospital in Buenos Aires has been mentioned as, probably, the only facility in the national hospital sector that attempts to import the DRG system from the United States in order to standardize case-mix groupings. Such standardization, using DRGs or other classification, is essential for prospective case based payments.

The countries reviewed in more detail below find themselves at various stages of conceptual design and preparation for experimental trials that would involve prospective, case based, hospital budgeting.

4.1.1 Chile

Until 1978, the Ministry of Health financed public hospitals through budgetary allocations based on historical trends. In 1978 a fee-for-service reimbursement system was adopted, known as Billing for Provided Services (*Facturación por Atención Prestada – FAP*). Since the early 90's, hospital funding has been evolving into a more diversified system, including the following three methods:

1. Prospective Payment for Provided Service (*Pago Prospectivo de Prestaciones – PPP*). This is a traditional fee-for-service method of provider reimbursement.
2. Diagnosis-Related Payment (*Pago Asociado a Diagnóstico – PAD*): hospitals receive their payment per treated case. Payment rates are established by a broadly defined case mix category.
3. Complex procedures, e.g., organ transplants, angioplasties, valvuloplasty, etc. are reimbursed under separately established rates. PPC is focused on cases in which total case cost is heavily influenced by the cost of the principal surgical procedure.

Diagnosis-related payments, or PAD, account for 1/3 of allocations to the public hospital sector. In the mid-90's, this system was successfully pilot-tested in several facilities and has been rolled out to a larger number of public hospitals. The PAD rate schedule, initially comprised of 25 diagnostic categories, now includes 30 case mix groups (see Table 1). PAD groups do not cover the entire case mix but rather focus on cases that stand out in terms of their volume and/or cost. PAD rates are differentiated by three hospital levels and by geographic location: for the so-called "extreme areas", PAD rates are marked up by 12 to 30% of the standard. Rates are adjusted upward by 2 percent for teaching hospitals.

TABLE 1. DIAGNOSIS RELATED GROUPS IN CHILE AND RATES BY HOSPITAL LEVEL, 1996, IN CHILEAN PESOS

DIAGNOSIS PAD		HOSPITAL LEVEL		
		1	2	3&4
1	Cholelithiasis	216,392	210,392	198,392
2	Appendicitis	121,392	117,092	109,092
3	Peritonitis	206,583	197,583	179,583
4	Uncomplicated abdominal hernia	100,929	97,929	91,929
5	Complicated abdominal hernia	273,243	264,243	246,243
6	Malign tumor, stomach	457,165	437,165	397,165
7	Complicated gastric ulcer	309,555	297,555	273,555
8	Complicated duodenal ulcer	270,524	260,524	240,524
9	Child delivery	131,351	127,851	120,851
10	Ectopic pregnancy	193,122	188,622	179,622
11	Complicated pregnancy	146,873	137,773	119,573
12	Uncomplicated abortion	86,996	84,996	80,996
13	Complicated abortion	199,036	192,036	178,036
14	Tonsillitis	99,257	96,457	90,857
15	Adenoids	128,103	125,303	119,703
16	Hyperplasia of prostate	281,521	270,821	249,421
17	Phymosis	104,620	101,820	96,220
18	Cryptorchidism	159,570	156,770	151,170
19	Jaundice of newborn	20,035	20,035	20,035
20	Acute bronchopneumonia	148,886	139,886	121,886
21	Cataract	221,012	219,012	215,012
22	Kidney transplant	1,228,120	1,222,120	1,210,120
23	Cardiosurgical procedure with major use of extracorporeal circulation (EC)	2,280,926	2,274,926	2,262,926
24	Same w medium use of EC	1,466,002	1,460,002	1,448,002
25	Same w minor use of EC	1,005,975	999,975	987,975
26	Vaginal prolapse, anterior or posterior			
27	Intracranial tumors or cysts	...	...	...
28	Aneurysms	...	...	...
29	Dysphasia	....	...	...
30	Hernia of pulpous nucleus	...	...	...

FONASA. Quoted from: Bitrán et al. *Equidad en el Financiamiento del Seguro Público de Salud. Informe final. Vol.3. Santiago de Chile, 1996; Personal communications with Ms. Consuelo Espinosa, Bitrán y Asociados, August 1999.*

4.1.2 Costa Rica

In Costa Rica, the health care reforms of the mid-90s postulated the need to overcome inefficiencies resulting from historical allocation of resources by level of care and to specific providers. The Costa Rican Social Security Fund (*Caja Costarricense de Seguro Social -- CCSS*) proposed in 1998, as part of its modernization plan, that reimbursement should be linked to provider performance and population health gains. The separation of purchasing and provision of services was announced as the key policy. Management contracts were to be signed between CCSS as the purchasing agency, and physician practices, hospitals and 'health areas', as providers of care.

Management contracts with hospitals would set out performance targets related to quality, organization, and delivery of services. To increase productivity, hospital contracts would relate financing to output measurements, e.g., number of discharges, hospital-based consultations, and other health activities. Hospitals would be encouraged to maximize production within a pre-determined global budget. Expenditures in excess of the budget cap, would be reimbursed at the amount of variable cost per specified production unit. Subsequent stages of the reform would feature gradual introduction of prospective budgeting related to the volume of hospital production adjusted for complexity and quality of care.

A pilot demonstration initiated in December 1996 involved seven hospitals that were transferred to the aforementioned management contracts between the hospitals and the Medical-Administrative Division, i.e. local health administration. The original plan was to extend the demonstration project to 10 more hospitals in 1998. As of 1998, however, there was no additional information found on case-based reimbursement for Costa-Rican hospitals. However, the content and the language of the initial, proposed, and piloted reforms imply use of this method of payment and bodes well for its experimental implementation in the near future.

In the 1997 CCSS policy document "Towards a New System of Resource Allocation", the concept of performance-based hospital reimbursement was elaborated in more technical detail. Hospital production was presented as a combination of activities: hospitalization; hospital-based ambulatory care; emergency services; specialized health care programs, teaching and research activities. All activities would be measured in hospital production units (HPUs) and related to one, discrete hospitalization (see Table 2).

