Nederlandse Zorgautoriteit

Paying for performance:

past, future & present of regulation of physician's fees

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Introduction

mal management, improving the surveillance of influenza, and satisfying parents, rather than telling them, "It's just a virus."

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Contributors: AH, ACH, DC, MZ, and DM designed the study. AH and JW took part in the fieldwork. AB, DC, and MZ were responsible for the laboratory work. AH and SS did the analysis. AH drafted the manuscript, and all authors commented on the text. AH is guarantor for the study.
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1. Neuzil KM, Mellen BG, Wright PF, Mitchel EF Jr, Griffin MR. The effect of influenza on hospitalizations, outpatient visits, and courses of antibiotics in children. *N Engl J Med* 2000; 342:225-231.
2. Delaney BC, Hyde CJ, McManus RJ, Wilson S, Fitzmaurice DA, Jowett S, et al. Systematic review of near patient test evaluations in primary care. *BMJ* 1999;319:824-827.
3. Rodriguez WJ, Schwartz RH, Thorne MM. Evaluation of diagnostic tests for influenza in a pediatric practice. *Pediatr Infect Dis J* 2002;21:193-196.
4. Carman WF, Wallace LA, Walker J, McIntyre S, Noone A, Christie P, et al. Rapid virological surveillance of community influenza infection in general practice. *BMJ* 2000;321:736-737.
5. Zambon M. Laboratory diagnosis of influenza. In: Nicholson KG, Webster RG, eds. *Textbook of influenza*. Oxford: Blackwell Science, 1998:291-313.

Physician compensation, past and present

Since earliest times, wise men have experimented with various methods of compensating physicians. Fee for service is the oldest documented model. The Code of Hammurabi (1792 – 1750 BC) specified physicians' fees: "If a doctor has healed a freeman's bone or has restored diseased flesh,... the patient shall give the doctor five shekels of silver." The Mesopotamian rulers set the amount to be paid for each procedure, just as the Canadian government does today.

In 2000 BC, Egyptian physicians were salaried, employed by the army or the temple. They would not charge for services, only for the medication they dispensed. Their contracts resemble those of contemporary military and industrial-based physicians in the United States.

Ancient Chinese physicians were members of the upper class and were philanthropists, receiving no pay. Some worked on a retainer, serving special interest groups such as the court or wealthy families, foreshadowing today's sports team physicians.

In India, the laws of Manu (200 BC – AD 200) stipulated that charges reflect income; the sliding fee scale is not a recent invention. The successful doctor could claim the patient's property in case of non-payment.

In Greece, Hippocrates advised that patients should pay in advance, experimenting with prepaid medical plans circa 400 BC. Hippocrates also emphasized that doctors could justify their bills only by participating in continuing medical education. Greek physicians were upper-class citizens and did not treat the poor or slaves. Plato explained the Greek tier system: Slaves were treated by physicians' assistants; rich people, by doctors. Today, medical students run free storefront clinics and specialists run "boutique" offices for the wealthy.

In Europe during the Middle Ages, doctors and patients agreed on a fee, and the doctor made a deposit. If the patient died, the doctor was not paid but got the deposit back. If a procedure was unsuccessful, the doctor paid a fine, and only if all were happy did the doctor get the deposit and payment. Punishment for lack of success could be severe. Queen Austrechild (? – AD 568) had her doctors beheaded for their failure to cure her.

Doctors in the Middle Ages objected to regulated fees for the rich. Doctor Guglielmo da Saliceto of Italy complained, "It would not be a bad thing to ask the highest possible fees for medical treatment, giving the examination of excrement and urine as a reason." During this time there existed an installment system to pay for surgery; surgeons would receive a lifelong annuity if the patient could not pay for an operation in a lump sum.

The monasteries, which dispensed care in the Middle Ages, were motivated by Christian charity and dependent on donations. The hospices provided unequal care, with some treating all who came as worthy of the best care, and others, as the Council of Clermont declared, "promising health for filthy lucre." The American Medical Association code of ethics states, "Each physician has an obligation to share in providing care to indigent patients." Present day physicians fail in this effort, as did the monastic Christian healers.

Are there lessons to glean from the past about the future of health care?

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Remuneration models in the Netherlands

1. **Basic model (ca. 1983)**
   - F = (PI+C)/WL
     - F = fee
     - PI = standardized personal income
     - C = standardized reimbursement various costs of practice
     - WL = workload

2. **Medical specialists: varieties of the fee for service system**
   - DTC system is essentially a fee for service as far as fees are concerned

3. **GPs: mixed model retainer / ffs**

4. **Various temporary government interventions:**
   - Tariff cuts (1983-1995, 2010, 2011)
   - Fixed fee system / revenue caps (1995-2007, 2012-2014)

