Physician Payment in International Perspective

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Long History of Using Physician Payment to Change MD Behavior

- Macro/organizational change level
  (cooperation/acceptance)
  (Aneurin Bevan, UK Health Minister, 1947:
  "Stuff their mouths with gold")

- Micro/institutional level
  (quality,effectiveness,efficiency,equity)

The Policy Challenge

Harnessing physicians to (enthusiastically) support

- organizational change
- clinical change

Necessary path to successful health reform

Multiple Structural Dilemmas

- 3 payment types: salary/capitation/FFS
  (each advantage is its disadvantage)
- New objectives: - team approach
  - upstream focus(prevention)
- Primary Care/Specialists have different concerns/perspective
- Professional incentives as important as financial incentives
  (peer prestige/practice size)
- National context and culture constrain policy options

This Presentation:

- Comparative Pay Differentials
  - baseline across countries
- Primary Care Physicians
  - private GPs
    (Netherlands, Germany, France,
    Denmark, Norway)
  - publicly salaried PCPs
    (Finland, Sweden)
- Hospital Specialists
  - publicly salaried (Sweden, Andalucia, Estonia)
  - private w/ contracts (Netherlands)

Average Annual Income as Percentage of GDP per capita

Income ratio to GDP per capita 2006 (or latest available data)

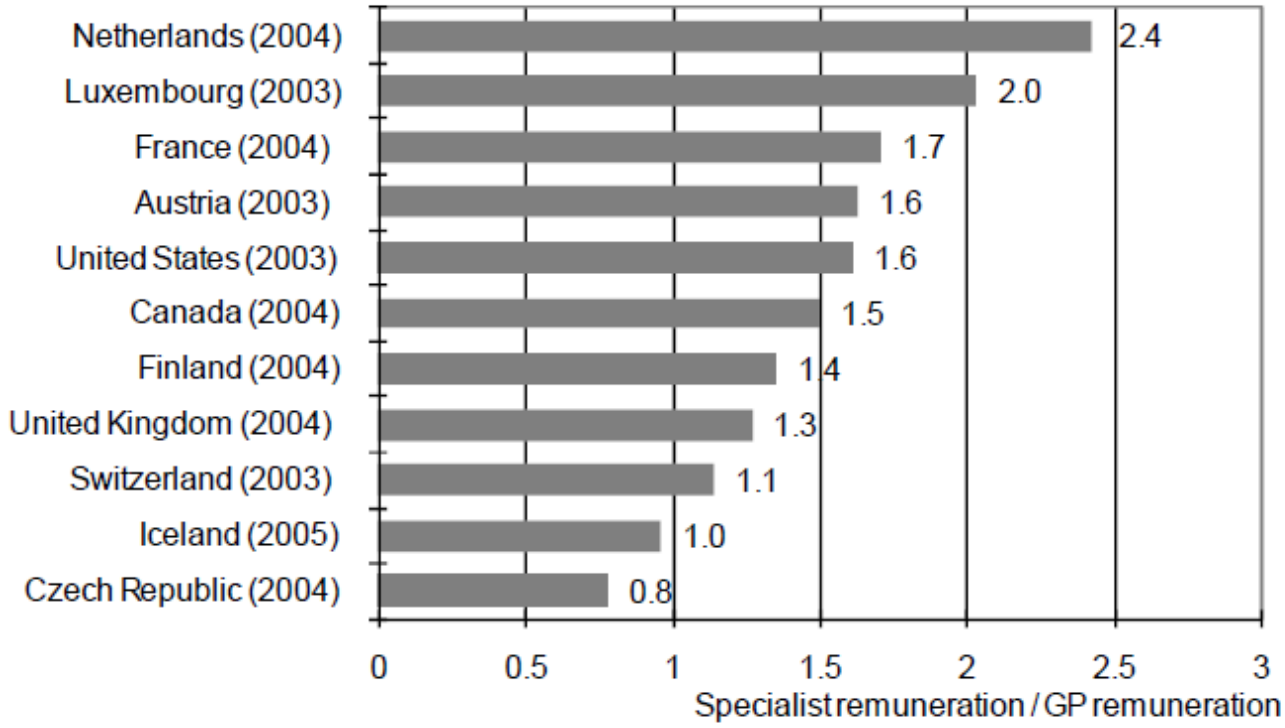
	GP		Specialists	
	Salaried	**Self-employed**	**Salaried**	**Self-employed**
Canada		3.2[1]		4.9[1]
France		3.6		4.5
Germany		3.7[2]	2.7[2]	
Netherlands		3.4	3.8	8.3
Sweden	2.2[4]		2.5[4]	
Switzerland		3.2[2]		3.7[2]
UK		5.4[1]	4.8[2]	
US	3.8[5]	4.4[5]	4.8[5]	6.5[5]

1. 2005
2. 2004
3. 2003
4. 2002
5. 2001

Source: OECD Health Data (2007; 2008)

Specialist/GP Income Ratio

Figure15. Ratio of remuneration of specialists to remuneration of GPs, selected OECD countries, 2004 (or closest year available)



Source: OECD Health Data 2008

Private GP Payment Strategies

Netherlands – mixed capitation/FFS

- Capitation – 13 euro per qtr<65; up to 17.40 euro >75 in "problem areas"
- FFS – 9 euro<20 min; 18 euro>20 min; 4.5 euro tel./higher fees for non-listed patient
- Night/Weekend – max 50.20 euro/hr

