



Publicly Funded Services and Incentives: How to pay the Ferryman

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Greek Myth vs. Health Services



- Charon – the Ferryman – paid by the living, a fixed sum in advance
 - Fixed price prospective payment
 - DRG type systems



- ‘Traditional’ health care providers – reimbursed by insurance companies or government for the cost of their services
 - Cost reimbursement

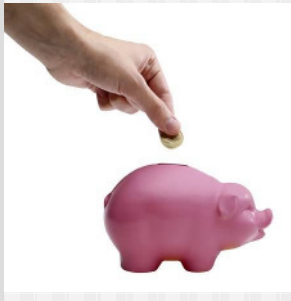


Cost and Quality Incentives

- Improving quality adds to costs (e.g. keeping infection rates down -> more infection controllers, more cleaning, lower utilisation)
- Being frugal is also costly in a different sense – e.g. firing 'unnecessary staff' is unpleasant



Cost and Quality Incentives



- Prospective payment – controls cost (provides strong incentives to perform those unpleasant tasks -- but also incentive to skimp on quality)
- Cost reimbursement – ensures quality of service (allows recovery of costs of quality improvement – but also reduces incentives to do the unpleasant business of eliminating waste)
 - Watch out you really can have too much of a good thing!
- Now a huge literature on how to manage these trade-offs



Real Prices under cost reimbursement - US Medical Services

	U.S. Price Indices (1950 = 100)		
	Consumer Prices	Physician Services	Hospital Rooms
1950	100	100	100
1960	110	112	200
1970	121	126	620
1980	310	508	1630
1990	550	1180	4200



Lessons for BURDEN?



- Payment system is an important part of the health care context.
- Move to DRG -> prospective payment may be problematic
 - But a lot depends on the detail of the system
 - At the very least needs to be thought about.



Patients and quality under prospective payment



- If patients have a choice (and can express it) they can provide an incentive for quality under PPS.
- But perception of quality can be problematic –
 - May incentivise investment in car-parks and disinvestment in infection control