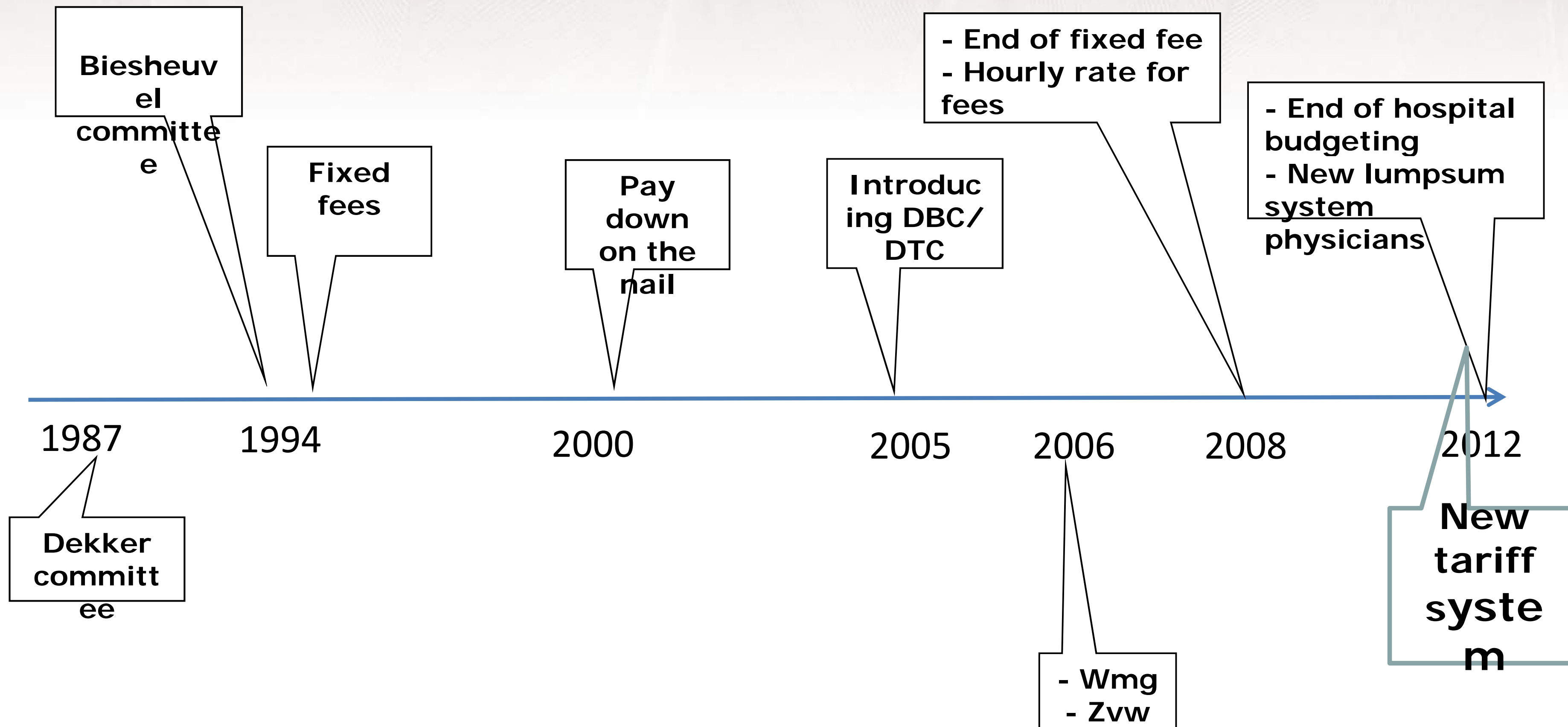
Outline of today’s presentation

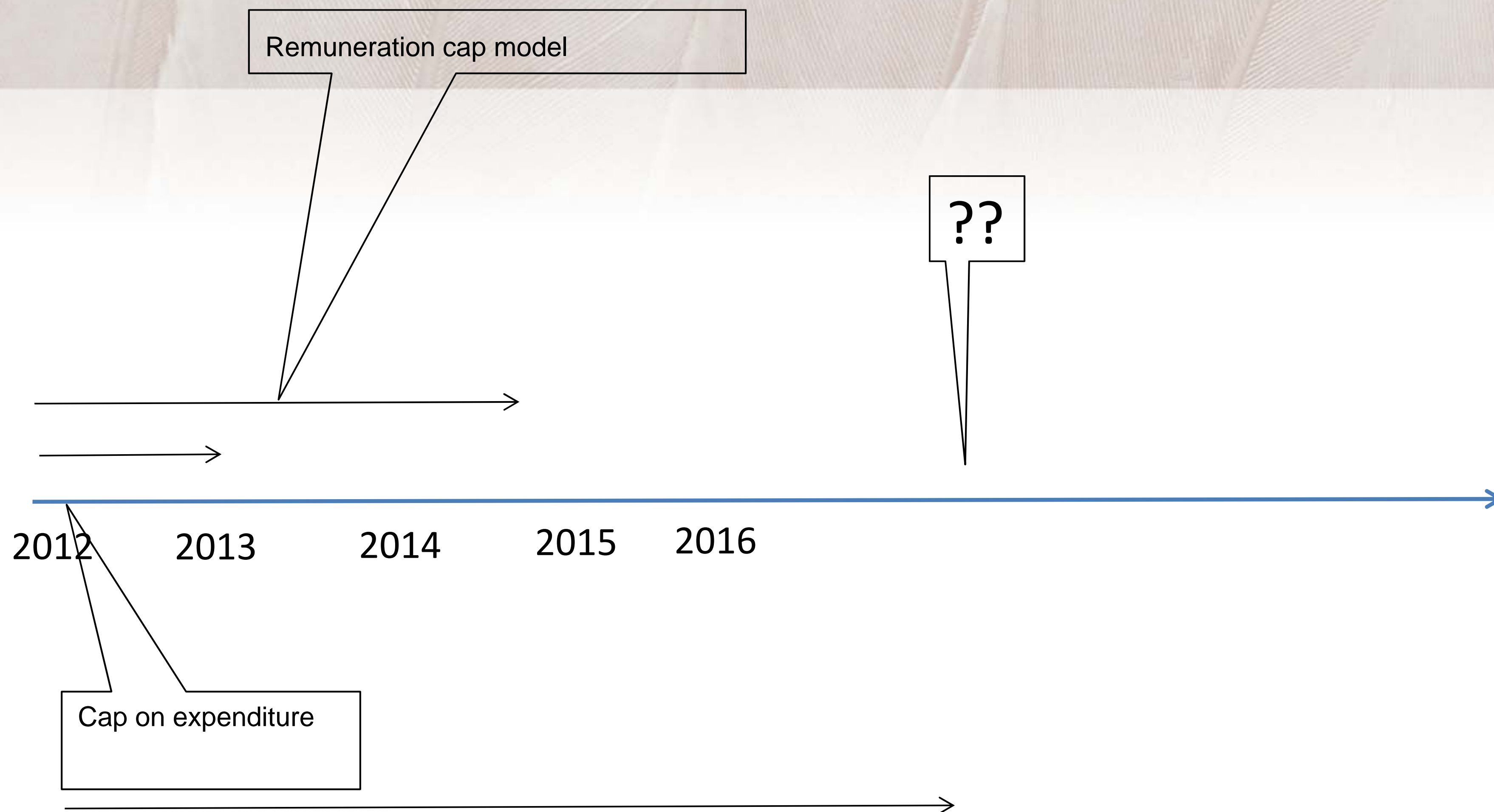
1. **Short historical overview**