TABLE 2. EQUIVALENCE RATIOS FOR HOSPITAL PRODUCT PRICING PROPOSED IN COSTA RICA	
HOSPITAL ACTIVITIES	HPUS
Hospitalization	1
Emergency	0.35
First visit to a specialist	0.40
First visit, other	0.25
Follow -up visit to a specialist	0.20
Follow -up visit, other	0.10
Dental visit	0.10
Visit not involving physician	0.05
<i>Hacia un nuevo sistema de asignación de recursos. Proyecto modernización CCSS. San José, 1997: 52.</i>	

Hospital budgeting would involve planning and projection of the following indicators: (1) *Allocated budget*, the annual funding cap close to the hospital baseline spending; (2) *Programmed budget*, the allocated budget minus 10% set aside in the *Incentive Fund* and *Solidarity Compensation Fund*; (3) *Projected clinical volume*, the aggregate number of HPUs that reflect projected inpatient and ambulatory volume; Inpatient HPUs would be based on LOS standards set forth in the hospital contract. (4) *Payment rates per activity-*

specific HPUs would be based on the hospital historical costs and administrative level. It was assumed that higher-level facilities would be paid at higher rates to allow for their higher fixed costs; (5) *Production budget*, the total amount of revenues projected from each of the four hospital activities. Revenue by activity would be the product of activity-specific clinical volume in HPUs (see item three) multiplied by the activity-specific HPU payment rate (item four).

At the end of the fiscal year, reported expenditures (so called ‘executed budget’) would be compared with the production budget (item 5). When the executed budget exceeded the production budget, the hospital would end up in the red. This would be viewed as inefficiency, i.e. it took the hospital more than the resources planned to produce the contracted clinical volume. The deficit would be given to the provider as a ‘subsidy’ and the hospital’s performance would come under scrutiny to identify possible roots of the inefficiency.

If the executed budget stayed equal to or below the production budget, this would mean that the hospital achieved the contracted clinical volume at the planned or reduced cost. 80% of the savings would be retained by the hospital, and it would gain access to the Incentive Fund. The remaining 20% of the savings would be paid to the hospital for the excess of the reported volume over the contracted volume (in the event that the hospital reported both the cost savings and the surplus of clinical volume). If this amount were insufficient for covering costs associated with extra volume, the remainder would be reimbursed to the hospital from the Solidarity Compensation Fund.

If the hospital exceeded the planned volume at an additional cost, (i.e. without reducing unit costs), additional expenditures would be reimbursed from the Solidarity Compensation Fund at 40% of the hospital HPU rate. The total amount of such reimbursement would not exceed 50% of the funds available in the Solidarity Compensation Fund.

As the implementation of the above described system proceeded, the HPU rates, initially, adjusted for the hospital level, would be differentiated further, according to a hospital-specific case mix index, thus, giving more funding per HPU to hospitals with higher clinical complexity.

4.1.3 Peru

The main purchasers of hospital care in Peru are the Ministry of Health (MoH) and the Peruvian Institute of Social Security renamed in 1999 into *EsSalud*. Health Care Provision Entities (*Entidades Prestadoras de Salud – EPSs*) mandated by the 1997 health legislative reform, are expected to grow into the third payer in the institutional layout of the Peruvian health sector. EPSs are public or private providers of group insurance coverage and medical services to employers who partially opt out of the EsSalud system. EPSs will operate on an increasingly competitive basis with EsSalud and one another. Seeking to provide care in a cost-efficient way, EPSs will be more conducive to performance-based methods of hospital budgeting. EPSs may become a driving force behind the implementation of case-based payment mechanisms.

In 1998, the MoH, through an agreement with the USAID-sponsored PHR project and Project 2000, initiated a Hospital Payment Experiment seeking to introduce the following

reforms into the hospital sector of Peru: (1) Separate purchasing from provision of services; (2) Advance management autonomy of hospitals; (3) Gradual introduction of competitive contracting within the MoH-operated hospital sector and, longer-term, among all hospitals regardless of their jurisdiction and predominant source of funding; (4) Implement payment methods that encourage productivity and efficient use of hospital resources; (5) Set the stage for incremental structural modernization of the national hospital sector, both at the level of facilities and regional networks.

Based on a 1998 survey, the health care regional administrators and hospital directors in eight pilot territories of Peru shared the following views on future payment mechanisms, consistent with the aforementioned objectives: (1) Hospitals should be funded according to a volume-related budget. (2) Volume and financing should be determined by the number and resource intensity of discharged inpatients and services provided to outpatients. (3) Both discharged inpatient cases and furnished outpatient services should serve as the units of hospital budgeting and reimbursement and should be priced at prospectively determined rates. (4) The rates should be averaged across groups of inpatient cases and outpatient services with similar clinical parameters and resource requirements.

A tedious system design and validation process resulted in the choice of the health resource groups (HRGs) from Great Britain as the methodological tool of inpatient grouping and rate setting. According to the preferred methodology, cases were assigned to groups on the basis of their clinical and cost homogeneity. The MoH standards of patient coding were updated to enable introduction of ICD-10 for diagnosis coding and OPCS-4 for surgical procedure coding. Recording of surgical procedures was pivotal for the assignment of surgical cases to HRGs. Several months of intensive capacity building led to a dramatic improvement in clinical coding skills and information resources in the participating hospitals. A patient file of over 70,000 records was produced by the end of 2000 for a case grouping and rate setting exercise that will lead to an experimental design of a case mix payment schedule for the public hospital sector of Peru.

Average costs will be calculated for each group across all experimental hospitals as average per diem costs for a pertinent clinical specialty, multiplied by group-specific average LOS. Surgical cases will be marked up by a surgical intensity factor. Thus calculated average monetary costs will be transformed into relative values. The uniform list of relative values will be applied to hospital-specific historical rates of per-case financing, to create hospital-specific payment rate schedules by case mix group.

