From financing healthcare providers to clients!

The last 20 years, healthcare reforms in various European countries seem to converge, but a single healthcare system in Europe is not realistic. Healthcare is a national matter, because a healthcare system highly dependent and embedded in the history of a country, national culture, political circumstances, economic context, social system and other circumstances. However, legislation and reforms are increasingly looking beyond their own national borders.

Four studies (1997, 2007, 2018 and 2019)[1] describe the healthcare system of 11 and 22 European countries. The series of articles will discuss trends in the past 20 years:
- Decrease growth healthcare expenditure in the USA and Europe (see dd-dd-dd)
- Reform trends: from (macro) cost-control to market elements
- Towards a stronger primary care
- From financing healthcare providers to clients
- Out-of-pocket payments in European countries studies
- Which country has the best healthcare system?

Over the past 20 years, changes in the funding of general practitioners, (outpatient) medical specialists and hospitals in the European countries studied, have focused on incorporating incentives (efficiency and quality) into supply-oriented funding. In recent years new ways of funding have emerged, focussed on quality, performance and efficiency-enhancing incentives for the benefit of the health and well-being of patients.

Payments general practitioners and (ambulatory) medical specialists
Twenty years ago (1997), general practitioners were mainly paid fee-for-service or salary (in health centres). Ten years ago (2007) we mainly see combinations of payments of general practitioners (fee-for-service, capitation with or without salary).
From 2007, combined forms of payments have emerged at general practitioners. Currently, almost all European countries studied have mixed payment systems for general practitioners, usually consisting of salary or capitation combined with extra payments for certain tasks.
A few countries (France, Italy, the Netherlands, Slovakia, UK, Sweden) have introduced payments related to performance (pay-for-perfomance, P4P).
In the Netherlands, general practitioners have a so-called 'segmented' payment system, consisting of capitation-payment and fee-for-serice (segment 1), bundled payments (case payment for specific disease programs) and P4P (segment 3). The funding system for general practitioners in the UK and Slovakia consists of a combination of fixed and variable capitation-payments, performance payments (P4P) and fee-for-service.
In Turkey, GPs receive a reduction in payment if they do not perform certain activities.

Payments of (outpatient) specialists is still mainly based on fee-for-service and salary (public hospitals), but a trend has been started towards combined payments (fee-for-service, capitation) and based on performance (France, Norway, Portugal, Sweden). In Switzerland, specialists have in principle a salary, but in specific managed care models they receive combined payments. In Belgium, Luxembourg and the Netherlands, most in-patient specialists receive a fee-for-service. In Portugal (model B), Sweden and Turkey (public / private) specialists in public hospitals receive a mix of capitation, fee-for-service and P4P.

Payments hospitals
One of the most important reforms in the hospital sector in the period 1997-2007 was the transition from a retrospective (budget based on historical, justified costs) to prospective global budgets, whether or not combined with daily allowances, such as in Belgium, Greece and Switzerland . In some countries, DRG[2]-systems developed and were introduced slowly (Austria, Germany, Italy, Norway and Portugal).

[1] Healthcare in Europe 1997, 2007, 2018 en 2019. The finance and reimbursement systems of 11/22 European countries: Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Norway, , Poland, Portugal, Romania, Slovakia, Spain, Sweden, Switzerland ,Turkey, UK.
[2] Diagnostic Related Groups

Ten years later (2007) we see that in almost all European countries studied, different forms of DRG systems have been/are being introduced and have been further implemented and refined over the last 10 years. The DRG systems are often combined with other forms of payments, such as fixed (prospective) budgets, fee-for-services/ service and activity-related funding. In Norway, hospitals receive a mix of global budgets, activity-related payments and a maximum of 2% bonus (based on quality program). In Sweden, hospitals are financed by global budgets, whether or not, combined with DRGs and P4P (Karolinska University Hospital).

In recent years, new forms of payments have emerged, releasing the traditional funding of the healthcare providers described above, such as:
- Specific activities: including care coordination and prevention activities (Italy, France).
- Target groups (bundled payments): consisting of payment per chronic patient that covers the costs of all care services provided by the full range of care providers during a certain period.
- Population groups: population-based payments to groups of healthcare providers, such as independent primary care physicians, specialists, practice networks or hospitals, who cover most healthcare services for a defined group of the population (Gesundes Kinzigtal in Germany).

These new forms of payments contain quality, performance and efficiency-enhancing incentives, with which an attempt is made to limit the established (financial) interests of care providers for the benefit of the health and well-being of care recipients.

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