2. **Regulation measures in recent years**

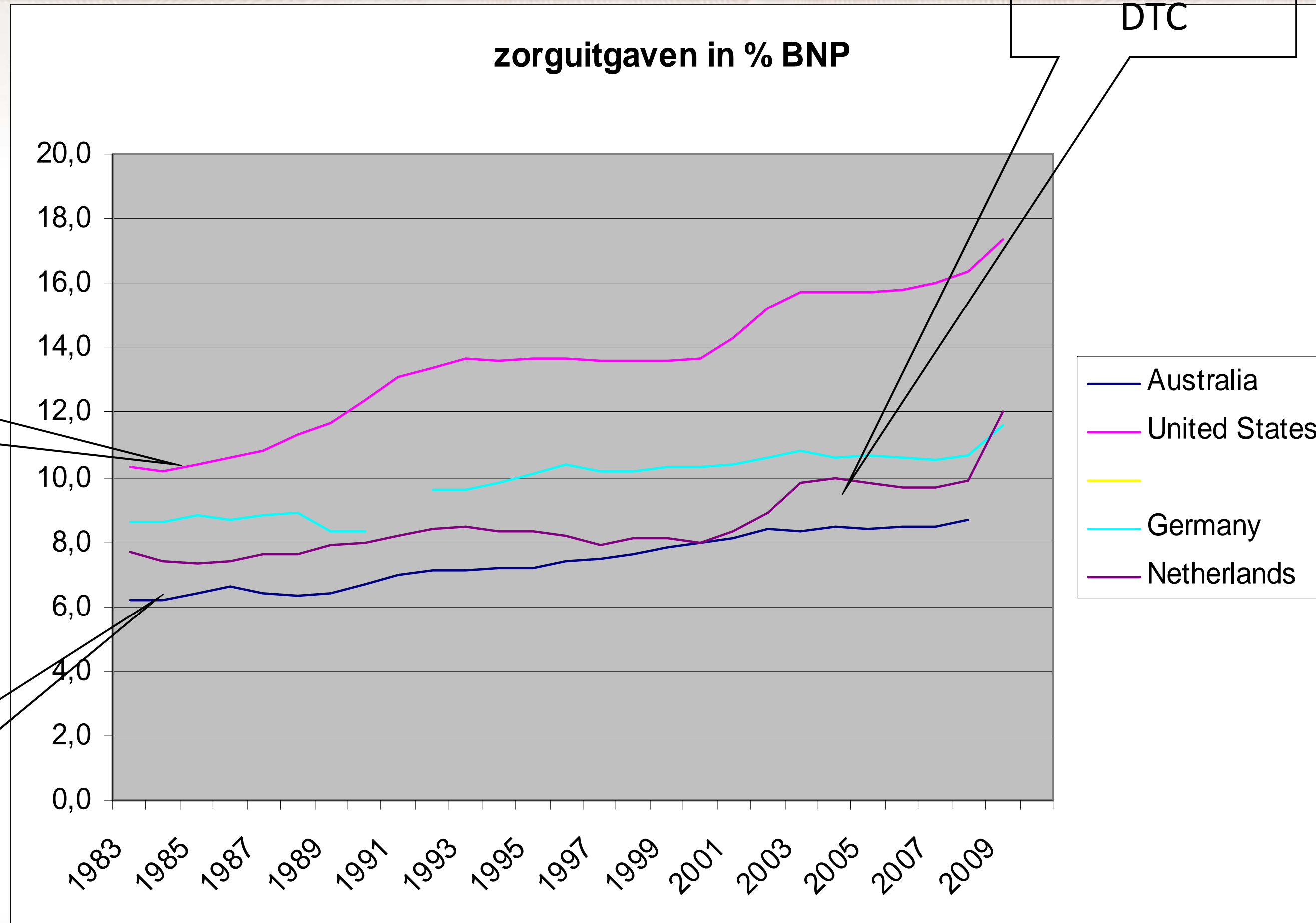
3. **Future situation**
   - Negotiations hospital board/ physician