France – FFS

- 71% self-employed
  (FFS negotiated schedule)
  (15% are "Sector 2" – higher charges/balance bill)
- 29% salaried (1/2 in hospitals/also take private patients)
- Income range: 70,000 euro average (2006)
  Top 10% - 114,000 euro
  Bottom 10% - 29,000 euro

Private GP Payment Strategies

a) Quality

England: "Quality and Outcomes Framework" 2004 contract

Up to 25% additional payment per practice based on 5 components:

- 80 clinical standards (65.5% of total score)
- 43 organizational standards (18.1%)
- 4 experience of patients (10.8%)
- 8 preventive services (3.6%)
- holistic care (2%)

Private GP Payment Strategies

b) Prevention/Care Coordination

Denmark

- extra fee for diabetes patients (pilot)
(7500 DKK signup; 1000 DKK annual checkup)

France

- extra 40 Euro/yr capitation for patients with "long and costly diseases"
- 2004 "medecin traiteur" care coordination (no extra fee)

Private GP Payment Strategies

c) Patients with greater needs

Netherlands

- up to 125% higher capitation fee>75 in "problem area"

England

- capitation adjusted for age/sex/morbidity of patient list

Private GP Payment Strategies

d) Cost Control

Germany

- FFS "points" above individual MD's threshold paid at reduced rate
- Prescriptions
  - -15% over target cost – warning letter
  - - 25 % over target cost – justify or MD payback
  - - non-formulary/ off-label payback – 25,000 MDs each year pay something back

Public PCP/Private GP Payment Strategies

Three Nordic cases:

Norway:

- Pre-2001: private GPs on contract to municipalities, working in municipal health offices
- Post 2001: private GPs paid 70% FFS
  (Better service; higher costs)
  (Policymakers still not happy)

Salaried PCP/Private GP Payment Strategies

Finland:

- Health Center model under stress
  - hard to hire new salaried PCPs
  - 2 week waiting times for appts
  - Private contracting firms emerging
    - temporary PCPs (higher pay)
    - managing public health ctrs
- Losing competition w/ 3 forms of private primary care services: - public PCPs working private (afternoons)
  -private GPs
  -occupational health

Salaried PCP/Private GP Payment Strategies

Sweden:

- 4th effort to introduce choice/incentives in primary care
  - 1983: Citi-Akuten (private walk-in clinics)
  - 1988: Stockholm/Other County Models (patient choice)
  - 1991-4: Huslakare (retained in Vasteras)
  - 2005: Vardval (5 counties)

    Small portion pay/tied to performance

    - Halland: lump-sum penalty if no diabetes quality register
    - Stockholm: - lump-sum penalty for no info
      - 3% pay linked to targets (phone; formulary)
    - VG, Skane: 7-12 targets [phone access, formulary, preventive, diabetes register, clinical process indicators(diabetes; asthma), patient survey]
  - 2010 Vardval national law

Specialist Payment Strategies

- Most hospital specialists are salaried (except Netherlands: contracts)
- Some countries allow salaried specialists to also see private patients
  (France: up to 30% total income)
  (England: private practices allowed if 4 hrs additional NHS work per week)
  (Germany: private patients w/ commercial indemnity insurance)
  (Switzerland: private patients w/ supplemental ins)
- Some hospital specialists can receive extra productivity payments (Denmark; England)
- France: salaried, 113,000 Euro average, but 3-6 fold differences in income depending on specialty, including more for nights/teaching (no performance-based pay)

Specialist Payment Strategies

England:

- overtime rewarded w/ higher wage rates
- earning progression tied to objectives set w/ clinical manager
  - quality and efficiency
  - clinical standards and outcomes
  - local service objectives
  - resource management
  - service development
  - multi-disciplinary team working
- private practice requires 4 extra hours NHS work/ week

Specialist Payment Strategies

Estonia

- Post-2002 many hospitals are publicly-owned "joint stock companies" (w/ own Supervisory Board)
- Incentive pay for specialists up to 25% total pay (little union role)
- Pay variation dependent on specialty and workload
- (in private hospitals, up to 2/3 incentive pay for some specialists)

Specialist Payment Strategies

Andalucia/Spain

- New hospitals since mid-1990s are “public healthcare companies” (EPS) w/ own Board and substantial management autonomy
- Specialists are salaried employees of regional government
- Performance incentives split: 40% to MD, 60% (in equal parts) to clinic “team”
- Unions sit on hospital staff-employer committee and supervise these incentive agreements

Specialist Payment Strategies

Norway

"all hospital specialists are fully salaried – there is no pay for performance. The unions will not allow it."

Jon Magnussen

Prof of Health Economics

NTNU, Trondheim

March 2010

Specialist Payment Strategies

Netherlands:

- Specialists work in/own private group practices
- Group practices contract directly with one/more hospital(s)

Pulling the European Evidence Together I

- Wide range of pay incentives at both primary care and hospital levels
- Different approaches to primary care vs specialist MDs
- Focus still on physician, less on team
- Major increase in activity compared w/ 1990s
- Still very much evolving area of knowledge

Context and (national) culture continue to constrain policy options

Pulling the European Evidence Together II

Most policymakers remain dissatisfied with their current physician payment arrangements:

Typical comment:

"increasing dissatisfaction w/ current system which has proved to be very difficult to modify"

Zeynep Or, Director, IRDES, Paris

March 2009