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Provider payments and patient charges as policy tools for cost-containment: How successful are they in high-income countries?

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Abstract

In this paper, we focus on those policy instruments with monetary incentives that are used to contain public health expenditure in high-income countries. First, a schematic view of the main cost-containment methods and the variables in the health system they intend to influence is presented. Two types of instruments to control the level and growth of public health expenditure are considered: (i) provider payment methods that influence the price and quantity of health care, and (ii) cost-containment measures that influence the behaviour of patients. Belonging to the first type of instruments, we have: fee-for-service, per diem payment, case payment, capitation, salaries and budgets. The second type of instruments consists of patient charges and reference price systems for pharmaceuticals. Secondly, we provide an overview of experience in high-income countries that use or have used these particular instruments. Finally, the paper assesses the overall potential of these instruments in cost-containment policies.

Introduction

While many low-income developing countries still need to muster an appropriate and sometimes even a minimum amount of resources, many high-income countries are addressing the question of how to contain their health care costs. This question is not brand new, however. OECD countries already became confronted with this question some 30 to 40 years ago, when health expenditure grew almost twice as fast as Gross Domestic Product (GDP). A downward economic cycle in the 1970s as well as increased ageing of the population enhanced the concern to control health care costs[1].

Cost-containment as a policy issue is related to the question what the right amount is that countries should spend on health care. Society's preferences, and not just economics, have an important impact on choosing the appropriate amount of care. For example, an increase in the share of health expenditure in GDP is not just to be understood as a cost explosion, but could simply be a response to population's preferences for more and better care. This illustrates that it will be tedious to establish when cost-containment is exactly needed.

An additional question is whether cost-containment should be directed at *total* expenditure or *public* expenditure on health. We chose to focus on public expenditure on health, in view of an overriding and steady concern about cost-containment by governmental and quasi-governmental institutions. As to the need for cost-containment, few countries use precise criteria that would trigger cost-containment measures. It seems to be accepted