4.1.4 Mexico

Hospital financing and provision of care are fragmented in Mexico among several institutional systems. In the public health care sector that accounts for less than half of the national health expenditure, the major purchasers are the Mexican Social Security Institute (*IMSS*), covering approximately 34 million private sector employees and their family members, the Social Security Institute for Public Employees, covering about 9 million public sector employees, the *IMSS-Solidaridad*, targeting services to about 11 million rural population lacking health insurance coverage, and the Secretariat of Health, providing government-funded care to 30 million citizens. Public sector purchasers allocate resources to hospitals mostly on the basis of historical spending. By contrast, the private sector,

represented by private health insurance plans and private Managed Care Organizations (MCOs), funds hospitals, predominantly, through fee-for-service.

In 1995 health care reforms were moved up on the list of government priorities, and a new five-year program of strengthening the national health sector was adopted. The introduction of performance-based methods of payment, including case-based reimbursement of hospitals, can now be viewed as a likely development concurrent with the following policy goals: (1) The clear separation of financing from provision of services, as a key element in the introduction of competition, transparency, and accountability to the health insurance system; (2) Development of internal market mechanisms to ensure that resources follow the patients, rather than the other way around; (3) Pursuit of the highest value with the resources available in the system; and (4) Gradual introduction of competition, both among public health care providers (IMSS and others) and between public and private providers of health care.

As an initial approach to case-based payment, the IMSS sought to introduce diagnosis-related groups (DRGs) into internal clinical and resource management processes in the participating hospitals. Hospital-based physicians and administrators would be encouraged to set up a peer evaluation process. It would allow each facility to identify high-volume diagnoses and cluster them into clinically similar groups of cases (40 to 60 groups in total). Case-based evidence would inform professional discussions, examination of clinical profiles, utilization patterns (e.g., variability of LOS within and among hospitals), services provided, costs per procedure and average case, and clinical outcomes reported in each DRG. Such discussions and analyses would lead to the development of clinical protocols and case management guidelines to promote the most effective and efficient ways of treating patients in specific DRGs, and reflect the best practices in the Mexican hospital sector.

The initial sets of DRGs were based on an intuitive approach and limited patient data (usually, just principal diagnosis). Not surprisingly, such 'homegrown' sets varied widely across 15 hospitals that, according to the IMSS estimate, have been using them since May 1999, and could not provide a consistent methodological base for a uniform system of case mix grouping. The need for such a system became evident as 60-70% of IMSS hospital directors opted, in the recent survey, for a more rigorous and comprehensive methodology of DRG formation. There are indications that HCFA DRGs designed in the United States for the Medicare and Medicaid programs of health insurance are viewed by IMSS as a viable international prototype for the Mexican system.

An evolutionary approach to the implementation of DRGs is expected to prevail in the IMSS hospital sector. Case mix analyses for hospital management purposes would be the main function of a newly designed DRG system at the initial stage of its implementation. Longer-term, DRG payment rates will be developed and introduced as the key tool of hospital budgeting and competitive contracting. This will enable a transition from historical hospital funding based on production capacity towards performance-oriented funding linked to clinical volume and intensity.

4.1.5 Colombia

Public hospitals in Colombia account for 75 percent of all discharges and surgeries, the rest being provided by private facilities. The 1993 health legislative reform that mandated

competition in the insurance market and provision of services led to decentralization of decision-making and allocation of resources. An estimated 85 percent of hospitals has evolved into autonomously managed entities.

Providers of services would come under increased cost-containment pressure from Health Promotion Organizations (*Entidades Promotoras de Salud -- EPSs*).¹ The latter had established themselves as multiple insurance carriers and purchasers of services, operating at unrestricted competition with one another. In order to stay in business, an EPS would seek to maximize its enrollment base and be efficient in spending its premium revenue on reimbursement of medical care. The currently dominant fee-for-service payment system promoted unnecessary services and excessive billing and was unlikely to be tolerated by the EPSs. Apparently, a more cost-efficient payment method, e.g., per admitted/discharged case would come to substitute for the fee-for-service.

According to the Harvard 1996 Report, it is “unrealistic” to expect Colombia to develop a full-blown payment system based on DRG rates, at least in the short to medium term. Uniform and sophisticated diagnostic and surgical procedure coding required from every hospital by the DRG system exceeds the institutional capacity currently present in the hospital sector of Colombia. A more viable proposal would be to pay hospitals per admission by rates differentiated by hospital level, location, and a broad category of patients with similar clinical conditions and resource requirements.

An important recommendation from Harvard was to adjust case payment rates based on the costs of the lowest-level hospitals that deliver the service with appropriate quality. This would discourage the currently over-utilized and expensive tertiary care hospitals from admitting routine cases and treating them at a relatively high cost. An estimated 20-30 percent of inpatients could be treated in Colombia at the lower-level hospitals that are currently under-occupied.

In order to make incentives for productivity work in a consistent and uniform way, all main purchasers of hospital care need to coordinate their payment policy. It is particularly important that public purchasers of care on behalf of the subsidized regime (*Administraciones del Régimen Subsidiado -- ARSs*) join private EPSs of the contributory regime in a drive for a more rational and equitably targeted use of hospital resources. The Colombian government funds hospitals in two ways: direct ‘supply subsidies’ for the benefit of individuals with no health coverage, and allocations to ARSs that purchase care for beneficiaries under the subsidized regime. Approximately 80 percent of public hospital revenue comes from budgetary financing. These allocations are related to hospital production capacity or made out per procedure. Neither of these two allocation methods stimulates efficiency.

Two additional objectives are: 1) the coordination of *payment rates* between the contributory and the subsidized regimes; and 2) the straightforward assignment of patients to either the contributory or subsidized regimes at the point of billing for care provided. Coordination of reimbursement rates also means that the government needs to increase its payments to the hospitals under the subsidized regime to a level at which such payments become competitive relative to what EPSs pay for the insured under the contributory regime. This would eliminate the current, existing disincentive for the hospitals to treat the poor. The

¹ More on EPSs and the subsidized and contributory modes of the national health insurance in Colombia, see the next section titled “Prospective Capitation in the Outpatient Sector”.

per capita amount of health expenditure under both regimes will be equalized in 2001. This will set the stage for equalizing hospital payment rates, be it per procedure or treated patient.

