Unit 4: Is health care production the same as any other occupation ?

2. Methods of payment for doctors

The richness of health economics comes from a more pronounced combination of market failures than in other fields. For example, dealing with life or death situations creates a field in which economists are forced to measure these particularities by adapting their tools accordingly. They must interact closely with all actors, decision makers, and patients and integrate other disciplines into their work. In this module on health care professions we will consider how health providers are paid. What are the main stakes when designing methods of payment for health providers? The main challenge is to establish a system of payment in hospitals or in outpatient care which reconciles quality of care and appropriateness by reducing unnecessary or even detrimental expenses for the patient. We can draw four main points from countries that have tried innovative billing methods. The first is that no system of payment is neutral in medical practice. Rather, any form of payment will already include incentives, which can be implicit or explicit positive or negative, i.e. sanctions or rewards financial or otherwise. For example, fee-for-service systems the most widespread form of payment for outpatient services in France means payment is calculated per service which can have an inflationary effect. On the other hand, in the UK the dominant method of payment is capitation which means a physician is responsible for a population in an area over a given period of time. This form of payment also has incentive effects such as a lack of attention or time devoted to the patient. Economic literature shows that, in theory asymmetric information between health care providers and patients requires us to implement performance incentives called mixed payment schemes. What we can see in the countries studied is a convergence of the systems of payment which results in a mixed form of payment including a part for incentives which are linked to results and a part that takes into account the costs in terms of both money and time associated with health production. The second main point according to feedback from case studies is that financial incentives are always a double-edged sword. They certainly encourage agents wherever verification is not possible but they can also have very different effects on different individuals. For example, altruism is very much present in health care. This is a form of intrinsic motivation i.e. the importance given to doing one's job to doing it for the patients. Intrinsic motivation is very strong. Establishing extrinsic motivation i.e. financial incentives could therefore crowd out the more fundamental motivation. The third main point is that all mixed payment schemes that we establish are systems subject to gaming meaning that strategic behaviors will be adopted by individuals who benefit from these systems. These strategic behaviors are used in order to bend the rules and manipulate the system. We can only partially predict these effects. For instance giving financial incentives to a team rather than an individual can lead to the free-rider problem whereby some individuals act as stowaways and work less than the others who take up responsibility for the whole team. On the other hand establishing financial incentives on an individual level might decrease cooperation within a team which can be very detrimental when working in a team situation such as in a hospital. The final key message according to feedback from case studies is the importance of finding incentive methods of payment that truly respect health care professionals' primary responsibilities. For instance, in France the 2018 Social Security Financing Act allowed experimenting and establishing innovative billing methods to better take into account quality, performance, appropriateness and coordination between inpatient and outpatient care. What conditions are needed to create incentive pay plans based on care pathways?

- At this stage, some conditions can be put forward for the creation of incentive pay plans based on care pathways i.e. including both outpatient and hospital care. The first is to build the incentive pay plans jointly with health care professionals. The second is to set up, in advance, a system of reliable and consensual indicators concerning both process and results. The third is to set up mechanisms that prevent health providers from choosing patients with less serious conditions reducing their quality of care or substituting their activities for ones with a smaller effect on health. The fourth condition necessary to implement these incentive mechanisms is to prioritize incentives for a team rather than individuals at least for hospitals and to combine financial incentives with non-financial ones, such as organizational incentives. Finally, and this is an important topic we must first define the conditions for sharing any productivity gains among those involved in this care pathway. As you can see this project opens up great prospects for Heath care economists.

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