Notes on Contracting Health providers

- These notes are concerned with a non-integrated system, which assumes a contractual relationship between a Risk pooling entity (also referred to as a third party payer, (TPP), i.e., an insurance company, social insurance, government...etc) and health care providers; and therefore transaction cost economics.
  - If the TPP and health care providers are the same entity the system is said to be integrated.
- Types of Reimbursment
  - Payment per case
    - Prospective payment: price is set before treatment therefore financial risk is felt by the hospital
    - Retrospective payment: price is set after treatment therefore risk is felt by the TPP
  - Historic block grant (block contracting): a large sum of money is paid to the hospital for the predicted future patronage. The amount is based on a historic appraisal of past patronage.
    - Means that financial incentives are not as salient, and administrations must be used to control hospital behaviour.
    - This seems to me to be pretty close to, if not actually, an integrated system
  - Per diem: payment per patient days in hospital
  - National pricing: the budget is fixed nationally, which means that activity in one hospital comes at the expense of another, i.e., people can choose which hospital to go to meaning that the patient ceiling is relaxed at the hospital level, but more or less fixed at the national level.
- Problems with reimbursement
  - Diagnosis resource group (DRG): patients are placed in a category based on their diagnosis and therefor predicted treatment
    - DRG drift: hospitals may tend to put patients in a more expensive DRG and therefore must be monitored (which is expensive and an ex post transaction cost)
  - Data in health systems
    - We see that funding in many systems is based on historical data, but the quality of data may have an impact on funding
      - Note: this is more of a health policy analysis than one done by transaction cost economics
- Integration does not mean a public system, insurance companies are often forced to own hospitals themselves in order to provide cheap enough care (HMOs are like this in the states but it should be clear that these only serve members of the HMO and not the population in general
- Side point: New institutional economics
  - Is concerned about the contractual relationships between firms, relative power, exploitation, etc. And how these relationships compromise efficiency
  - Existed before economics was concerned with competition in this area
- Costs of making a market
  - Contracting takes place in a market therefore we can talk about the ex ante costs as “market costs”. This demonstrates that markets come with a price.
- Budget constraints

  - Soft: if you go over budget you get bailed out, this is common in an integrated system
  - Hard: if you go over budget you go bankrupt, common in a non-integrated systme
- Levels of de-integration: the policy question is do the increases in efficiency gained from a marketization of healthcare outway the transaction costs of creating it.
  - Full Management (Hierarchial
  - Internal Market (Purchaser(TPP)/provider split, but providers are still government bodies. I think this is what is happening in England
  - Full Market: what it sounds like, TPP and providers all exist in a market
- What happens to residual claims: the money left over after the contract has be fulfilled
  - The contract likely covers operating expenses
    - Does the contract include money for capital spending (money on new equiptment or facilites)
    - Providers may need to use residual claims to make these capital investments.
  - Incentives to operate efficiently depend on two factors
    - Ability to make a surplus (residual claim)
    - And ability to keep it.
- Beck and Pedistal, 2002 - On TCE as applied to ownership