



How health care providers are paid is one key policy lever to drive health system performance.

This publication presents broad trends in three recent payment innovations: add-on payments for co-ordination and/or quality, bundled payments and population-based payments. It assesses the policy impact of these innovations, showing patients are benefitting from these reforms, and outlines policy directions to achieve better ways to pay for health care.

Predominant ways to pay health care providers do not reward value

Most often, traditional ways of paying providers – fee-for-service (FFS), capitation, salary, global budget or more recently diagnosis-related groups (DRG) (Table 1) – are often poorly aligned with contemporary health system priorities such as improving quality or delivering care more efficiently. Ageing societies and changes in life styles such as unhealthy diet and physical inactivity have led to a rise in the prevalence of chronic conditions. More and more patients now suffer from multiple morbidities. Typically, payment systems do little to support new care models that for instance improve care co-ordination, or develop services for patient populations with complex health needs that span across levels of care, as health service provision is predominantly financed in a “silo”. Frequently, this results in fragmentation of care with poor patient experience and poor health outcomes.

When it comes to meeting policy objectives, improving quality and efficiency, each of these modes of payment in their “pure” form have strengths and weaknesses.

- FFS payments typically incentivise providers to increase their clinical activity and as a result the associated costs.
- Capitation payments control costs better but can encourage providers to deliver less health care than optimal for patients.
- Global budgets, too, control total costs, but may lead to access problems and waiting times.
- DRG payments focus on technical efficiency to make better use of available resources and reduce average length of stay but they also encourage hospitals to increase the number of patients.

Table 1. An overview of traditional payment methods in health care systems

Payment method	Description	Setting	Degree of bundling
Fee-for-service (FFS)	Retrospective activity-based payment: billing of individual services and patient contacts	Predominant mode of payment for GPs and for outpatient specialist services	unbundled bundled
Payment per case (diagnosis-related groups)	Prospective activity-based payment per patient, patient classified into groups based on diagnoses and resource use	Payment for hospital inpatient cases in many countries	
Capitation	Prospective lump-sum payment per enrolled patient covering a range of services	Mode of payment for GPs in a number of countries	
Global budget	Prospective lump-sum payment covering a range of services independent of actual volume provided	Payment for public hospitals in a number of countries	

Note: The predominant method of payment was determined by countries based on its share of total spending, number of contacts or number of providers (*OECD Health Systems Characteristics Survey 2012*).

Source: Adapted from Charlesworth, A., A. Davies and J. Dixon (2012), "Reforming payment for health care in Europe to achieve better value", Nuffield Trust.

Box 1. Blending payment systems and adaptations of traditional payment methods

In primary care, the vast majority of OECD countries use blended forms of payments, for example combining capitation with FFS payments. Blended payments can mean that different payment mechanisms are applied to different primary care providers, or individual providers are being paid through a blended mix of payment types.

Blended payments are less widely used for outpatient specialist care where the predominant payment method remains FFS. Nevertheless some countries such as Sweden and the United Kingdom have incorporated blended forms of payment, such as global budgets along with combinations of pay-for-performance (P4P) and additional payments.

In inpatient care, blended payment systems are the norm. A mix of payment schemes can mean a combination of DRG and global budgets but can also include FFS payments for certain procedures, per-diem rates or line-item remuneration (less common). A number of countries have moved towards case-based payment to meet specific health policy objectives to replace global budgets (Greece, Ireland), FFS (Korea) or per diems (Israel).

A second response is to adapt traditional payment systems. In primary care, nearly all OECD countries that use capitation adjust the payment for risk factors (e.g. age, gender, health status) to discourage skimping of care and “cherry-picking”.

