5
Maintaining a balanced budget, adjustments to prices, and incentives for quality

Price setting may result in different prices set or negotiated with different providers. These price differences may not only reflect supply and demand (and monopsony/monopoly pricing) but other factors as well, including expenditure control, promoting quality, providing public health goods and attaining other public health goals.

5.1. Maintaining a balanced budget

Prices are influenced by the budget envelope. In some settings, overall growth in spending is constrained by macro-economic metrics, e.g. economic growth rates, expected payroll increases, inflation rates, increases in utilization, and population growth and ageing (Reinhardt 2012).

Prices have been used to respect the overall budget and redistribute resources for LTC among various providers. In Australia, the national government applies planning and supply limits to maintain control over the LTC budget. The supply of home support is controlled by capping annual funding grants to providers. The annual budgetary determination of the amount of grants available to service providers is based on a broad assessment of need and the government's fiscal capacity. For home care and residential aged care (as well as the short-term care programs), the national government manages the planning of and expenditure on services by specifying a national target provision ratio. The 'aged care provision ratio' is the number of subsidized aged care places for every 1000 people aged 70 years and over and is an estimate of consumer demand. The government also exercises control over the size of the home care market through demand-side queuing. Older persons who have had an assessment and are eligible for a home care package are placed on a national prioritization queue for their package level according to the date of approval and their priority level. The size of the residential aged care market is controlled through supply-side capping of the number of places allocated to providers through a periodic competitive allocation round. The number of places released in each allocation round is determined by the target aged care provision ratio and the level government funding expected in the forward estimates, demographic projections, current levels of service provision (i.e. number of operational places, occupancy levels), and newly allocated places from previous rounds that are not yet operational. The median waiting times for future residents from the time of their assessment by an aged care team to accessing a residential aged care place in 2018-19 was 152 days, though many older people assessed as eligible for residential aged care choose not to enter a facility when offered a place (Australian Government, Productivity Commission 2020).

In France, skilled nursing facilities and residential nursing homes are funded by annual prospective global budgets adjusted to consider the volume and case-mix of the patients

treated, while home care nursing services are funded only on the basis of volume without considering patient severity.

In the Netherlands, the national government sets a macro budget for all care financed through social LTCI for the coming year based using forecasting accounting for changes in wages, prices, demographics, and policies. The macro budget is then divided across the regional purchasing offices. The allocation of funds across regions is currently based on past trends. The regional purchasing office responsible for the procurement of care within their region comply with the lump-sum regional budget set by the government. This implies that regional purchasing offices must adjust prices and/or volume of the contracted care to fit the regional budget restrictions.

5.2. Price adjustments and add-ons payments

Price adjustments and add-on payments are common when prices are set unilaterally or negotiated collectively to ensure that specific services or care for populations in need, particularly where there are additional costs of providing care or it is considered unprofitable. In this manner, pricing can be an important tool in allocating resources to meet public health goals (Table 6).

Prices can be adjusted for geographical location, the degree of dependency of beneficiaries and the type and length of the home care service to recognize the legitimate and unavoidable cost differences among providers. In Australia, the Netherlands, and the USA, geographic price adjustments are made for facilities in rural areas. In Japan, the base rates differ across geographic area: supplemental payments made to metropolitan Tokyo are up to 11.4%, reflecting the higher wage levels there.

Outlier payments are made for additional care needs including veteran status and oxygen and enteral feeding (Australia), palliative care (Australia, France), short and long stays (France), and specific conditions such as dementia (Australia) or Huntington's disease (the Netherlands). In the Republic of Korea, co-payment ceilings depending on income levels are used to reimburse specific co-payment amounts if a patient stays for a long time in an LTC hospital.

Supplemental support is provided to ensure services in indigenous communities in Australia. In Japan, the fees and conditions of billing have been revised to align with policy goals for access and quality. For example, bonus payments for home care agencies are given to employ more experienced workers.

In the Netherlands, an additional payout to compensate providers of nursing home care or substitute round-the-clock home care in relatively expensive regions can be made if the regional budgets are not sufficient (for instance, because of high turnover in personnel in urban regions).

Table 6. Price adjustments and add-on payments

Country	Geographic adjustments	Outlier payments	Public health goods
Australia	Supplement for rurality / remoteness	Supplements paid for specific health needs, e.g., dementia, enteral feeding, oxygen therapy, and palliative care (residential care only)	The National Aboriginal and Torres Strait Islander Flexible Aged Care Program supports culturally appropriate residential and home care services to older Indigenous Australians on Country (ancestral land), close to family, community and language, mainly in remote areas. The Multi-Purpose Service (MPS) Program supports sustainable health and aged care services in sparsely populated communities. The national government's grant for aged care places is 'pooled' with state government funding for hospital and community health services.
France	Not applicable.	For palliative care in acute hospitals, prices are adjusted for very short (<4 days) and long (>12 days) stays.	SHI prices in nursing homes are adjusted for having their own, integrated, primary care services (GP and pharmacies)
Germany - residential care	Variation in gross salary for LTC staff. Different requirements across states (Länder) for providers, such as staffing regulation. Adjustments are subject to negotiations.	Not applicable.	Not applicable.
Republic of Korea	Not applicable.	Specific amounts of co-payment over a set ceiling reimbursed if a patient stays for a long time at a LTC hospital	Not applicable.
The Netherlands	Nursing homes in relatively expensive regions receive an additional markup on the per diem tariff	Nursing homes receive markups on the per-diem tariff for additional care for patients with specific diseases, such as Huntington's, or additional services like transport	Not applicable.
United States: Medicare	Skilled nursing facilities (urban versus rural; wage component); home health care (wage component)	Not applicable.	Not applicable.