A short history




Remuneration cap model
??
2012
2013
2014
2015
2016
Cap on expenditure

Expenditure on hospital care



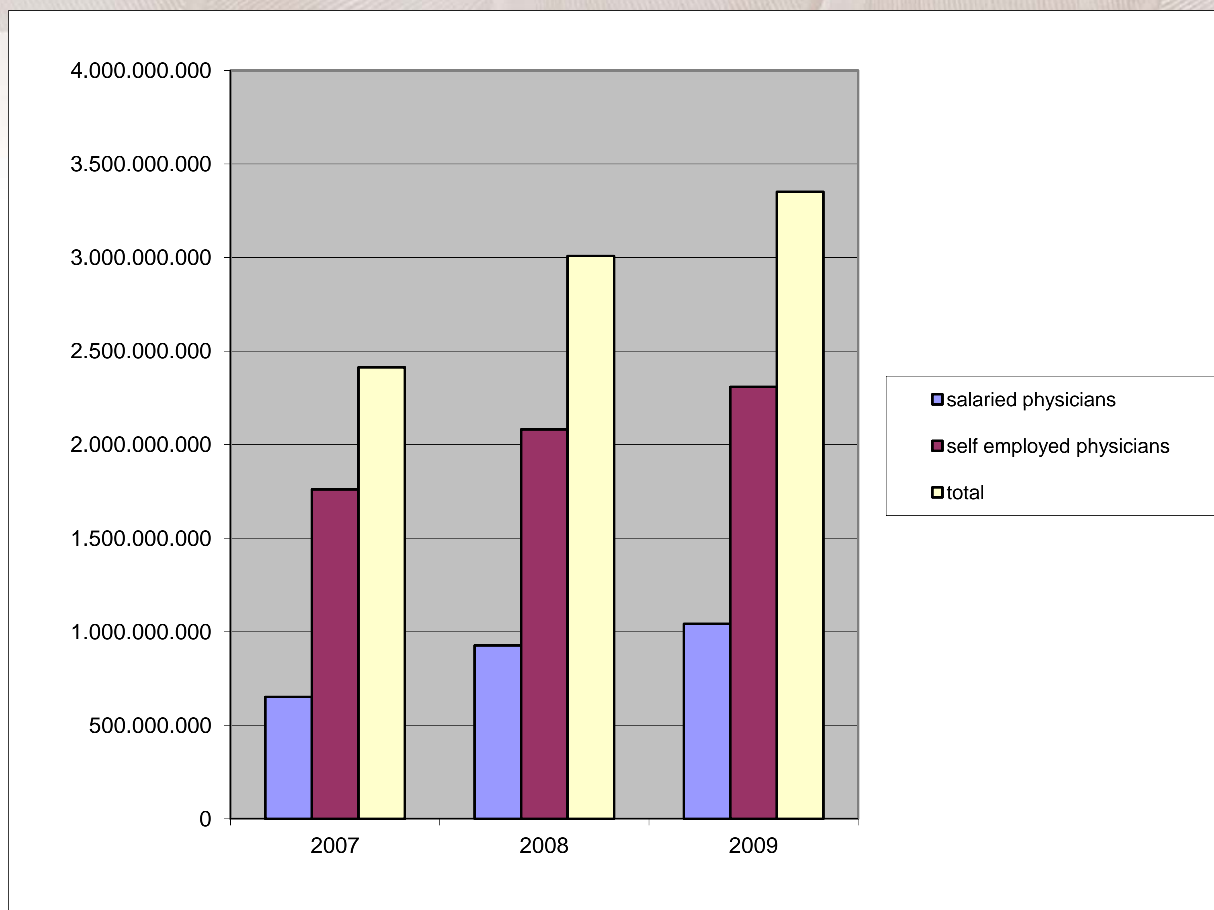
Introducing DRG

Introducing Budgeting/ expenditure caps

Bron: OECD Health Data 2011

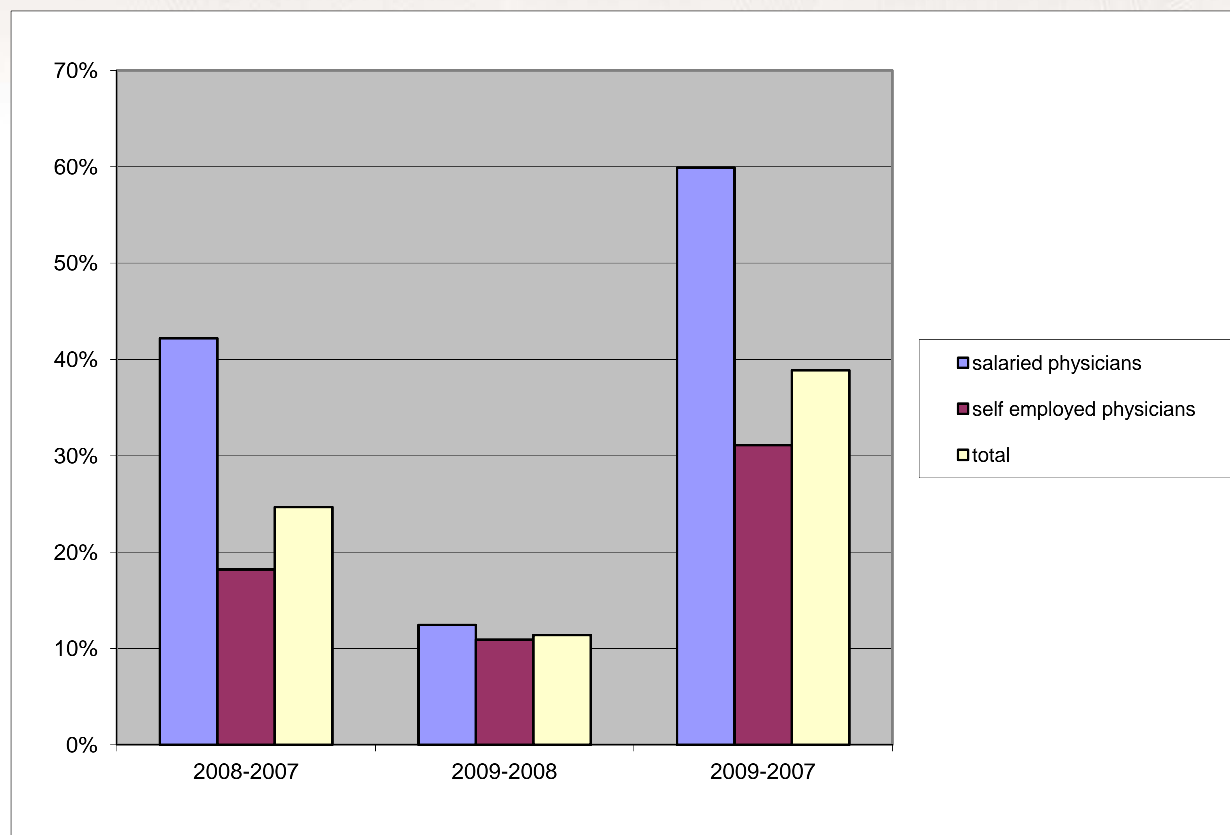
http://stats.oecd.org/Index.aspx?DataSetCode=SHA

Total remuneration medical specialists 2007-2009



2007 marks the last year of ‘fixed fee’ system

Growth of expenditure on medical specialist's fees



Type of hospital	Self employed	Salaried employee
General	7260	2860
University Hospitals	-	3600
	7260	6460

Nearly 50% of medical specialists are in pay of hospital

Regulation system is completely based on self employed

Data: NZa survey 2011

Regulation in recent years

1. 1995-2007: voluntary fixed fee system
2. 2005: introduction of DTC system,
   - approx. 10% of production without tariff regulation
   - Regulated fees for specialists (hourly rate)
3. 2008: end of fixed fee model
4. 2010/ 2011: tariff cuts up to 25%
5. 2012: re- introduction of revenue caps (self employed)
   - In combination with changes in staff/hospital relation

