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Journal of Health Economics 22 (2003) 419–443
JOURNAL OF HEALTH ECONOMICS
www.elsevier.com/locate/econbase

Cream-skimming, incentives for efficiency and payment system

Pedro Pita Barros*

Faculdade de Economia, Universidade Nova de Lisboa, Travessa Estêvão Pinto, P-1099-032 Lisboa, Portugal

Received 2 November 2000; received in revised form 17 July 2002; accepted 24 October 2002

Abstract

Reform proposals of health care systems in several countries have advocated variations of a risk adjustment/capitation system. These proposals face a serious objection: incentives to risk selection are prevalent in the system. By now, considerable literature has been devoted to finding ways of mitigating, if not eliminating, this problem, while at the same time preserving incentives to efficiency. We contribute to this debate presenting a transfer system that, under some circumstances, attains both provider efficiency and no risk selection. The transfer system extends typical linear payment systems. It can be interpreted as a fixed transfer in the beginning of the period plus an ex-post fund at the end of the period. The novelty rests in the way contributions to this fund are defined.
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JEL classification: I11; I18

Keywords: Payment system; Health care financing

1. Introduction

The increasing relevance of the health care sector in modern economies, and the numerous reform attempts around the world, are well documented by now. One reform proposal in several instances is the development of sophisticated financing schemes involving capitation transfers from a funds' collector (the Government, for example) to health care purchasers and/or providers (the purchaser can coincide with the provider, as in HMOs and fund-holding GPs). Such transfers call for adequate risk adjustment. Following Keenan et al. (2001), formal risk adjustment is defined as the adjustment of premiums paid to health plans (or

* Tel.: +351-213-886-73; fax: +351-138-860-73.
E-mail address: ppbarros@fe.unl.pt (P.P. Barros).

0167-6296/03/$ – see front matter © 2003 Elsevier Science B.V. All rights reserved.
PII: S0167-6296(02)00119-4

to insurance companies) based on a formula employing individual level diagnostic and/or demographic information. Capitation systems and risk adjustment have been used in The Netherlands, Israel, and the United Kingdom, among other countries. A similar system appears in proposals for the US, characterized by a single payer contracting with competing health plans (Newhouse, 1994). The issue of risk adjustment is also important in the US context, as clear incentives for risk selection in health plans have been empirically identified (Newhouse et al., 1997).[1]

Two main problems with this approach have been exposed in the literature, and several remedies to mitigate them have been put forward. The problems are risk selection, on the one hand, and providing incentives to efficiency of health care delivery, on the other hand.

Cream-skimming means selection by providers (or entities responsible for health care provision) of those consumers expected to be profitable, given the system of risk-adjusted capitation payments. A central element of health systems in some countries is a capitation system against which providers can play strategically.

Avoidance of cream-skimming has been discussed along two main lines: adequate risk adjustment and pro-competitive regulation. The latter typically involves open enrollment rules and definition of standardized benefits. The former encompasses two aspects extensively investigated: the refining of the risk-adjusted capitation, and imposition of some sort of high-risk pooling.[2] The risk selection issue is far from being settled. In a recent account by Newhouse (1998) a pessimistic picture of future prospects is drawn, as the following quote illustrates:

> The physician treating the patient will have more information about the patient's likely future spending than the risk-adjustment formula will incorporate. As a result, the incentives to cream and dump will remain.

The recent paper by van de Ven et al. (1998) discusses the current difficulties in improving capitation formulas by estimation of average risks. Marginal improvements in the capitation formula are obtained at a considerable research cost. Moreover, it is argued that avoidance of cream-skimming requires strong regulations and possibly some sort of mandatory high-risk pooling. In the papers by Shmueli et al. (1998) and Smith (1998), the same type of analysis is carried out, in the sense that both attempt to econometrically approximate risk-adjusted capitations.[3] Newhouse (1996b) states that current adjustments to capitated payments do leave substantial "between-person variance in expected health care costs unexplained." Nonetheless, in a recent work, van de Ven et al. (2000), based on simulations of risk-adjusted premiums, conclude that such risk-adjustment is the appropriate strategy to avoid risk-selection and dumping of patients.

Another way to proceed is to recognize the difficulties in estimating risk-adjusted capitations, which must not be vulnerable to superior information by recipients. This leads

[1] For a detailed analysis of risk adjustment mechanisms in several countries, see van de Ven and Ellis (2000), Tables 5 and 6. Another recent account of the importance of defining appropriately the payment system can be found in the special issue of *Health Care Management Science* in 2000, devoted to risk adjustment and capitation. See Rice and Smith (2000).

[2] The literature on risk adjustment is too vast to be fully reviewed here. See the recent overview by van de Ven and Ellis (2000).

[3] See also van Vliet and van de Ven (1992).

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