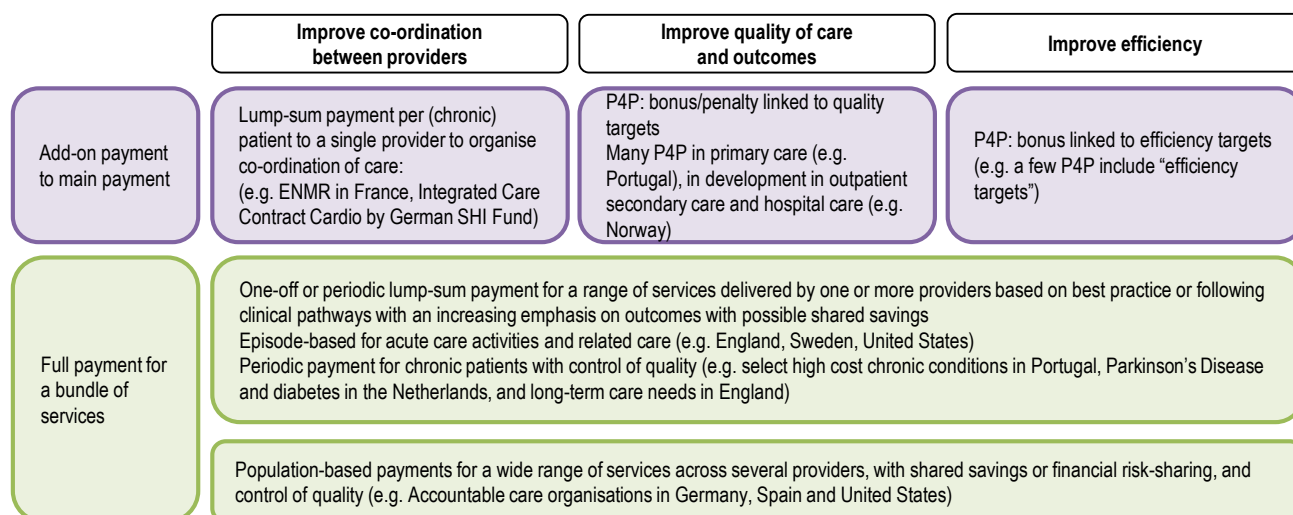
Global budgets have evolved beyond resource-based or historical budgets. In some countries, budget allocation is also adjusted for risk factors (e.g. age, gender). Hospital budget allocation based on case-mix as measured via DRGs can help to benchmark hospitals and incentivise the efficient use of hospital resources. The introduction of volume thresholds can put a limit to spending increases. They are used in primary care for FFS or inpatient care for case-based payment by a number of OECD countries.

As a result, policy makers have increasingly sought to reform payment systems to encourage greater correspondence between what is being paid for, and broader health system objectives. Developments in payment reforms have included three main broad approaches. Blending payment methods and adapting traditional modes of payment include combining different payment mechanism and adjusting for population characteristics in payment methods (Box 1). They have worked well to attach specific health policy objectives to delivery, or to balance the negative and positive incentives of different payment mechanisms. These approaches encourage a greater focus on quality and to discourage skimping of care and “cherry-picking”.

Recently, some health systems have embarked on more innovative changes to better meet contemporary health policy objectives: improve co-ordination, improve quality and outcomes; and improve efficiency. Three distinct payment trends can be observed (Figure 1):

1. Add-on payments — ex post or ex ante — are made on top of existing payment methods for co-ordinating activities; or pay-for-performance (P4P) — focussed on improving quality of care;
2. Bundled payments for episodes of care or for chronic conditions, often relevant to a specific medical condition and treatment and grouped together for payment, aim to improve care quality and reduce costs;
3. Population-based payment in which groups of health providers receive payments on the basis of the population covered, in order to provide most healthcare services for that population, with built-in quality and cost-containment requirements.

Figure 1. Innovations in payment systems



Innovative payment reform focus on quality and efficiency

Latest evidence from OECD countries shows that innovative payment policies differ in the services they incentivise, stretching from primary care to secondary care and beyond. Many of these innovations have positive impact on the intended policy objectives — generating either quality improvements, or savings or both. Key success factors involved the transparency of criteria for tariff setting and clarification in identifying the targeted patient population. A focus on wide stakeholder engagement seems to be key in catalysing buy-in. Evaluation of payment innovations have mostly been built into the policy. Important spill-over effects include the increase of data collection that helps to expand knowledge on quality metrics and performance. However, there are challenges including the complexity of the designing and implementing payment policy, increased administrative burden and the reluctance among some providers to bear more financial risk.