Proposed future model

Change in hospital-specialist relation

1. Basic idea:
   - Negotiating fees between hospital board and medical staff

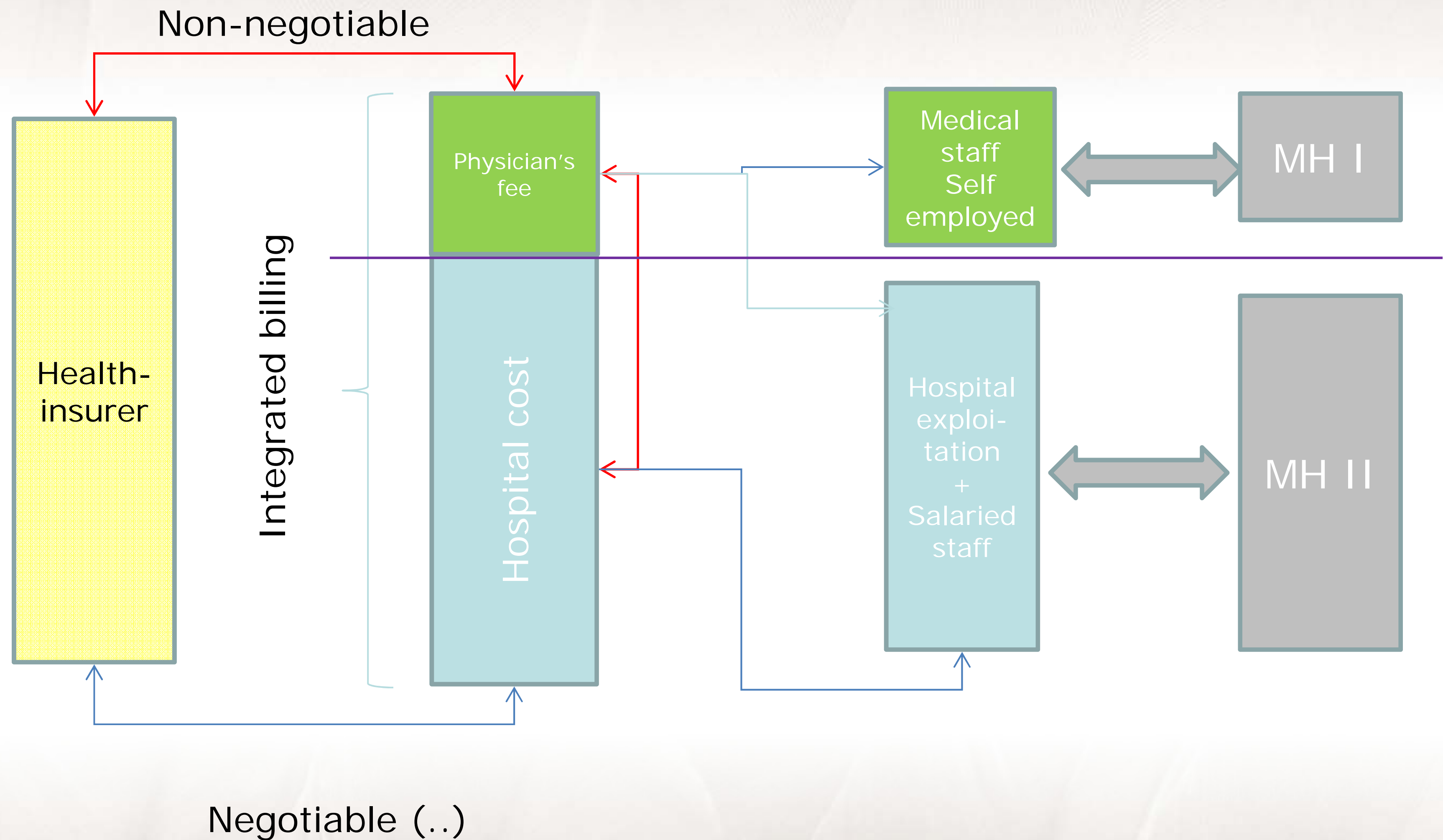
2. Part of recommendations Biesheuvel (1994)
   - 18 yrs of progress

3. Resisted by both parties ((hospital association(NVZ) and association of medical specialists (Orde)) for various reasons

