Prospective payments in the health care sector

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Erik Schokkaert and Carine Van de Voorde provide in their contribution a clear overview of the issues related to the organization of health insurance in Belgium. In order to design a system that guarantees universal access to all health services, including the medically advanced technologies, they highlight how crucial it is to promote efficiency while making solidarity as transparent as possible. Interesting paths for future changes are suggested and this commentary text addresses two considerations related to the use of prospective payments in the design of health care systems. The first suggests that risk-adjusted prospective payment for physicians' services would advantageously complement the health care system described by the authors. The second indicates that if a risk-adjusted prospective financing of the regions was implemented, the levels at which prevention policies are organized would condition the negotiation about the risk-adjusters to include in the distribution formula and would therefore influence the individual characteristics subject to the interregional solidarity.

The budgetary consequences of the expected growth in health expenditure (even if this growth is from an economic point of view not necessarily unjustified) coupled with the progress in Flanders of political movements questioning the desirability of a federal health insurance make it necessary to rethink our health care system. In this context, the sustainability of a universal health insurance system depends - as Schokkaert and Van de Voorde emphasize - on the extent to which it creates inefficiencies in the use of resources (people are not willing to pay for a system that does not avoid wasteful spending) and on the perception that some groups in the population have about the potential abuse of the health insurance system by other groups.

To tackle the inefficiencies, microeconomic incentives have been introduced in the eighties in the financing of hospitals. The previous payment, solely based on the reimbursement of costs incurred, has been (partially) replaced by a diagnostic-based prospective financing mechanism. The idea was to move from an expensive system to another one more susceptible to simultaneously achieve various objectives such as cost containment, efficiency, quality of care, access to care,*etc*. Risk-based prospective payments have later also been implemented to finance the sickness funds in order to give them the incentives not to reimburse unnecessary medical expenditure. This measure should ideally have been coupled with the introduction of the instruments the sickness funds need in order to control their expenditure. These instruments are however still missing in Belgium. Their introduction (selective contracting with preferred providers and freedom to charge lower premiums for members that accept some restrictions on their freedom of choice are mentioned as examples of instruments that could be potentially implemented) would enhance the function played by the sickness funds within the health care system. The authors suggest to move cautiously towards this model of regulated competition that has the potential to generate greater efficiency while maintaining the access to care for all. It moreover constitutes - given the financial responsibility of the sickness funds implemented in the nineties - the most natural extension of our current health insurance system.

We could go one step further by financing physicians' services through prospective payment based on case mix. In the health care system defended by the authors, the sickness funds are made financially responsible for their members' health expenditure while they only exert an indirect control over this expenditure. Given this framework, the only level at which the financial responsibility is not introduced is that at which medical decisions are made (*i.e.* at the level of the interaction between patients and physicians). Just as hospitals, health insurers and patients are partly financially responsible for their expenditure, it would seem natural to abandon the fee-for-service as the unique physicians' mode of payment. Even if there are no unambiguous evidences of supplier induced demand[1] (the source of inefficiency usually suspected under fee-for-service payment systems), the economic literature indicates that mixed payment systems perform better than purely retrospective or purely prospective payment systems (see Ellis and McGuire (1990), Ma (1994) and Newhouse (1996) among others) when multiple objectives are simultaneously pursued. A well designed payment mechanism (which could be a mix of fee-for-service, risk-adjusted capitation, pay-for-performance,*etc.*) is indeed more sophisticated and thus probably more efficient than a fee-for service payment combined (for instance) with selective contracting in order to achieve quality of care, cost containment, access to care,*etc*. It is therefore important to consider this issue.

We now come to the second comment. In order to deal with the perception that one region may have about the unnecessary use by other regions of the limited resources dedicated to health care, Schokkaert and Van de Voorde suggest the implementation of a risk-adjusted prospective distribution of the global budget (still raised at the federal level) to the regions. This idea is appealing. Instead of reducing the debate to whether the Belgian regions should organize the compulsory health insurance system together or separately, thus, instead of leaving only two options open, the risk adjusted distribution mechanism would bring a lot of flexibility. Several characteristics could indeed be included as risk adjusters in the formula used to allocate the means over the regions. The definition of these characteristics would be the key point of the distribution mechanism since it would determine the degree of interregional solidarity. The public debate organized to identify these characteristics would be important since the support for the compulsory health insurance system depends on the transparency with which the interregional solidarity is organized.

The level at which prevention policies are implemented is however of crucial importance in the definition of the risk adjusters. The authors indeed highlight that this regional financing mechanism preserves the incentives for efficiency since "A *region with lower expenditure than predicted from the characteristics of its population will obtain a financial surplus. If a region manages to decrease its expenditures by better prevention or a more efficient organization, it will reap the fruits of its efforts*" (page 15). This is true as long as prevention actions modify characteristics that are not included as risk-adjusters in the distribution formula over regions. Otherwise regions are covered through the regional distribution mechanism and this incentive for prevention weakens. Consequently, since prevention policies are organized at the regional level in Belgium, the concern for efficiency should exclude from the regional distribution formula risk adjusters that can be modified through individual behaviour. Smoking behaviour or alcohol dependency (for example) would hardly be considered in the debate about the characteristics that should be subject to the interregional solidarity. Since a limited number of characteristics cannot be modified either through individual behaviours or through collective public health policies, we should end up with few risk adjusters in the regional distribution formula.

The objective of this comment is not to reject this regional distribution mechanism to the motive that it excludes some characteristics as risk-adjusters. Its purpose is rather to highlight that a real and exhaustive debate about the characteristics that should be subject to solidarity between Flanders and Wallonia could not take place if we take for granted that prevention policies are organized at the

[1] Belgian data are not fully supportive of the supplier induced demand phenomenon. In an analysis of the correlation between the medical density and health care utilisation, the Belgian Health Care Knowledge Centre indicates in a recent report (2008) that even when evidence of supplier induced demand exists, the extent of the phenomenon is rather weak. The review of the literature provided by Mc Guire (2000) also shows a great variety of results in this regard.

regional level. It instead recommends that the issue of regional solidarity must be included within a global debate that also considers the organization of prevention policies.

References

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