In addition to its straightforward function of setting incentives for productivity, competition, and structural change, case-based hospital reimbursement in Colombia will promote a more 'personalized' hospital financing. It will allow a better headcount of patients by source of coverage and, therefore, a more accurate assignment of hospital cost and revenue to the contributing, subsidized, and uncovered populations. Case-based payment, as a 'patient-oriented' method, provides a favorable environment for those socioeconomic measurements in the hospital sector that are necessary to extend coverage and improve the targeting of social health insurance programs. This is an important issue in Colombia, given that an estimated one half of the patients covered under the subsidized regime are enrolled in it erroneously, having income levels above the eligibility threshold.

The case-based payment method involves a conveniently defined production and payment unit (such as patient admission or discharge) that serves as a common "currency" in a hospital's dealings with multiple purchasers of care. Each ARS or EPS can easily quantify its share in a hospital output (number of patients adjusted for resource intensity) and pay strictly for that share. By contrast, financing per unit of production capacity creates discomfort among the purchasers, since there is always a suspicion that physical resources are used to the benefit of other contractors, and that the hospital inflates its need for recurrent funding in order to compensate for its own inefficiency. Case-based reimbursement will intensify competitive contracting and facilitate institutional integration of the hospital markets in Colombia, thus, making it easier for hospitals to compete for funds from a variety of sources.

4.2 PROSPECTIVE CAPITATION IN THE OUTPATIENT SECTOR

Prospective capitation is a method of financing in which health care providers receive a pre-determined payment for each patient who registers with them. In return, providers agree to deliver specified services to any member of the defined population, on an as-required basis, during a period of time laid out by the contract. Prospective capitation exposes providers of care to the risks and consequences of spending in excess of predefined and prepaid budgets. To manage such risks, prospectively capitated providers seek clinically effective and cost-efficient ways of delivering their services, e.g., by strengthening prevention and primary care services, favoring hospital-substituting clinical strategies, limiting referrals to higher levels of care, and controlling resource utilization by subcontracting providers.

Prospective capitation strongly supports the following health policy goals: (1) increased participation of general practitioners in determining clinical strategies, referral patterns, and allocation of resources among levels of care; (2) improved coordination of services among the primary, secondary, and tertiary levels; (3) broadened access to care and liberalized consumer choice of provider while, at the same time, restricting indiscriminate "doctor shopping," that can result in too many office visits, tests and prescriptions; (4) improved professional and economic satisfaction of health care providers; (5) increased cost efficiency in the health care sector.

International recognition of prospective capitation has grown in the past 15 to 20 years. It has been a factor in the market-driven US health care sector as well as the government-

dominated health sector of Great Britain. Both positive and negative experiences have been widely documented thus making prospective capitation an accessible target for experimental application in LAC countries where, as a provider payment tool, it is making its entrance.

It is necessary to consider the institutional structure of the health care sector within the region, and its impact on the organization of health financing and service delivery before exploring specific examples of prospective capitation.

There are three clearly distinct tiers in the health care sectors of countries such as Chile, Argentina, Uruguay, Colombia, and Peru, i.e., public, social health insurance, and private health care systems. The private tier is ‘populated’ by organizations that match the concept of a *managed care organization (MCO)*. Most MCOs that combine insurance and delivery functions, may be considered as ‘naturally’ capitated systems since insurance premiums are prepaid *per beneficiary*.

A number of options exist regarding the allocation of premium revenue to providers of services. The capitation principle can be operationalized by making funds available on a full capitation basis to a fund-holding primary care practice, or as a partially capitated budget for ambulatory services combined with fee-for-service, per diem, or DRG-related payments to the hospitals. Alternatively, premium revenue raised by MCOs on a per capita basis, may be allocated to providers, predominantly, on a fee-for-service basis. To make such allocations predictable and compliant with the MCO budget constraint, the rate schedule and the volume of services need to be pre-negotiated and fixed in the contracts. Clinical volume, in turn, needs to be set out as service utilization rates, i.e., implicitly, per enrollee. From here, there is one step to capitation rates calculated as the total of service-specific costs multiplied by the service-specific utilization rates.

Reportedly, in Chile, Prospective Health Institutions (*Instituciones de Salud Previsional – ISAPRES*) that compete as private MCOs, pay primary health posts an annualized rate per enrollee. In Uruguay, Collective Institutions of Medical Assistance (*Instituciones Asistenciales Médicas Colectivas*) are the main vehicle of employer-based health insurance and are financed by a combination of monthly per capita prepayments and user charges.

In Argentina, *Obras Sociales* (OSs), a network of approximately 300 employer-based statutory sickness funds, operate as integrated insurance/delivery plans similar to preferred provider organizations in the United States. As regards financing of care, reports are contradictory. Some assure that Obras Sociales moved away from fee-for-service and towards capitation. This shift, apparently, occurred in the 90’s. The amount of per capita spending and benefit package varies widely by OS. Such variation often reflects operational inefficiency of OSs due to their small size, as well as weak premium revenue-generating capacity in certain industries and geographic areas. A mechanism of risk-adjusted transfers and consolidation in the market place may be needed to ensure the OSs’ equitable and efficient performance. Some reports assert that the prevalent provider reimbursement method remains fee-for-service. There is the national rate schedule called “El nomenclador nacional”. It lists ambulatory and major inpatient procedures, and is used as a reference price list by OSs and independent practitioners and health facilities. Rate setting is deregulated and left, therefore, at the discretion of the negotiating parties.

In Brazil, private Medical Group Organizations operate similarly to HMOs in the United States. There are also private medical cooperatives that resemble preferred provider

organizations in the U.S. Both types of institutions are prepaid plans, drawing their revenue from capitated premiums. In the mid-90s, provider payment innovation was reported in the *public* health care sector of Brazil. In 1995, the Health Action Plan was introduced in Sao Paulo. The city municipal services, including hospitals and basic health services, were organized into cooperatives competing for enrollment. The resident population was encouraged to choose the cooperatives according to their needs. The municipal government was then required to make an annual payment to each cooperative at a pre-established rate per enrollee.

The experience with prospective capitation in the outpatient sector of Colombia, Peru, Mexico, and Costa Rica is reviewed in the following subsections.