5.3. Payment mechanisms and other incentives for quality

Quality in LTC is particularly difficult to measure and monitor, given the diversity of providers and institutions involved in care provision. A few countries, however, do take quality into account in their pricing and payment systems. A few examples are noted here.

In the Netherlands, additional funding for quality improvements of nursing homes based on lump-sum funding is distributed across care providers. The regional purchasing offices distribute these funds across providers based on mandatory quality plans.

To assure quality of care in the LTC sector, the Korean NHIS implemented a quality evaluation system in 2009. The number of quality indicators varies by type of service provider, and indicators are grouped into five domains, namely management of institutions, environment and safety, guarantee of rights of beneficiaries, process, and outcome. Evaluation scores are disseminated through an official LTCI website, and high-performing institutions have received 1%–2% additional payments (Jeon and Kwon 2017).

Sweden has made use of financial incentives for better performance, and there have been occasions since 2010 when governments in connection with the transfers from the state to the municipalities have included performance targets based on outcome results for the care of older persons. The *Ädelreformen* reform, the Law on System Choice in the Public Sector, and the use of conditional budget transfers have created an environment where providers' performance is encouraged through incentives for providers to compete, for users to choose across providers, and for municipalities to deliver value and quality.

Publishing information about prices and quality is one means to help beneficiaries make informed choices and has the potential to reduce price variation and promote quality. Provider prices for residential and home-based services are published by the government or an associated independent institution in all countries in this study, with the exception of Germany, where providers must publish their price schedule on their websites. However, there is little evidence about the associations between the publication of prices and quality of outcomes for choice, price variation, and quality (Cornell et al. 2019).

As for quality of care, periodic quality assessments are made publicly available in Australia, Germany and the Republic of Korea. In the Netherlands, nursing home and home care providers (offering personal care and nursing only) are required to report information online about patient-reported metrics. Sweden and the USA publish online comparative quality indicators to facilitate patient choice of providers at the local level.

Table 7 shows the type of information on prices and quality that is available in the countries in this study.

Table 7. Public release of information about price and quality

Country	Published prices	Published information on quality
Australia	Providers must publish a schedule of prices for services.	Quality report and non-compliance notices are publicly available.
France	Skilled nursing facilities and hospital at home prices are published by ATIH on is website. Residential nursing homes and social residence prices are published on government website (since 2016)	Not available
Germany	Prices of home care providers are published by each provider on their respective home pages. Prices of residencial care homes are published by each residencial provider on their respective home pages. Additionally, prices are made available by social LTCI funds on four internet plaforms.	Annual, structured assessment of home and residencial care providers. They are made publicly available by providers at a visible location (e.g., entrance), and by social LTCI funds on four internet plaforms.
Japan	National government sets prices and conditions of billing for all items covered by social health insurance and LTCI	Reporting of quality limited to voluntary decision of each hospital
Republic of Korea	Price schedule of SHI and LTCI	Periodic quality assessment
Netherlands	Maximum tariffs for nursing home care and for home care (personal care and nursing only) are published by the Nederlandse Zorgautoriteit (Dutch Healthcare Authority). Some municipalities choose to report the prices for assistance on their website. Health insurers are required to put the payouts for nursing and personal care provided by uncontracted providers on their website	Providers of nursing home care and home care (personal care and nursing only) are required to report information on patient-reported experience measures online.
Spain	Average prices in Spain and its regions (ACs) of public LTC services, as well as reference prices for subsidized private day centres and residential care centres.	Not available
Sweden	Not available	Sweden publishes the Open Comparisons report annually showing providers' quality of care to the elderly based on 28 quality indicators along with grading of their performance. A relative comparison between municipalities is provided using a traffic light system. Quality of care to the elderly indicators are also avaialble online (kolada.se).
United States: Medicaid	Fees by provider are usually posted on to Medicaid webpages at State level	Not available
United States: Medicare	Fee schedules are reported in the annual Federal regulations and notices	For people with Medicare or their caregivers who want to choose a Medicare provider (such as nursing homes and home health care), the Care Compare tool provides a single source search and compare experience, that lets the user make more informed decisions - also based on quality of care - about where to get services

Sources: Aged Care Quality and Safety Commission (2020), ATIH (2021), CNSA (2021), AOK (2021), BKK Dachverband e.V. (2021), KNAPPSCHAFT (2021), Verband der Ersatzkassen e.V. (2021), Ministry of Health, Labour and Welfare, Japan (2021), Ministry of Health and Welfare, Republic of Korea (2021a, 2021b, 2021c), Nederlandse Zorgautorieit (2020a, 2020b), Zorginstituut Nederland (2018, 2019), IMERSO (2020), National Board of Health and Welfare (Socialstyrelsen) (2021), US National Archives (2021a, 2021b).