Lecture 9:
Remuneration of general practitioners

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<table>
<thead>
<tr>
<th>Teaching programmes:</th>
<th>Master of Public Health, University of Tromsø, Norway</th>
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<tr>
<td></td>
<td>HEL-3007 Health Economics and Policy</td>
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<td></td>
<td>Master of Public Health, Monash University, Australia</td>
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<td>ECC-5979 Health Economics</td>
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<td>Master of Health Administration, Monash University</td>
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<td></td>
<td>ECC-5970 Introduction to Health Economics</td>
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Who knows what best?

- \( U = u[H(HC)] \)

- The doctor is the best to know: \( H = h(HC) \)
  - i.e. the production function

- The patient is the best to know: \( U = u(H) \)
  - i.e. the utility function

- How should we pay doctors to make them keep one eye on the production function and the other on the *patient’s* utility function?
3 ways to pay GPs

• Dependent of activity
  – Fee-for-service
  – Capitation

• Independent of activity
  – Salary

Nothing is perfect!

“There are many mechanisms for paying physicians: some are good and some are bad. The three worst are fee-for-service, capitation and salary. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of ‘ping-pong’ referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure and fosters a bureaucratic mentality in which every procedure is someone else’s problem”

1. Fee-for-service (FFS)

- Paid by patients, out of pocket
- Reimbursed by third party

→ The more services the GP provides, the higher their income

Supplier induced demand, SID

- Defined: Demand in excess of what would be chosen if patient had available the same information and knowledge as the physician

- Roemer’s Law: “a hospital bed built is a bed filled”
  - a positive correlation between the number of short-term general hospital beds available and the number of hospital days used

- More generally, when faced with increased supply (provider entry), health care providers respond by ‘inducing demand’ (shifting the demand curve) for their services
Supply & demand for GP-services

Increased supply
Supplier-induced-demand, $D_2$ – or an elastic demand, $D_0$?

Supplier-induced-demand might be weak, $D_W$, or strong, $D_S$. 
How likely are these scenarios?

• Context specific:
  – What incentives are there to induce demand?
  – What constraints are there on inducing demand?
  – Differences across disease areas – headache vs cancer (severity of consequences, repeatability)

• Significant factor is structure of health system
  – Patient payment
  – Doctor reimbursement

• But problems in identifying (degree of) SID

2. Capitation

• List patient system
  – Organisation model, ‘family doctor’
  – Reimbursement model

• Two different reimbursement models
  – Flat rate per patient on the list
  – Needs-adjustment depending on how ‘heavy’ patients are

→ The more patients on the list, the higher the income
→ The more substitution of own service provision with referrals to specialist care, the lower own costs (i.e. higher net income)
3. Salary

- Depends on number of hours worked
  - No financial motivation to increase efforts or productivity

- Income-leisure trade-off
  - Higher wages are required in compensation for more hours worked

Trade-off between income vs leisure
Trade-off between income vs leisure:

Case I: Higher wage → more work

Case II: Higher wage → less work
Two effects pulling in opposite directions

• Income effect
  – With higher income, you can afford to demand more leisure
  → You work less

• Substitution effect
  – With higher wage-rate, leisure becomes more expensive, so you demand less of it
  → You work more

Salary: $I = w \times H$

• The more hours we work (H), the higher the income (I)

• The higher the wage rate (w), the higher the income (I)

• The higher the wage rate, the more we work??
A backward bending supply curve for labour

Trade-offs: income vs leisure
Increasingly higher overtime wages → more work
What we know and what we don’t know

• We know
  – A combination of low basic wage rate and increasingly higher overtime rates lead to higher labour supply than if the same total salary came in terms of one higher base rate irrespective of the number of hours worked

• We don’t know
  – The net effect of an increased base wage rate
    • Culture dependent
    • Absolute or relative income ("target income" hypothesis)

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Key characteristics of GP payment systems

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<th>Fee for service</th>
<th>Capitation</th>
<th>Salary</th>
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<tr>
<td>Behavioural response</td>
<td>Increase provision of services to all patients</td>
<td>Keep all(?) patients satisfied (at least those who need few services)</td>
<td>‘The patient in front of me shall be my only consideration’</td>
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<td>Negative effects</td>
<td>Overprovision of own services Supplier induced demand (SID)</td>
<td>Underprovision of own services Cream skimming</td>
<td>Cost-inefficiency in primary care Waiting time</td>
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<td>Cost control within primary care</td>
<td>Bad</td>
<td>Good</td>
<td>Very good</td>
</tr>
<tr>
<td>Gate keeping</td>
<td>Good</td>
<td>Bad</td>
<td>Good</td>
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Blended systems

- When no single payment system is perfect, combined systems emerge

- Standard GP contract in Norway
  2/3 fee-for-service
  1/3 capitation