Add-on payments for co-ordination work but difficult to attribute to cost savings

Add-on payments have helped to co-ordinate health services across different levels of care, as seen in the ex ante payment to multidisciplinary structures in France (*Expérimentations de nouveaux modes de rémunération* – ENMR), and in the ex-post payment to individual providers for patients with cardiovascular disease in Germany. While they are additional sources of revenue, they account for a relatively small share of total provider income, 5% or less.

In both countries, add-on payments are associated with an improvement in quality and reductions in health spending (Table 2). But it is difficult to establish clear causality. In France, the multi-disciplinary structures achieve better results for nearly all care indicators (e.g. diabetes care processes; prevention) with the most significant improvements in controlling HbA1c levels than traditional practices – although they were already performing better before the introduction of the innovation. Costs in multidisciplinary structures were lower (between 0.5% and 2.3%) than in traditional practices. However, the cost differences pre-date the introduction of the payment scheme in France.

In Germany, there has been a reduction in repeat examination and better patient-centred collaboration between doctors. About 89% of patients acknowledge better co-operation between GP and cardiologist and 65% of patients report an improvement in their health status after enrollment. While the programme generated savings after nearly five years, it is difficult to separate out the contribution of the add-on payment as it overlaps with a Disease Management Programme for cardiovascular diseases.

Add-on payments for co-ordination are easy to implement but limited in scope

Add-on payments were relatively easy to implement, with little provider resistance and generally required few IT investments and data exchanges. The administrative burden of these innovations was comparably small. Yet the scope of these incentives was limited, as they focus on the improvement of co-operation of health professionals and incentivise specific behaviours at specific points of the care pathway.

Reward for quality show success but no clear breakthrough in performance

Add-on payments rewarding quality or pay-for-performance (P4P) schemes are applied ex post. P4P schemes are now widespread. In 2012, nearly two thirds of OECD countries reported having at least one P4P scheme in place. They are predominantly found in primary care but are also spreading to specialists and acute hospitals. In Ontario, Canada, P4P was introduced to primary care practitioners. In Portugal, P4P was introduced in newly established models of primary care – Family Health Units. Norway introduced P4P in its four hospital regions. Performance-based payment is used in other settings or for specific patient groups as in the case of diabetes in Australia, France or Germany.

Systematic reviews tentatively suggest a positive impact of P4P programmes on performance, but evidence on wider impact of P4P on health outcomes and cost savings remains inconclusive. In Portugal, the P4P component, which was introduced as part of broader reform in primary care, has shown improvements in care quality, patient and practitioner satisfaction in the Family Health Unit models compared to the traditional solo practices. While in some countries, P4P schemes have redirected existing resources (e.g. in Canada, Norway and Portugal), there were significant injections of new funds in other cases, such as the “Quality Outcomes Framework” in the United Kingdom and Turkey’s “Family medicine performance based contracting” scheme.

It is difficult to separate out the influence of the change in payment method from other factors, such as self-selection (that is providers who participate in a voluntary scheme may already be performing better, and simply get paid for what they are doing anyway), underlying trends in improving quality of care, or improvement to the

way that relevant data is recorded and reported. Given that the P4P component is usually small, the dominant payment system has the potential to either support the P4P programme or hinder its positive effects depending on how the payment incentives are designed.

P4P motivate providers around data collection

While in Norway and Portugal pre-existing rich data infrastructures have supported the introduction of P4P, in many countries good building blocks for P4P – notably appropriate performance measures – are missing. Data improvements have come through direct incentives for providers to invest in information infrastructure (IT, electronic medical records in Australia and France), or minimum IT standards being a criterion for participation in the P4P scheme (United Kingdom). Pre-existing data sources may help improve reporting rate and fidelity.

P4P schemes are complex to administer as they require data systems for collection, measurement and the calculation of rewards. Most P4P schemes use process indicators or intermediate outcome indicators, with a more limited number of P4P programmes including patient experience measures or negative penalties. They are in large part focussed on clinical processes, and incentivising care that is consistent with best practice guidelines, but also cover access and efficiency domains (Canada, Portugal). Indicators of quality also include outcome indicators, such as intermediate outcomes – controlled blood pressure, blood sugar, cholesterol (United Kingdom, Portugal). Norway uses non-intermediate outcome measures, notably cancer mortality. Patient experience is an important outcome indicator of quality and a potential lever for quality improvement (e.g. Portugal, Norway, England, Israel and Korea).

