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Price setting and price regulation in health care

Lessons for advancing Universal Health Coverage

Executive summary

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This study was carried out to support countries in meeting international commitments towards Universal Health Coverage. It aims to gather experiences in price setting and regulation, generate best practices, and identify areas for future research. There is a special focus on the implications for middle-income settings, which represent more than 70% of the world's population. The share of public spending on health in these settings doubled between 2000 and 2016. This increase in public spending has been accompanied by new ways of financing, organizing, and delivering health care. A key question is how to make use of all health resources – from both private and public sources – to attain health-related goals.

Health care is far from being a classic market for goods and services. Individuals are usually represented by a purchasing agent (i.e., health insurers) instead of operating by themselves, and do not have complete information. This makes people less sensitive to prices. However, prices provide important signals to health care providers, given that they determine the level of financial resources to deliver health care services.

Provider payment systems consist of one or more payment methods and their supporting systems such as contracting and reporting mechanisms, which are used to create economic signals and incentives that influence behaviour. Any payment method has three dimensions: the base upon which prices are defined and set; the level of payment per unit of the chosen base; and the administrative and economic process by which that price level is determined. This study focuses on these key dimensions.

Among the case studies reported, the base for payment for primary care is primarily fee-for-service and capitation; fee-for-service is typically used in outpatient settings; and diagnosis related groups are commonly used in hospital settings.[1] Increasingly, payment methods have been combined with specific performance-based rewards or penalties; they have also been combined across providers to facilitate a more coordinated and flexible approach to care. All payment models have strengths and weaknesses; therefore, the impact of each depends not only on the method chosen but also the price paid. The price not only ensures that the costs of delivering services are covered, but also provides incentives for health care providers. Price adjustments are typically made to ensure coverage and access, for example, to health care providers in rural and remote areas; those treating disproportionately high numbers of low-income or high-cost patients to ensure coverage and quality; and for facilities providing medical education. Prices are also adjusted to attain broader health-related goals.

1 In this study, we use the term "base for payment" for the unit of activity upon which prices are set (i.e., fee-for-service, diagnosis related groups, per diem, and capitation). This differs from the "base rate" or the standardized payment that a hospital receives for covered services.

The study generates lessons learned in price setting, particularly for low- and middle-income settings. They include:

Investing in data infrastructure. In setting the level of payment, the ways of calculating prices are linked with the strength of data collection systems about input costs, output volumes, and outcomes. Low- and middle-income settings can initiate payment reforms while also building critical capacities in health information systems and data collection. Where data are limited, information can be used from available sources while also investing in data infrastructure.

Building institutional capacities. In several settings, specialized institutions have been established to separate the technical task of determining costs from the more political exercise of negotiating how much to pay for services. In some cases, such institutions commission or collect data to estimate the cost of providing services upon which prices are then based. Whether an independent entity or designated institution, characteristics of successful systems include political independence, formal systems of communication with stakeholders, and freedom from conflicts of interest. Given finite resources for health, price regulatory systems can be used to promote greater efficiency and attain value for health spending for resources from both public and private sources.

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Planning sequenced implementation. Particularly for settings that employ line-item budgets, substantial long-term planning is needed to change payment systems, estimate costs, and use prices and payment systems to reach policy goals. For any payment reform, the starting point is developing a classification system of the services that are currently being delivered. Given that the strength of health systems can affect the speed and quality of implementation of reforms, continued investments in broader capacities should receive greater attention including, for example, clinical guidelines, regulatory frameworks, and strengthening professional associations.

Establishing prices that approximate the most efficient way of delivering care. Prices should approximate the cost of delivering services in the most efficient way that enables quality and health outcomes. This minimizes incentives for inappropriate and low value care and enables accurate budget projections. Costing exercises can be useful if they reveal information about the underlying cost structure of service delivery and enable the development of alternative scenarios about models of service delivery that offer high levels of efficiency and quality.

Using prices as instruments to promote value for health spending. Pricing is not only about covering costs but also providing the right incentives. Pricing, payment systems, and their regulatory frameworks can be powerful tools to drive broader health system goals. For example, in some settings, balance billing is prohibited, and patients are fully reimbursed for covered services to ensure affordability and access.

Strengthening the national role in setting prices. To align prices with policy goals, a strong national role is required. While the methods for price setting vary, we conclude that unilateral price setting by a regulator eliminates price discrimination and performs better in controlling growth in health care costs. In contrast, individual negotiations between buyers and sellers are the weakest along these same parameters. Both collective negotiations and unilateral administrative price setting also have the potential to improve quality better than individual negotiations.

Establishing systems of ongoing revision, monitoring and evaluation. Flexibility is needed to adjust to the evolution of pricing and payment methods, factors outside of the control of providers and changes in market structure. Many experiments are underway to adjust prices to achieve broader health policy goals, such as better coverage, quality, financial protection, and health outcomes. It is not always clear whether the price set will result in the intended provider behaviours – or unintended consequences will occur. Yet, few of these initiatives have been fully evaluated for impact. This limits the lessons learned both within and across countries. More systematic testing and evaluation is critical to inform about the impact of such initiatives and determine the feasibility of scale-up within a given setting, and replicability elsewhere.

Policies about pricing and purchasing health care services are grounded in institutional history and the level of resources for health. As such, there is no ideal price level or payment mechanism. Each country has implemented approaches that help address broader system objectives within a given setting. Ultimately, it is these objectives that guide policy choices. Lessons from other settings should be viewed considering their feasibility and responsiveness to unique contexts.

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