4.2.1 Colombia

The 1993 health regulatory reform in Colombia mandated a two-tier system of social health insurance comprised of the contributory and subsidized regimes. The former is financed from payroll taxes and covers formally employed populations. The latter is designed for low-income recipients and is financed from budgetary transfers supplemented with solidarity contributions as a minor part of premiums under the contributory regime. Both contributory and subsidized regimes are administered through multiple entities that accept premium revenues from employers, employees, and the government. Such entities are named Health Promotion Organizations (*Entidades Promotoras de Salud* -- EPS) and Health Service Provider Organizations (*Instituciones Prestadoras de Servicios* -- IPSs) in the contributory regime, and Subsidized Regime Authorities (*Administraciones del Régimen Subsidiado* -- ARSs) in the subsidized regime. An EPS and an IPS can operate both in the contributory and the subsidized regimes, thus, becoming an ARS. Funds are increasingly allocated to EPSs, IPSs, and ARSs in the form of the *capitated payment unit* (UPC), an annual amount to be spent on medical services per head of enrolled population and adjusted for sex, age, and geographic location. This is a typical prospective capitation. UPC, as a capitated rate, is determined per package of benefits and is subject to mandatory coverage under social health insurance. In the contributory regime such a package is titled a Mandatory Health Plan (*Plan Obligatorio de Salud* -- POS). In the subsidized regime it is known as the Subsidized Mandatory Health Plan (*Plan Obligatorio de Salud Subsidiado* -- POSS). The per capita monetary value of POS is twice as high as that of POSS. This gap will be closed in 2001, as a result of accelerated growth of per capita funding under POSS.

The core budget of an EPS, IPS or an ARS, the product of the UPC multiplied by enrollment. Capitated payments, accounts for 44% of IPS contracts, according to a recent survey. Capitation is supplemented with fees-for-service that are billed to institutional purchasers of care and/or patients. Each EPS, IPS and ARS represents an integrated insurance/delivery plan. It uses its own clinical base to provide services to the enrollees, or contracts out services to independent physicians, polyclinics and hospitals. Participating facilities are reimbursed, predominantly, on a fee-for-service basis. Packaged fees akin to sub-capitation only play a minor role.

According to Law 100 that was adopted in 1993, part of a UPC should be pooled to form a government-sponsored reinsurance fund to protect EPSs against eight catastrophic conditions, including premature childbirth and related neonatal conditions, AIDS, trauma, cancer, kidney disease, heart disease, and stroke.

4.2.2 Costa Rica

The thrust of the reform agenda proposed in Costa Rica in the mid-90's, was to provide universal and equitable access to basic care for the nation's entire population. This was to be achieved by dividing the national territory into 90 Health Areas (*Areas de Salud*) and setting up 800 Basic Teams for Integrated Health Care (*Equipo Básico de Atención Integral de Salud – EBAIS*). In 1995-97, 427 EBAIS were placed in 52 health areas, predominantly in rural, marginalized communities. Each basic team represented a primary care practice staffed with a general practitioner, a nurse and a technician. Several basic teams shared a Support Team (*Equipo de Apoyo*), comprised of a family doctor, nurse practitioner, dentist, pharmacist, microbiologist, social worker and nutrition specialist. EBAISs and support teams located in the same health area formed a Health Team (*Equipo de Salud*). It was reinforced with secondary and tertiary care provided by local specialized and regional facilities.

EBAIS were conceived to be the locus of public health and primary care activities in five settings: family, community, educational, workplace, and medical. The reform concept was not specific as to how these activities were to be financed. Social and medical prevention, and curative care, when organized by place of residence, facilitates the introduction of prospective capitation. Should this method of financing be chosen it would reinforce provider incentives to resolve the following problems identified in the 1996 EBAIS survey and by local policy analysts: lack of motivation among community and health personnel; consumer preference for curative services over prevention; excessive demand for medical consultations; referral patterns biased for higher levels of care; lack of coordination among levels of care; and labor remuneration in the health care sector that is not reflective of labor productivity.

A pilot demonstration of competitive contracting (*Compromisos de Gestión*) has been underway in five health areas in Costa Rica since 1996 with the extension to 14 more planned in 1998. This pilot provides a good testing ground for the opportunities and challenges of prospective capitation in the rapidly reformed primary care delivery system of Costa Rica.

4.2.3 Peru

One of the pivotal directions of health care reforms in Peru, according to the MoH Health Policy Guidelines for 1995-2000 was: “to restructure the sector in order to make it more effective and efficient; enable extended coverage; increase quality of health care services; promote competition among providers of care; set up multiple health care networks; and move financing towards demand-side tools.” As a result, there was a consistent effort by the MoH and affiliated technical assistance projects to create area-serving integrated health care systems, referred to as “health service networks” or simply “local networks” (*redes locales*).

TABLE 3. RISK-ADJUSTED CAPITATION IN PERU

Risk adjusted capitation rates are computed by differentiating the regional aggregate average according to province-by-province variation of poverty rates and health risk ratios by population group. The following table shows that funding ratios are calculated for each province/population group by multiplying a population health risk ratio by province poverty factor. E.g., children of Piura will be funded at $1.80 \times 0.93 = 1.67$ of the province-wide per capita average, i.e. 67% beyond that average.

PROVINCES OF THE PIURA SUBREGION	CHILDREN	STUDENTS	FERTILE AGE WOMEN	ADULT MEN	AGED	POVERTY FACTOR
<i>Health Risk factor</i>	1.80	.30	1.46	.70	1.26	
Piura	1.67	.28	1.35	.65	1.17	.93
Ayabaca	1.99	.33	1.62	.78	1.40	1.10
Huancabamba	2.00	.33	1.62	.78	1.40	1.11
Morropón	1.96	.33	1.59	.76	1.37	1.09
Sechura	1.78	.30	1.44	.69	1.24	.99

Resulting funding ratios are then multiplied by population size in the respective group and the region-wide per capita rate.

Aplicaciones Iniciales de Reforma en Regiones y Subregiones de Salud. Acuerdo de gestión con la Dirección Regional de Salud Piura y la Red Morropón-Chulicanas, MINSA, 1998: 22

A health service network (HSN) was defined by the MoH as “an alliance of public and private entities providing health care of different levels of complexity and diverse clinical content, associated with various levels of operating cost, and integrated by a road network and functional and administrative community ties that assure the provision of the [designated] package of priority health services”.