Table 2. Assessment of policy impact of add-on payment reform in select OECD countries

Country	DEU	FRA	PRT	NOR
Type and name of payment reform	Add-on co-ordination (Cardio-Integral)	Add-on co-ordination (ENMR)	Add-on payment (P4P) in primary care	Add-on payment (P4P) in hospitals
Quality	+	+	+	Evaluation due later
Savings	+	+	+	Evaluation due later
Unintended consequences				

Source: Authors' compilation.

Bundled payments improve quality but require sophisticated IT systems

Innovations in bundled activities grouped into a single tariff go beyond simple DRG payments and can cover both acute care and chronic conditions.

There are a number of examples of bundled payments for acute care episodes and chronic conditions from the United States – Medicare’s initiative for inpatient cardiac and orthopaedic procedures as well as private sector initiatives such as ProvenCare for coronary artery bypass surgery. Other initiatives include the pilot of the PROMETHEUS model covering episodes-of-care and chronic conditions and the Integrated Healthcare Association for orthopaedic surgery. The United Kingdom (England) developed best practice tariffs and more recently a bundled payment for maternity care was introduced. Sweden launched a nationwide collaboration to develop bundled payments focussing on eight areas covering both episodes of care (e.g. hip replacement, spine surgery) and chronic conditions (e.g. diabetes).

Portugal launched pilot bundle payments in 2007 for select high cost chronic conditions (e.g. HIV/AIDS, multiple sclerosis). The Netherlands established a bundle payment for patients with type 2 diabetes, COPD and vascular risk management, where “care groups” are contracting partners for insurers for the provision of pre-defined activities within a year. For patients with Parkinson’s disease, regional networks of different types of health providers (ParkinsonNet) began in 2004 to first improve the delivery of care while maintaining the traditional modes of payment. The second phase, currently not yet fully implemented, involves a bundled payment.

These innovations show promise although results depend on the condition or episode targeted. For example, for acute conditions, there have been reductions in readmission rates, complications and improved mortality for hip and knee replacement and bypass surgery in the United States, England and Sweden (Table 3). In the case of chronic conditions, the performance and patient satisfaction improved in the Netherlands and better adherence to medication and treatment protocol in Portugal.

There is some evidence of costs reduction, for example for bypass surgeries and hip and knee replacements, mainly achieved by reductions in average length of stay and reduced number of readmissions, in the United States and Sweden. Treatment costs for HIV were reduced in Portugal through better adherence to treatment plans. However, costs increased in the case of diabetes patients after the introduction of bundled payments in the Netherlands, which may be partly driven by delayed specialist care – not included in the bundled tariffs.

Stakeholder support led to improved protocols of care, despite added administrative burden

Stakeholder participation can catalyse the implementation of bundled payments (England, Portugal, Sweden and the Netherlands), but balancing opposing interests between purchaser and provider can be challenging. Health care providers intensified their collaboration within and across settings and a greater standardisation of care was achieved in the country examined. Generally, this was facilitated and accompanied by the development of guidelines, the monitoring of cost and quality including feedback loops to providers. In the Netherlands, contracts between care groups and insurers were based on standardised protocols of care drawn from national guidelines for diabetes care.

The move towards bundled payments has been frequently tested before being rolled out on a greater scale. Portugal began a five-year pilot payment for HIV/AIDS in selected hospitals before expanding it nationwide two years later. Furthermore, there is an increased attention to data on health outcomes. In Sweden, 10% of the payment for spine surgery is related to the patient’s functionality after surgery. Bundled payment led to further improvements in data systems including integrated information systems. In the Netherlands for diabetes, better monitoring systems to allow for rapid feedback in Sweden, new data collections in Portugal and in the Netherlands for Parkinson’s disease. Despite payment reform being abandoned or not implemented, IT helped to identify data needs for measurement of quality and cost in the US PROMETHEUS initiative.

