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Letter to the Editor

Insight into Provider Payment Mechanisms in Healthcare Industry: A Case of Iran

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Dear Editor-in-Chief

Planning for reforms in payment methods and determining which payment method better achieves cost savings, provides the right level of care for patients and improves their outcomes, has long been an issue of debate among healthcare providers, research scholars, health authorities and patients (1).

The provider payment reform in Iran has been the subject of long-standing controversy, as treated as a function of the politics, policies, and practices that surround it. It is now one of the major priorities of Ministry of Health and Medical Education (MOHME) (2). Through a national survey of all medical university chancellors, MOHME found that for more than 80% of those chancellors the current payment methods to providers have led to chaos in health sector (3).

This study aimed to develop a potential model of payment for healthcare providers at all levels of healthcare delivery in Iran. This is the first attempt to propose healthcare provider payment mechanisms (PPMs) which possibly fits the three levels of healthcare delivery in the country.

Our findings tentatively showed that adjusted capitation payment is a beneficial payment method at the first level of healthcare delivery. This payment method should adjust according to socioeconomic status (SES). It is stated that adjusted capitation payment method may benefit socioeconomically disadvantaged patients with poor health conditions (4).

The challenges faced by the health system may add further complexities to PPMs at the secondary and tertiary levels of healthcare delivery. This may reflects the lack of an effective and well-organized payment system in the country (2, 3). At these two levels, the combination of diagnosis related group (DRG) and pay for performance mechanisms are great options for inpatient sector (5).

A few developing countries such as Turkey have also applied DRGs, resulted in a positive change in provider payment (6). Scientific evidence shows that this mechanism can result in improving the hospital efficiency, reducing unnecessary

length of stay and strengthening the appropriate use of medical resource (7).

Previous studies suggest that hospitals applying pay for performance mechanism have experienced greater quality of care, as it offers incentives to healthcare providers in order to achieve their goals by e.g. improving preventive care and establishing and utilizing information technologies (8).

In addition, the fee for service (FFS) payment method was considered to be effective in outpatient departments. In this case, relative value units (RVUs) fee schedules would improve more than what it used to be (9). RVU is considered as an objective measurement to gauge the cost of healthcare services more realistically and to assists PPM system move towards value-based health services as well. In some countries like Japan, FFS payment method is combined with a nationwide price setting system in order to control costs. In other countries such as USA, FFS payment method is implemented especially in private sector ambulatory care with satisfactory results. In these contexts, patients feel more satisfied with their access to health services, and providers can also provide quality health care which would ultimately result in their patients' satisfaction (10).

Due to the limitations of the current payment methods, we considered different assumptions in order to design an appropriate PPM model which suits financial systems across all levels of healthcare delivery. It is evident that the Iranian healthcare delivery policy has shifted to privatization in some area of hospital services, and as such historic or planned budgeting mechanisms will not efficient enough for delivery of needed care. There is a possibility that out-of-pocket expenditure will decline due to private fees being competitive or cheaper and services being better than that of other healthcare providers. Fee-for-service payments cannot merely enhance the reimbursement rates for in-patient and out-patient admissions unless it is accompanied by other mechanisms such as DRGs. It is at this interface that we can expect providing useful incentives to reduce unnecessary costs (11).

No single method has proved superior to others. The hybrid system has the potential to balance the opposing influences, and thus has the potential to complement disadvantages of various methods. Some of the modes require high levels of infrastructure, and this is strongly emphasized for developing countries. Establishing reliable regulation system and, at the same time, encouraging competition in both public and private sectors would also improve the performance of PPMs.

The key to success of this hybrid model would be step-by-step implementation and monitoring of the mechanisms. This would help navigate the change over the time, and mitigate the possible negative effects. Finally successfully implementation of such interventions requires both internal and external collaboration of all stakeholders in the country.

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