4. Planning: 2015
   - In the meantime: tariff regulation + revenue caps

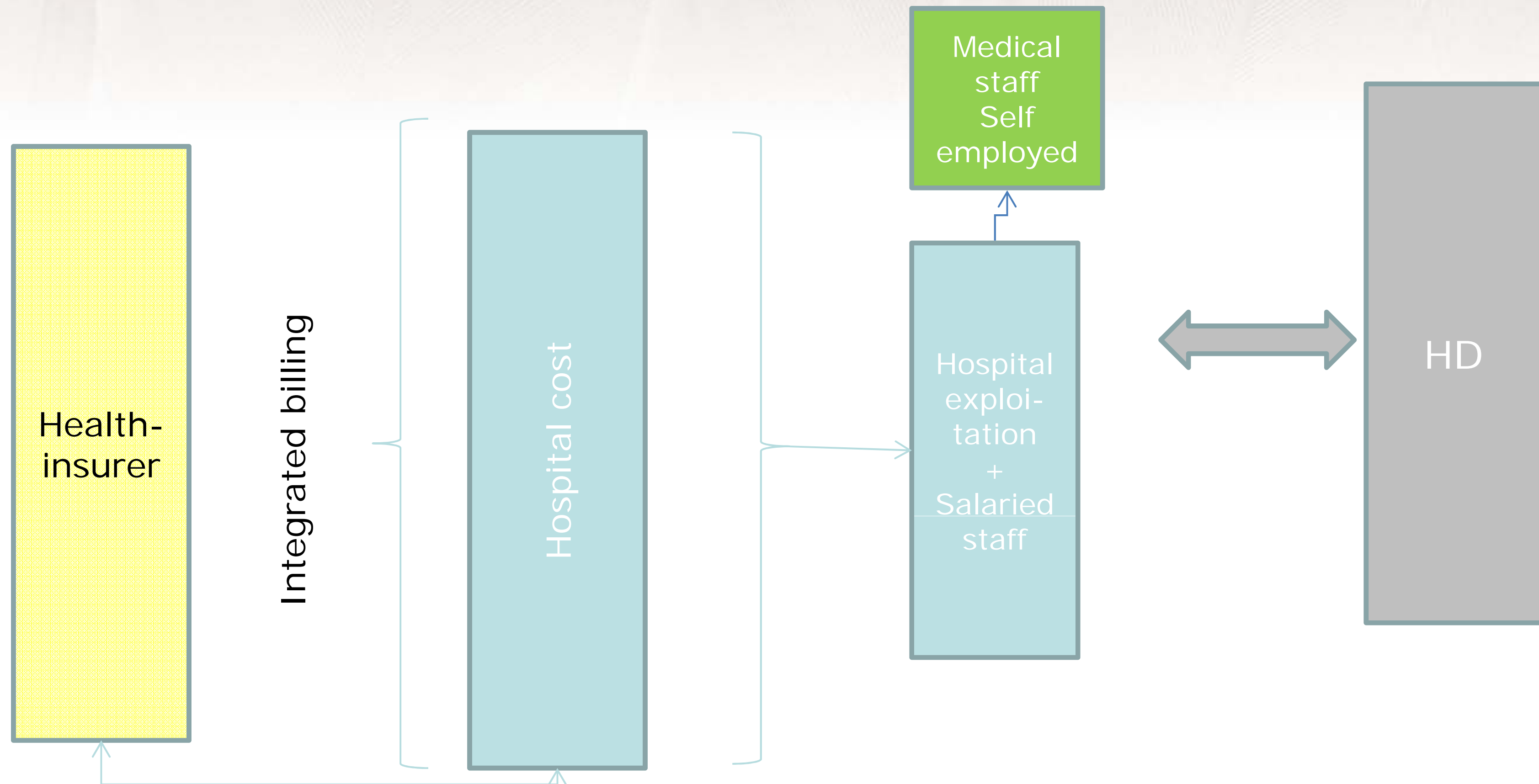
5. Different timetables: hospitals are compensated on fee for service basis as of 2013

DTC concept (present situation)



Negotiable (..)

DTC concept (anytime in the future)



Negotiable (..)

‘integrated’ tariff

1. **Like liberalizing prices:**
   - Not solving the problem
   - But making it someone else’s problem
2. **Why would hospital board be able to regulate their staff?**
   - Competive pressure on prices?
     - Shortage qualified medical staff
     - Both hospital and staff have incentive for increasing revenue
     - So far, countervailing power of insurers has been unsuccessful
   - Incentives for staff remain the same
3. **Basic flaw: model is based on old fashioned type of hospital organization**
   - 1 staff
   - Specialists working in 1 hospital

Relevant developments

1. Quality guidelines require increase of scale

2. Specialists are reorganising themselves:
   - Regional cooperations, working for several hospitals
   - Owner/manager of focus clinics
   - Partnership model
   - Shareholders of hospital (?)

3. Lifting restrictions on number of students in medicine
   - Increase in number of trainees

4. Impulse for change in the organisation within the profession and within hospitals:
   - Increase in female staff
   - More part time employment
   - Increase in salaried employees instead of self employed physicians

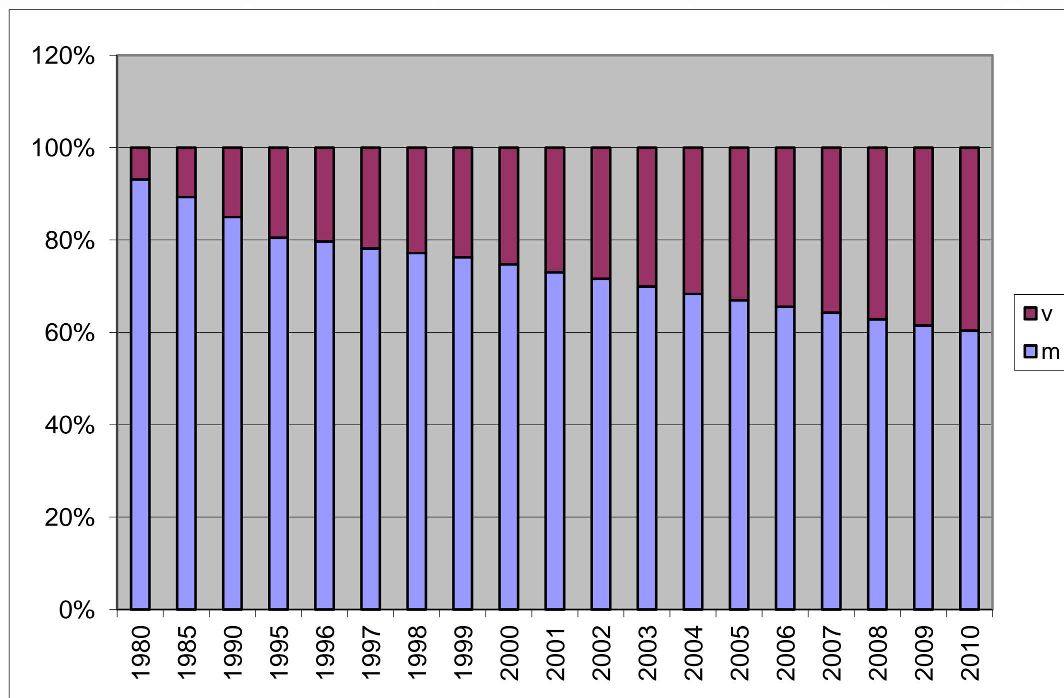
Developments in primary care

1. Traditionally: predominant model :
   - male GP in self employed practice, working alone
   - Still basis for tariff regulation (..)
     - Mixed form: capitation/fee for service