Table 3. Assessment of policy impact of bundled payment reform in select OECD countries

Country	USA	ENG	ENG	SWE	PRT	NLD	NLD
Type and name of payment reform	Bundled payment for acute care episodes cardiac and orthopaedic care (ACE)	Best practice tariffs in hospitals (BPT)	Maternity care pathway	Bundled payment for an episode of care (SVEUS)	Bundled payment for select chronic conditions	Bundled payment for Parkinson's Disease (ParkinsonNet)	Bundled payment for diabetes (select chronic conditions)
Quality	+	+/-	Evaluation not yet available	+	+	+(before payment reform)	+
Savings	+		Reduction in caesarean section rate but savings evaluation not yet available	+	+	+(before payment reform)	-
Unintended consequences	-			-		Competition concern	

Source: Authors' compilation.

However, tariff setting can be complex. It can include services that constitute best practice based on evidence, incorporate quality measures, and may refer to one single payment or be made up of several payments. In England, best practice tariffs can be higher or lower than national average costs. The best practice tariff for fragility hip fracture is made up of a base tariff and a conditional payment, payable if a number of characteristics are achieved (e.g. time to surgery within 36 hours from arrival in an emergency department). Diverging interests and fear of financial risk can impede implementation. Some schemes were subsequently not implemented as envisaged (Integrated Healthcare Association and PROMETHEUS experiments in the United States) or discontinued. In Denmark, a bundled payment for diabetic care was abandoned as the financial incentive was too low to encourage GP participation.

Carefully designed population-based payments meet policy objectives of improving quality and efficiency if carefully designed

Population-based payments are distinguishable from previous approaches, such as the managed-care contracts in the United States or GP fundholding in the United Kingdom that did not have any incentives to improve or maintain a minimum level of quality. Generally, the groups of providers are referred to as Accountable Care Organisations (ACOs). First implemented in 2012, there are currently three types of Medicare ACO programmes operating: Medicare Shared Savings Programme ACO, advanced Payment ACO (targets rural areas), and Pioneer ACO (most risk-involving for providers). Smaller initiatives exist in Germany, for example in a rural area in South-western Germany with a physician-led ACO

(Gesundes Kinzigtal GmbH - GK) and in the Spanish region of Valencia, where a private contractor (Ribera Salud Group) is accountable for primary and secondary care in several health areas. Providers are remunerated for the provision of services in the traditional way in all population-based payment models, which is mainly fee-for-service (United States, Germany). The Spanish contractors receive capitation payments to provide primary and secondary care.

There was reported better performance among some ACOs (Table 4). In the United States, Pioneer ACOs improved their performance in 28 of the 33 quality measures in their second year of evaluation. For Medicare Shared Savings Programme ACOs, patient experience improved, including timely access to doctors; patients were better informed by their primary care physician about specialty care. For a private ACO in Sacramento, hospital readmissions decreased within 30 days by 15% in the first year. Over the same period though, emergency department utilisation increased. In Germany, no quality targets are set but evaluations found reduced mortality rates, and higher survival rates for chronic heart disease patients. A programme for the elderly showed improved nutrition behaviour but no improvement in physical activity and no changes in health-related quality of life.

On an aggregate level, ACOs slowed health spending growth for Medicare in the United States, but not all ACOs were able to generate savings, and among those that did, not all realised the minimum savings required to be eligible to keep part of the savings. In Germany, Gesundes Kinzigtal GmbH kept their actual costs 6.6% below the benchmark budget in 2012.

Table 4. Assessment of policy impact of population-based payment reform in select OECD countries

Country	USA	DEU	ESP
Type and name of payment reform	Medicare (ACO)	Gesundes Kinzigtal (GK)	Ribera Salud (Alzira)
Quality	+/-	+/-	+
Savings	+/-	+	+
Unintended consequences	Best performing ACO can lose revenues		Contract renegotiation

Source: Authors' compilation.

Population-based payments encourage lower cost but add to the administrative burden

Population-based payments were part of wider health policy reform including legislative/legal changes in all cases examined. In Spain, the implementation of the ACO model followed a change in national law to allow for private-public partnership. In all countries, roll-out of the new model started on a smaller scale initially. Providers can freely decide to form an ACO as seen in the Medicare programme in United States, or contracts are negotiated as in Germany.