An HSN was conceived as a legal and administrative mechanism to align the public health, clinical, and financial goals of participating providers. Each HSN is seen as a vertically integrated health care system that would include rural health posts, community health centers, and a local support hospital.

An HSN administration enters, on behalf of participating providers, into a management contract with the regional health administration. The contract, among other provisions, sets forth the following:

- ? list of participating providers;
- ? total “user population” assigned to the HSN, including the estimated number of enrollees exempt from user charges;
- ? “user population” detailed by primary care health post;
- ? itemized list of health care services and production measurement unit for each service;
- ? target volumes of care and unit cost by service;

- ? list of quality indicators and their target values;
- ? annual budget, including revenues from third parties and user fees;
- ? risk-adjusted capitation as the basic payment method;
- ? capitation rates by each province of the region.

4.2.4 Mexico

The Mexican Social Security Institute (IMSS) remains the main purchaser of care in the national health sector. In the recent past it has made significant progress towards decentralized financing and provision of medical services. The most noteworthy outcome of decentralization has manifested itself in the creation of the Medical Areas of Decentralized Management.

In 1998, IMSS was planning to create 139 such Medical Areas (MA), an average of four per state, grouped under seven Regional Directorates. Each MA typically consisted of a secondary care hospital and several family care units. MAs were to increasingly take over the provision of primary and secondary-level care for the population of their service areas. As the number of MAs grew, so would their clinical, management, and financial strength. MAs were expected to evolve into integrated delivery systems taking care of all the health needs of their eligible population and funded at a risk-adjusted capitation rate. Reportedly, prospective capitation had been the main tool of MA annual budgeting since 1998. Over the medium term, MAs were to assume the fund-holding functions. As the fund-holder, an MA would autonomously allocate its capitated budget between the in-house provision of primary and secondary care for an average population of approximately 260,000 members, on the one hand, and, on the other, contract out complex, specialized, and tertiary hospital care to one of the 41 IMSS specialty hospitals.

By August 2000, the first 15 MAs were to undergo a comprehensive strengthening through the implementation of the following systems and processes: organizational development; a model of economic and financial management; integrated information system; identification of health status and needs of the enrollment pool; an integrated action plan matching local health priorities; program of innovation in community health; clinical and cost-accounting framework for the introduction of DRGs in a participating zonal hospital; need assessment for the participating Family Medicine Units; analysis of the clinical and resource capacity by level of care in order to improve vertical integration of services and optimize the patterns of upward and downward referrals. Additional variables were to be included in the capitation formula to account for differences in the health needs of the populations served by MAs.

In the medium term, based on the initial experience of MAs, health services were also to be contracted with private managed care organizations (MCOs) through prospective capitation. An MCO would provide a range of services specified in the contract with an employer under the “opt-out” arrangement. The opt-out scheme (*prestación indirecta*) was considered among the most far-reaching elements of the 1997 health insurance reform in Mexico. The beneficiaries of IMSS, through their employers, were given the option of receiving a per capita fee that could be taken outside the IMSS provision system in order to

obtain services from alternative public and private integrated care systems. Opting-out was projected to boost the expansion of private managed care, then in its infancy in Mexico. MCOs would be able to compete with IMSS, primarily, on the basis of cost-efficiency, quality, and user-friendliness. Prospective capitation was expected to set adequate incentives for MCOs for succeeding in such competition and, importantly, to coordinate provider incentives between the IMSS-affiliated MAs and private MCOs. Such coordination would also help ensure continuity of access to quality services in- and outside the IMSS.

5. RESULTS OF PROVIDER PAYMENT REFORMS

This section provides a review of some promising trends in health care financing and delivery of services, documented, primarily, in the industrialized countries, and attributable to provider payment practices akin to prospective global budgeting. Reformers in Latin America can learn from these positive results, as well as the concerns and consumer responses to prospective budgeting and managed care organizations that are outlined in the following section. As they can anticipate similar phenomena to occur in their own health care sectors with the progression of provider payment reforms, it will be helpful for our colleagues in LAC to define their attitudes towards the described changes, and decide which outcomes and reactions they would like to facilitate, neutralize, and/or avoid.

5.1 REDUCTION OF PER CAPITA HEALTH SPENDING IN PROSPECTIVELY BUDGETED CARE

The Rand Health Insurance Experiment found that health care expenditures per enrollee in a health maintenance organization (HMO) in the United States are 28% lower than in the insurance plans with no coinsurance that reimburse providers of care on a fee-for-service basis. Hospital use is also 40% lower. [Feldman, 2000]

5.2 BALANCE OF POWER SHIFTED AWAY FROM HOSPITALS AND TOWARD GENERAL PRACTICE

In the United Kingdom, fund-holding general practices have been fairly successful in altering the ways that hospitals provide services. They have persuaded some hospital-based doctors to see patients on GP premises, and have achieved quicker turnaround times for laboratory results at hospitals by threatening to use private firms instead. Still, in most cases, GP fund holders are content with the status quo, and have not changed their referral patterns. Moreover, their power to change hospital practices is *de facto* limited in many cases, because consolidation of services in many parts of the country has left them a limited choice of hospitals. [AC, 1995]

5.3 REDUCTION OF BED CAPACITY, CONTRACTION OF INPATIENT SERVICES, DIVERSIFICATION OF HOSPITALS INTO NON-INPATIENT ACTIVITIES

In the United States, inpatient care was delivered to fewer people for shorter periods of time during the period of 1980-94. Admissions per capita fell 26% and nearly one day was trimmed off the average length of hospital stay (ALOS), bringing it to 6.7 days. The result was a 34% drop in inpatient days per capita. Inpatient treatment has actually declined much faster than bed capacity. As a result, bed occupancy levels showed a gradual decrease from 76% in 1980 to 60% in 1995. [PPAC, 1996]

In 1985-95, the share of community hospitals offering home health care grew from 30% to almost 50%; for skilled nursing or long-term care the number rose from roughly 1 of every 5 to 1 of every 3 community hospitals. [Sochalski et al., 1997] The percentage of hospitals offering outpatient services climbed from 54% to almost 90% in 1985-95. The number of hospital-based outpatient visits rose 81%, and the percent of total surgeries performed in outpatient settings jumped from 23% to 55%. [AHA, 1995]

In Canada, there has been a decline in the number of inpatient days and hospital diversification into outpatient services and ambulatory surgeries. Hospital bed occupancy reported at 78.5% in 1993 has remained relatively steady since 1980. [Reamy, 1995] Admissions have declined by 25% in the 80's and 90's, while ALOS dropped from 8.2 to 7.8 days. Canada has been somewhat more successful than the U.S. in controlling the spending growth through tighter control in government funding of hospitals. The regionalization efforts undertaken by many provinces since 1990 resulted in the decline in hospital beds of up to 20% in several provinces.

