Characterization and analysis of the basic elements of health payment mechanisms and their most frequent types

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Abstract

Introduction

Healthcare systems are developed in imperfect scenarios, in which there are constant failures (uncertainty, information asymmetry, agency relationship problem, and supply-induced demand). These failures, based on the imperfection of the sector, determine the relationships and incentives between the actors. It is within this context that payment mechanisms regulate aspects of the system behavior and incentives, acting as instruments for the purchasing of health care from providers, mediated by health insurance on behalf of users.

Objective

To characterize the basic elements of most frequent payment mechanisms to help providers in their relationship with payers.

Methods

A review of the evidence was conducted in PubMed, Google, Google Scholar, and strategic snowball selection. Payment mechanisms consist of three classical microeconomics variables, fixed or variable: price, quantity, and expense. Time dimensions are used to analyze their attributes and effects. Different mechanisms emerge from the combination of these variables.

Results

Among the most used are: Fee-For-Service, Global Budget, Bundled Payments, Diagnosis-Related Groups, Per-capita, Performance Pay, and Risk-Sharing Agreements. A fourth has also gained importance: Financial Risk.

Conclusions

Payment mechanisms are essential to link health efforts with clinical practice. They make it possible to regulate relationships between insurers, providers, and users, which, depending on the architecture of the mechanism, can become beneficial or hinder the fulfillment of the objectives of the health system.

Palabras clave

Palabras clave de autor:reimbursement mechanisms; insurance; health; reimbursement
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Editorial

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