Payments give provider groups the autonomy to develop their own strategy to keep their costs down. Care models were rethought and pathways redesigned to make them more patient-centred with less fragmentation between the providers. In Germany, preventive activities targeted patients with specific conditions and rational pharmacotherapy. Successful arrangements use integrated IT systems that allow real-time monitoring of metrics which are connected to registries and public reporting systems. Some provide financial support to health providers to set up the required IT infrastructure (e.g. Medicare in the Advance ACO model, GK in Germany).

Arrangements can add an administrative burden due to contract managing, measuring and reporting of cost and quality indicators. In the United States, one health provider network working with four different ACO arrangements was required to report on 219 different performance measures.

Such reforms can bring unintended financial consequences. The financial exposure to payers will depend on a variety of factors such as whether there is a cap or maximum pay-out, and the rules for distributing the savings. In Spain, the initial contract (only covering secondary care) was not financial viable and had to be renegotiated. The regional ministry had to change it to include primary care resulting in an increase in the capitation rate.

Conclusions

Common ways to pay providers are at odds with current health system priorities of adapting care delivery models to changing epidemiology and the need to provide seamless, high-quality care to patients with complex health needs in a context of tight resources. A number of OECD countries have embarked on significant changes to their payment systems in response.

Add-on payments, bundled payments and population-based payment have shown to deliver better value and patients are benefitting thanks to these changes. Add-on payments for co-ordination have shown their potential to improve quality while controlling costs. The effects of P4P schemes are generally positive on quality-related processes. Although they do not necessarily improve broader health outcomes, they can generate system-wide benefits such as introducing better data collection or leading to more informed dialogues between purchasers and providers. A number of bundled payments have seen quality improvements, in some cases even with cost savings. Population-based payments show potential to overcome fragmentation of care leading to better quality, outcomes and a slowdown in spending growth.



Use payment systems to drive strategic objectives in health

- Align payment systems with health policy objectives. Payers need to be more innovative and providers should be rewarded for what they deliver – not simply what they can do.
- Encourage further experimentation. The three payment innovations show promise, but more needs to be learnt about why some initiatives perform better than others.

Design payment innovations

- Draw on evidence-based guidelines to inform tariffs. Transparent criteria contribute to better adherence to treatment protocols and more standardised care.
- Use transparent criteria to define the patient populations to the payment innovation – for example if it is only applicable to selected patients (e.g. high-risk patients or patients with multi-morbidity).
- Encourage quality targets to be based on best practice guidelines defined by institutions in charge of defining good practices for the payment innovation. Use a wide set of quality measures to make care delivery and performance more transparent for payers particularly for bundled and population-based payments.
- Use digital innovations and IT systems to help generate new evidence, identify high-need patients and facilitate interoperability of IT systems across health providers.

Implement payment innovations

- Target stakeholders from the start and keep them engaged.
- Share joint aims and motivation among key stakeholders to achieve buy-in, particularly for mitigating diverging financial interests.
- Reach a consensus among payers and providers on which quality targets to use in the payment reform.
- Make use of existing data and reporting requirements as a good starting point to minimise administrative burden.
- Strike a balance between additional data reporting requirements on quality and outcomes and the associated administrative burden for providers.

Evaluate payment innovations

- Pilot experimentation into the payment policy before being rolled-out on a larger scale.
- Allow for flexibility in the payment reform to adjust policy parameters if incentives do not have the desired effects.
- Embed evaluation into the payment reform to strengthen accountability and transparency of the payment policy.
- Encourage systematic independent evaluation to improve analysis as very often there are no control groups, and observable changes in quality, outcome or efficiency indicators cannot always be unambiguously attributed to changes in the payment scheme.
- Encourage monitoring, evaluation and feedback reporting to providers on a systematic basis as this has shown to encourage provider support and improve care processes.

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Contact

Michael Mueller – Health policy analyst

✉ michael.mueller@oecd.org

☎ +33 1 45 24 86 89

Emily Hewlett – Health policy analyst

✉ emily.hewlett@oecd.org

☎ +33 1 45 24 75 10

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