In the Netherlands, the hospital admission rate per capita dropped substantially, and the ALOS, though, still notably higher than in the U.S. and Canada, decreased approximately 30%. The number of hospitals and beds declined to produce a combined effect of significantly reduced bed-per-population ratio. Outpatient and day-treatment services rose significantly during this same period, as new technology allowed inpatient services to shift settings.

In the United Kingdom, reforms in the National Health Service led to improvements in hospital throughput as well as a shift in service settings. [Maynard, Bloor, 1996] Acute admissions to hospitals have risen in the 90's, however, addressing the increasingly long waiting periods for non-emergent procedures, and day-surgery cases have jumped dramatically since 1991. In parallel, ALOS declined significantly, and since 1990 there has been a growing shift of services to non-acute-care settings as well. Occupancy levels remain higher in the U.K. than in the U.S., as the product of a higher rate of inpatient admissions and a reduction in available inpatient beds.

In Germany, the expansion of bed capacity in the 60's and 70's, and the full-cost reimbursement principle prevalent in the acute hospital sector during the 70's and 80's led to much higher hospital admission rates and substantially longer LOS than in comparable countries. Starting in the 90's, acute hospital beds per capita and ALOS have been declining. The 1992 legislation removed restrictions on hospital-based provision of outpatient services, and hospitals have slowly begun to move toward diversification. Current direction of change is, clearly, toward reduction in inpatient activity and shifting care to the outpatient sector.

5.4 SLOWER GROWTH OF HOSPITAL EXPENDITURE ON INPATIENT SERVICES

In the United States, dramatic reductions in inpatient activity and changing patterns of service delivery, motivated in part by the cost-containment policies of public and private payers, were accompanied by a decline in the rate of growth in total hospital spending. In 1980-94, national health spending rose in the U.S. by 284% while hospital expenditures rose at 230%. Hospital expenditures thus declined as a share of total national health spending from 41.5% to 35.7%. Most of the decline occurred in short-term community hospitals.

5.5 INCREASED CASE-MIX INTENSITY OF THE HOSPITAL PRACTICE

In the United States in 1985-95, the Medicare case-mix index, a commonly used measure of inpatient complexity grew by 27%. [PPAS, 1995] This growth in patient complexity reflects: the wholesale shifting of less complicated surgical procedures (e.g., cataract surgery) to ambulatory surgery; the shift of less acutely ill patients, and those undergoing diagnostic assessments, to outpatient settings; and the trimming of the less acute days (i.e., preoperative and convalescent days) from each of the remaining admissions. The higher level of clinical complexity of the inpatient case mix contributed to the real growth of per patient hospital spending in the U.S. by 53% in 1980-93. [Reinhardt, 1996]

5.6 ACCELERATED GROWTH OF HOSPITAL EXPENDITURE ON OUTPATIENT SERVICES

Outpatient services accounted for a dramatically increased share of hospital spending in the U.S.: 24% in 1994, compared to 10% in 1980. Outpatient spending in hospitals accounted for 8.7% of the national health expenditure in 1994, up from 4.1% in 1980. [Sochalski et al., 1997]

5.7 HOSPITAL WORKFORCE RESTRUCTURING

Labor constitutes over a half of hospital operating costs in industrialized countries and from two-thirds to three-quarters in developing countries. Consequently, one of the key items for current hospital reform agendas is the reorganization of the hospital workforce in order to improve control over labor costs. Three strategies have been used to accomplish this: reduction in the overall number of full-time-equivalent employees (FTE); lowering the average compensation per employee by reducing the skill level of the workforce; shifting full-time/part-time mix toward the part-time in order to save on fringe benefits. In 1984-94, FTE nursing personnel in American hospitals declined by 7.3%, adjusting for changes in inpatient and outpatient activity and increasing patient acuity. The total hospital workforce, however, grew by 11.3%. Within the nursing staff category, it was observed that when hospitals faced explicit cost constraints, they substituted registered nurses for other nursing assistant personnel in a manner not necessarily consistent with growing case-mix intensity.

6. CONCERNS REGARDING PAYMENT REFORMS AND COST CONTAINMENT

Although the “numbers” above are impressive in terms of the “bottom line,” not everyone involved in the provision of health care sees cost containment measures from the same perspective. An article in *Medical Care* describes provider payment and related organizational changes as “*frenetic* restructuring and downsizing with inadequate data to say nothing of *meaningful information* and its intelligent *interpretation*.” Population-based information is critically missing and the ubiquitous focus on money – the bottom line – without concomitant attention to the results achieved and the value added could put the future of any other public or private health enterprise in serious jeopardy. [White, 1997]

Concern has also been expressed that contemporary downsizing of nursing staff and their collective skill level is based on the ever-expanding but erroneous notion that high-tech equipment and computers can supplant personal observation, clinical judgment, and caring. Physician reimbursement rates have, at times, been negotiated in an atmosphere of political conflict among specialists, health insurers, and the government. Specialty doctors have often been portrayed as greedy health professionals and their revenues as a source of waste. Attempts to control physicians’ revenue in order to reconcile direct labor costs with global budgets also stir powerful opposition to cost-containment on the part of the clinical elite.

