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Workshop on Primary Medical Care  
Financing Systems

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## SUMMARY REPORT

The Workshop, organized by the Institute for Health Systems Research in Kiel and sponsored by the Federal Republic of Germany, addressed the policy options for developing and implementing systems of financing, physician payment and budgeting that may encourage more effective and efficient resource deployment in primary medical care.

The mobilization of resources for health for all by the year 2000 requires an informed understanding of how financing, payment and budgeting systems may influence the structure, process and outcomes of health care. Building on a survey of existing financing, payment and budgeting systems in 14 European and 3 major industrialized countries outside Europe, the Workshop considered the possible impact of such systems on the function and range of services, the patterns of costs and expenditure, quality assurance and programme evaluation in the primary medical care sector.

### General conclusions

The identification of primary medical care objectives and priorities should, if possible, precede the design, implementation and assessment of financing, payment and budgeting systems. Objectives will typically encompass a trade-off between efficiency and equity. There was agreement on certain broad objectives for primary medical care, including equity of access and provision of cost-effective care. Different countries had adopted very different financing, payment and budgeting systems for meeting these objectives and most were concerned about the costs of services, the effectiveness of services or both.

Financing, payment and budgeting systems are interdependent and should not be seen in isolation from each other nor from the institutional, historical and political dimensions that underlie existing health care delivery systems. Moreover, arrangements for financing secondary care will in general affect the provision of primary care.

It seems likely that different mixes of financing, payment and budgeting systems may be capable of achieving similar objectives. To be more specific, some countries with open-ended budgets and fee-for-service payment systems

were concerned about cost containment and were experimenting with budgeting or capitation methods to cope with these problems. Other countries with close-ended budgets and capitation/salary arrangements were concerned more about quality of care and consumer satisfaction and were experimenting with or considering financial incentives or other encouragements for good practice. In this way, there may be some convergence between countries in the mix of financing, payment and budgeting systems.

The variety in the scale and pattern of provision and in the policies adopted in different countries provides a catalyst for the refinement and improvement of existing financing, payment and budgeting systems. Although international comparisons highlight the diverse policies that have evolved in response to the fundamental problems facing all national health care systems, national studies may provide a more powerful basis for enhancing primary medical care financing, payment and budgeting systems within countries.

There are inherent difficulties in ensuring the delivery of cost-effective care in all systems which bring about a wide separation between the finance and provision of care. There are considerable theoretical attractions in the health maintenance organization approach which encourage both the consumers and the providers of primary care to confront the trade-off between the quality and the cost of care. However, no country has yet chosen to rely on such arrangements for more than a small proportion of its primary medical care.

### Specific conclusions

#### Content and range of services

Although finance and budgeting systems are important, the method of physician payment or reimbursement is often a more fundamental determinant of the range and content of primary medical care.

In addition to providing a framework that facilitates service coordination, capitation and systems of salary-based physician payment do appear to constrain the use and intensity of some services. These payment systems may, however, encourage patient referrals to specialists, unless used in the context of a coordinated system (such as health maintenance organization).

Fee-for-service payment systems create incentives for physicians to provide a greater range and quantity of services, compared with capitation or salary systems. Reliance on the procedure as the unit of payment enhances service complexity and intensity, encourages referrals and specialization, accelerates the adoption and spread of new procedures and enables the targeting of services for specific client groups or health needs in a comprehensive insurance system.

#### Costs and their control

The optimal level of overall health expenditure is impossible to define. A stationary budget is not necessarily correct. Changing priorities, technological innovation and rising patient expectations are examples of factors that may lead to justifiable increases in primary medical care

expenditure. Thus, cost control should not be an end in itself. At some point, however, cost control may assume an important role, particularly if costs either exceed, or threaten to exceed, perceived benefits.

In general, supply-side approaches to the control of costs and expenditure were regarded as a more attractive policy option compared to demand-side approaches. Patient cost-sharing policies can vary; so too can their impact on health service utilization, outcomes and costs. Direct charges, co-payment and similar demand-side controls may influence patterns of health care expenditure. However, such policies may have a negligible impact on cost and expenditure trends, particularly if the causes of cost escalation originate on the supply side (e.g. rising physician numbers, fees and incomes).

Procedure based fee-for-service payment is likely to be the most inflationary system of physician payment, unless integrated into an overall system that can exert financial control over global expenditure. The choice of physician reimbursement should naturally depend on an assessment of how different payment systems influence service mix, cost, patient satisfaction and health status.

All primary medical care funding sources exercise some degree of control over both costs and quality. It is important to adopt a comprehensive definition of costs that embraces not only those costs borne by the primary medical care sector, but also the costs that may extend throughout the health care system and indeed society at large. Furthermore, costs must be evaluated alongside health and other consequences of care.

#### Quality and programme evaluation

Quality of care should not be regarded as solely a goal or a constraint. Rather quality of care and the budget constraint for primary medical care are both choices that confront all health care systems.

The precise definition, measurement and routine monitoring of primary medical care quality remain elusive in many countries, despite awareness of the need continually to improve and assure quality.

Although the ultimate objective is to influence the quality of health outcomes, a more immediate focus on developing and implementing quality standards for the process of care offers scope for improving existing patterns of health service utilization. Moreover, the information generated as a consequence of specific physician payment systems may be exploited to establish and monitor process standards.

Quality assurance in primary medical care should incorporate patient (and population) preferences. Patient satisfaction, for example, is one important component of quality. In addition to promoting and improving health, primary medical care in all countries is inevitably concerned with the attainment of other objectives.

Numerous examples, representing a diverse range of international approaches and perspectives, illustrate the inherent, though largely unrealized, scope for using finance, payment and budgeting systems in quality assurance.

Programme evaluation may assume a number of forms. Evaluations based on randomized controlled trials can be divided into explanatory versus pragmatic trials. Trials used to establish the efficacy of medical procedures or programmes of care should, where possible, be accompanied by pragmatic trials that permit an assessment of both effectiveness and, when relevant cost data are available, efficiency.

Evaluation should focus on health outcomes as well as on the process of health care. Evaluation based on the analysis of incremental costs and consequences, where consequences are measured according to the quality-adjusted life years attributable to a specific procedure or programme, represents a challenging and important method that should be carefully refined and extended to the primary medical care sector.

Programme evaluation is already influencing a growing number of policy decisions about the provision, organization and use of primary medical care. Its influence should grow, particularly if those responsible for funding care devote an increasing proportion of their budgets to programme evaluation.

#### Recommendations

1. The precise impact of alternative physician payment systems, when implemented in conjunction with different financing or budgeting mechanisms, requires considerably more research and evaluation.
2. More experimental and demonstration projects should be designed and comprehensively evaluated, focusing on how different financing, physician payment and/or budgeting systems influence the structure, process, costs and outcomes of primary medical care.
3. Physician payment, financing and budgeting systems in primary medical care should be planned, implemented and evaluated alongside each other to ensure that clearly defined policy objectives are attained.
4. Greater importance should be placed on evaluating both existing and proposed medical procedures, programmes of care and health policies. Resource allocation decisions in primary medical care, as well as throughout the health sector, should consider the nature and distribution of costs and benefits when viewed from a societywide perspective. This will inevitably require additional resources that also should be carefully allocated so as to maximize the impact of evaluative activities.
5. Effective collaboration between clinicians, epidemiologists, statisticians, economists and other disciplines is a necessary prerequisite to improving quality assurance and the quality of evaluation in primary medical care. Such collaboration must be encouraged and actively supported.
6. International organizations should help countries to monitor (a) the allocation of resources to primary health care and (b) the effects of changing provider payment, including diagnosis-related groups.