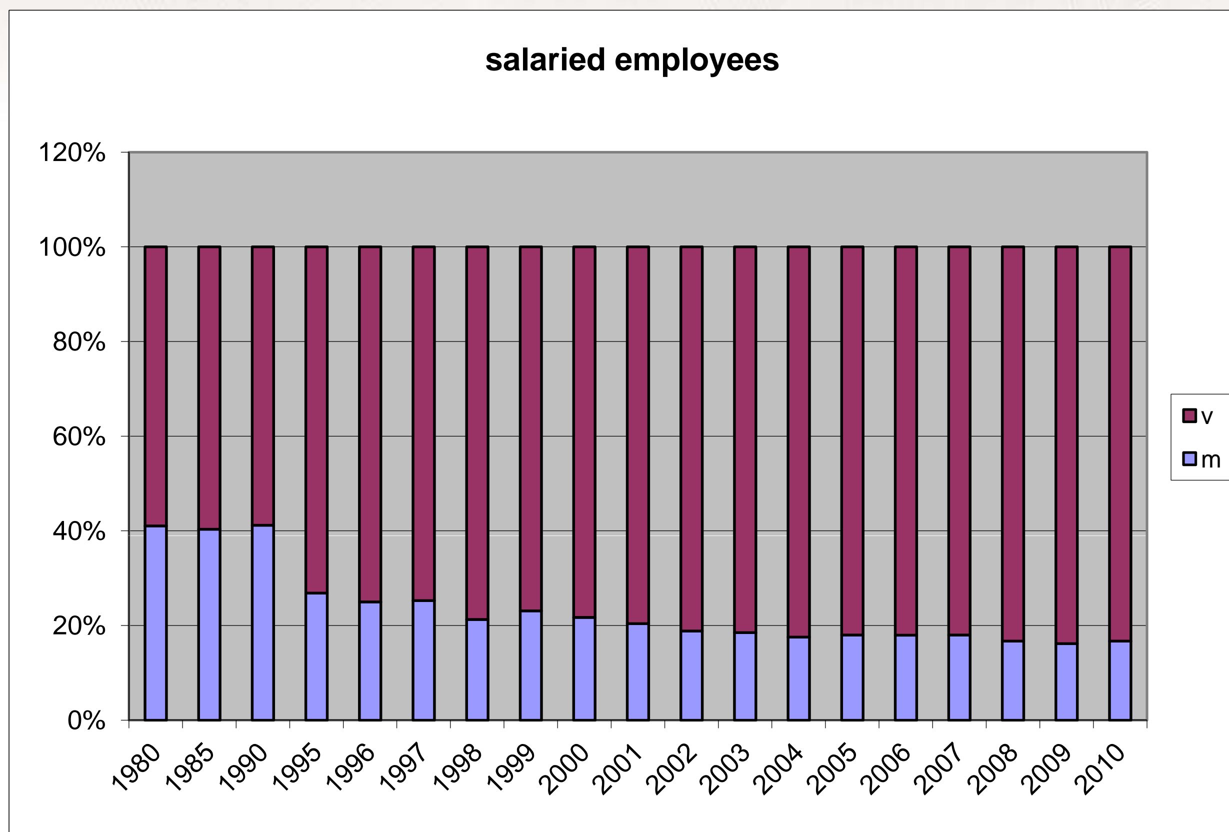
2. In 15 yrs, fundamental changes in the organisation of the profession
   - Increase in part time work
   - More salaried employees
   - Group practice
   - Regional cooperations for emergency care

3. **Not in regulation / financing**

Increase of number of female GPs



Data: Nivel, 2011


salaried employees
120%
100%
80%
60%
40%
20%
0%
1980
1985
1990
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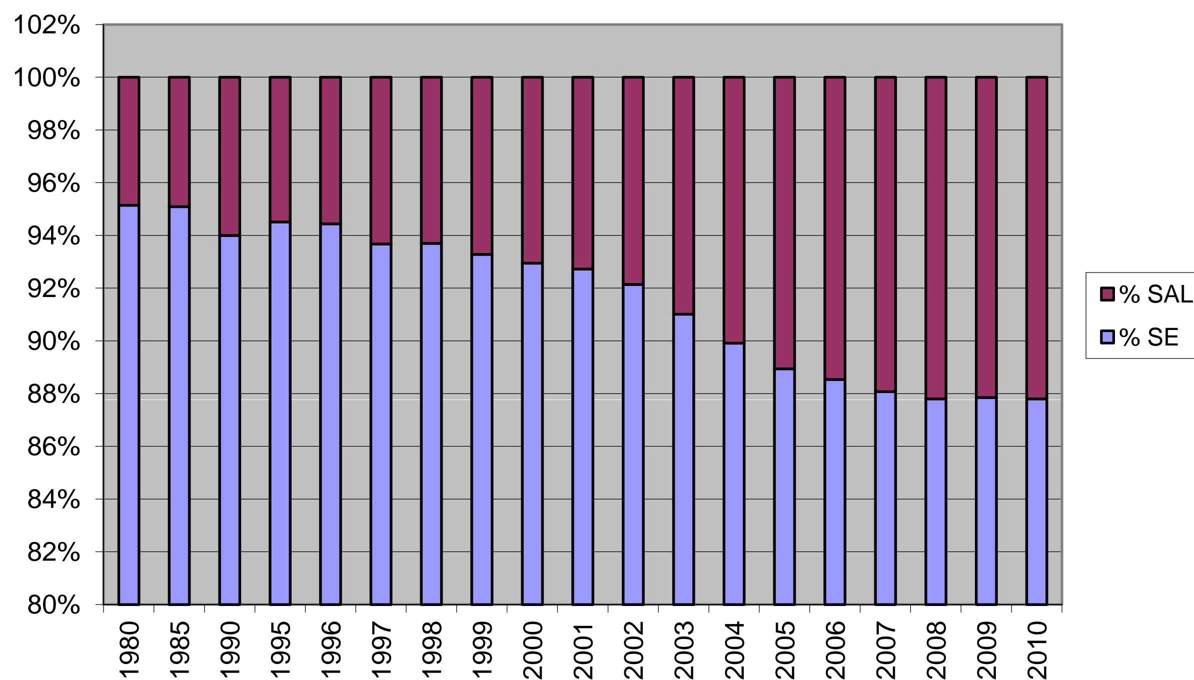