In the Netherlands, until the mid-90’s, specialists successfully opposed any proposal to integrate the specialists’ revenues into the hospital budget. In 1994, the Biesheuvel Commission indicated in its report on the modernization of curative care that the position of medical specialists needed fundamental reconsideration. It rejected fee-for-service funding arrangement for specialist care and recommended integration of their revenue into the hospital budget to underscore the status of the hospital as an integrated health care delivery institution. A number of pilot experiments were launched to align doctors’ compensation with the GB principles. Reportedly, professional behavior of physicians underwent controversial modifications. Gradually, however, mutual understanding between specialists and hospital management on budgetary and related topics has been growing. [Maarse et al.: 1997]

Concerns are also present that the epidemiological perspective, health care’s substitute for market analysis, is lacking in all but the most sophisticated contemporary health care systems such as a few Health Maintenance Organizations and perhaps systems like the Netherlands that serve populations defined by enrollment and geopolitical jurisdiction.

6.1 PATIENTS ARE CONCERNED ABOUT QUALITY AND ACCESSIBILITY

The redesign of care towards prospectively budgeted managed care networks has raised fears about undesirable tradeoffs being made between costs and quality of care. This has been seen in the United States in the form of negative consumer reactions. The public dislikes managed care organizations, feeling those will not take care of them when they are sick. [Blendon, 1998] The concern comes from the financial incentives behind prospective fixed budgeting for limiting spending in order to avoid budget overrun.

The summary of results of more than 20 studies conducted in 1995-97, suggests that most insured Americans are satisfied with their health plan, whether they have managed care

or traditional insurance. However, 45% of respondents believe that managed care has decreased the quality of care during the past few years, while only 32% believe that managed care has improved quality. A majority believes that the trend to managed care will harm the quality of health care in the future. Managed care enrollees are also more likely to report difficulties seeing medical specialists and consultants. [Kodelan, 1999]

6.2 LACK OF CONSUMER CHOICE ALIENATES NEW ENROLLEES FROM MANAGED CARE

A good way to track the popularity of managed care is to follow the recent enrollment trends in different types of managed care organizations (MCOs). In the United States, Health Maintenance Organization (HMO) enrollment has doubled since 1991 but the rate of increase has declined in each of the past 3 years. Furthermore, most of the managed care growth is occurring among point-of-service (POS) plans which let enrollees use providers outside the HMO's network for an additional charge. POS enrollment grew by 34% in 1998, whereas enrollment in standard HMOs (where members have to use providers in the HMO's network only) grew by only 4.1%. Meanwhile, preferred provider organizations (PPOs), which are organized by commercial insurers but are similar to POS plans, grew by 10% in 1998. [Feldman, 2000] It is clear from these trends, that managed care growth has shifted toward MCOs that allow enrollees more freedom of choice. Standard HMOs, with restrictions on the off-network option, are less desirable than POS plans and PPOs.

7. SELECTED CONCILIATORY STRATEGIES

Below is the summary list of stakeholder strategies and behaviors that have been laid out in this paper and supported with country-specific health sector reform experience:

Regulatory strategies

- ? Furthering purchaser/provider split
- ? Promoting deregulation and ownership reform
- ? (De)regulating supply of health care and resources
- ? Strengthening population-based information
- ? Establishing clinical output/outcome measurements
- ? Licensing of providers
- ? Quality control
- ? Regionalization of health care systems
- ? Changing hospital status and roles
- ? Channeling service, patient and resource flows away from the hospital sector
- ? Changing the market structure (concentration/de-concentration)
- ? Deregulating fixed investment

Purchasing strategies

- ? Controlling and managing utilization of care
- ? Changing payment principles and pricing techniques
- ? Delegation of fund holding functions to general practices
- ? Adjusting methods of labor remuneration to global budgeting
- ? Establishing competitive contracting

- ? Steering provider toward gradual organizational change
- ? Mandating changes in the workforce
- ? Facilitating structural change in care delivery

Provider strategies

- ? Changing referral and utilization patterns
- ? A paradigm shift: better care for the money rather than blunt cost reduction
- ? Improved reporting and research of the cost-quality tradeoff
- ? Benchmarking from 'magnet providers'
- ? Demanding protection of key care standards
- ? Reestablishing the role of nursing resources
- ? Reestablishing job certainty and professional self-esteem
- ? Shift toward a multidisciplinary management culture
- ? Building strategic alliances
- ? Leveraging revenue flow
- ? Organizational adjustment at the provider level

To gain consumer support

- ? Community participation
- ? Freedom of consumer choice
- ? Consumer-oriented marketing.

8. SUMMARY

To advance provider payment reforms in the direction of prospective budgeting, a national government may want to consider setting up an advisory committee representing the interests of health regulators, purchasers, providers and patients. Each strategy on the above displayed list needs to be reviewed and, if found relevant, included in the national reform agenda. As the next step, key stakeholder interests need to be assessed for each strategy on a continuum from 'supportive to neutral to opposed'. The findings from such an evaluation can be arranged into item-specific scores and aggregated by the reform agenda section. Scores will differ by country and will depend on a multitude of factors, e.g., on the local socio-cultural values and political environment; whether the reforms were designed in a participatory mode or imposed as a bureaucratic command; and how the reform proposal was packaged and presented to its participants. A stance of a particular stakeholder institution on a specific reform strategy may be quite unexpected and vary by country and even region of the same country from strong support to aggressive resistance.

A reform will only succeed if a critical mass of support and supporters exist. The stakeholder analysis will help identify key stakeholder and institutional interests. It will also identify the level of power and leadership held by those who support or oppose a particular strategy. The more informed policy makers, using this information, can then develop strategies to bring their supporters to action, and neutralize or decrease the opposition. Conciliatory strategies may include: removing a particularly odious item from the reform agenda; leveraging it with concessions on other agenda items; attenuating a controversy by reducing the intensity of change (lowering targets and opting for a gradual phase-in); building alliances and dealing with segments of the opposition separately, rather than as a united front; and seeking external support by appealing to the public, government, legislature or interest groups. A mix of these and other appropriate strategies should stem from the nature of each point of contention. The stakeholder analysis will also help health reform technical teams assess the feasibility of their proposed reforms and know where they may need to make technical adjustments.

Political will and consistency on the part of the government remain the key factors for successful reforms. Active advocacy efforts are also essential as is the ability to negotiate and resolve the inevitable conflicts that are part of the inherently political process of health sector reform.

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