self employed vs. salaried GP
102%
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
1980
1985
1990
1995
1996
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1998
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2002
2003
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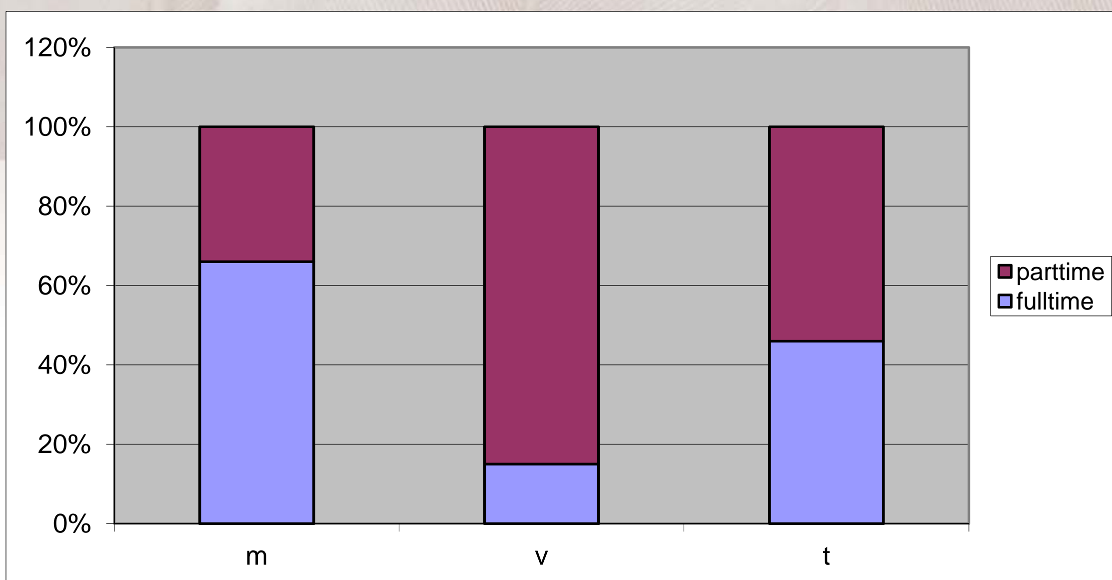
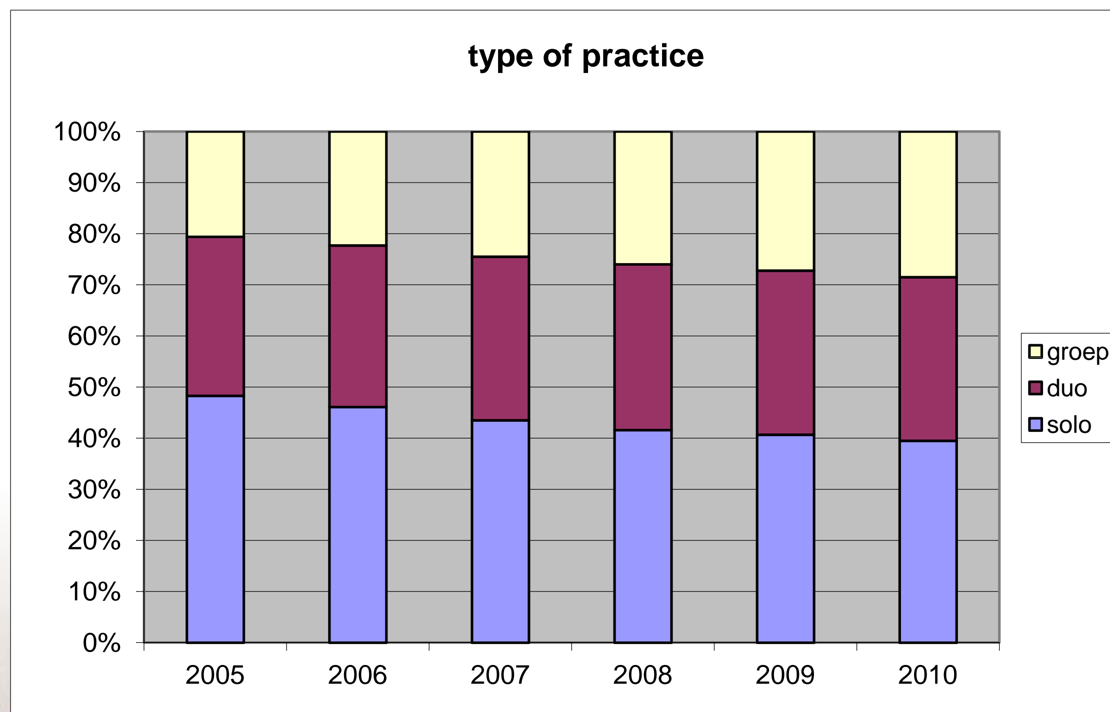
2006
2007
2008
2009
2010
% SAL
% SE


120%
100%
80%
60%
40%
20%
0%
m
v
t
parttime
fulltime


type of practice
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2005
2006
2007
2008
2009
2010
groep
duo
solo

Conclusion

1. Regulatory model for GPs differs from hospital physicians' fee for service model

2. Changes in organisation of GPs cannot be ascribed to regulation, but is more or less autonomous development

3. Despite tariff regulation total expenditure on primary care has risen and exceeds the targets of the Ministry of health
   - Capitation/ two part tariff not effective

Discussion

1. Will hospital staffs change in the way GPs have?

2. If so, what are the implications for the DTC model and relations between hospital and staff?

3. Incentives for specialists:
   - Stick to the competition model ?

4. Or new regulation:
   - Focus on (modern) organisations of care suppliers
     - Revenue caps, regional budgetting
     - Yardstick competition
       - Yardstick on price
       - Or on performance
       - Or on quality guidelines?
     - Paying for regional health care network

Thank you for your attention!