Aligning incentives and managing the conflict of interest between providers and payers

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What comes to mind first
Weaknesses of traditional ways of paying providers for chronic care

Fee-for-service
* Ill patients usually attractive
* Overprovision of Services
* Underreferral
* No incentive for high quality

Case payments
* Very ill patients not attractive
* Tendency to average provision
* Weak quality incentives

Capitation
* Ill patients not attractive
* Underprovision of services
* Overreferral
* Quality: bad results -> more work

* No incentives for appropriate continuity of care across providers
Current approaches

Focus on

• Access
• Quality of structures (e.g. DMPs - disease management programmes, registers), processes (e.g. appropriateness of services and referrals, recruiting for DMPs, documentation and procedural quality) and outcomes
• Continuity of care

But do financial incentives support these aims?
## Purpose of financial incentives and regulation for chronic disease care

<table>
<thead>
<tr>
<th>Focus</th>
<th>Purpose of financial incentives</th>
<th>Purpose of other relevant types of regulation</th>
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<tbody>
<tr>
<td><strong>Structure</strong></td>
<td>To implement DMPs, and recruit and enrol patients in DMPs</td>
<td>To implement systems of in-house quality management</td>
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<td></td>
<td>To put in place 'integrated' forms of care (mostly packages that cross institutional/sectoral</td>
<td>To detail structural requirements</td>
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<td>boundaries)</td>
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<td></td>
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<td>To implement systems of data collection</td>
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<td><strong>Process</strong></td>
<td>To keep patients in DMPs for a target period of time</td>
<td>To mandate evidence based standards (i.e. clinical practice guidelines)</td>
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<td>To ensure that the care protocols specified in DMPs are followed (e.g. in encounters with a</td>
<td>To implement/mandate targets on process measures of quality</td>
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<td>specific provider, over x months)</td>
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<td>To reach predefined targets on process measures (e.g. proportions of patients treated with a</td>
<td>To reach agreement on minimum volume of services</td>
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<td>particular drug)</td>
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<tr>
<td><strong>Outcome</strong></td>
<td>To reach predefined targets (e.g. proportion of patients with outcome x) or to reward the top</td>
<td>To implement/mandate targets on health outcomes and/or patient satisfaction</td>
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<td>y% of providers on an indicator</td>
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Examples of new payment measures

• ‘year of care’ payment for the complete service package required by individuals with chronic conditions (DK)
• Per patient bonus for physicians for acting as gatekeepers for chronic patients and for setting care protocols (F)
• bonus for DMP recruitment and documentation (D)
• 1% of overall health budget available for integrated care (D)
• bonuses for reaching structural, process and outcome targets (UK)
• ‘pay-for-performance‘ bonuses (US)
Paying for chronic care quality in the UK:
bonus of € 190 per quality point up to 1050 points

<table>
<thead>
<tr>
<th>Type</th>
<th>Indicator</th>
<th>Points</th>
<th>Target Range</th>
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</thead>
<tbody>
<tr>
<td>Structural</td>
<td>Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday.</td>
<td>1.5</td>
<td>yes/no</td>
</tr>
<tr>
<td>Structural</td>
<td>The practice establish a register for patients with stroke or TIA</td>
<td>4</td>
<td>yes/no</td>
</tr>
<tr>
<td>Process</td>
<td>The percentage of patients with history of myocardial infarction who are currently treated with an ACE inhibitor.</td>
<td>7</td>
<td>25%-70%</td>
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<tr>
<td>Process</td>
<td>Patient Survey: The practice will have undertaken an approved patient survey each year</td>
<td>40</td>
<td>yes/no</td>
</tr>
<tr>
<td>Outcome</td>
<td>The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less.</td>
<td>17</td>
<td>25%-55%</td>
</tr>
<tr>
<td>Outcome</td>
<td>The percentage of patients age 16 and over on drug treatment for epilepsy who have been convulsion-free for last 12 months recorded in last 15 months</td>
<td>6</td>
<td>25%-70%</td>
</tr>
</tbody>
</table>
Paying for chronic care quality in the UK:

- bonus of € 190 per quality point up to 1050 points

- Practices reached 91% of all points in first year, 96% in the second year
- for an average bonus of € 190,000/ year (or € 1.5 billion for the NHS)!
- i.e. documented “quality“ went up, e.g. 100,000 persons were newly diagnosed with diabetes: prevalence from 3.3 to 3.6%
- Younger, middle-class patients more popular with GPs (higher compliance) -> access problem
Very few well conducted trials (9!) – mainy on prevention and only one on chronic care!
Issues in Pay-for-Performance (P4P) design

• Individuals vs. groups (institutions, all physicians in one department)
• Paying the right amount (US: 9% of income)
• Selecting the right performance measures
• Paying for improvement vs. reaching threshold (US: 70% threshold, 25% improvement)
• Priority for quality improvement of underserved populations?
BUT

If third-party payers/purchasers spend appropriately more for chronically ill, then they will

• charger higher premiums/contributions
• cream-skim potential insurees
• need to be adequately funded from the pooled resources
An extended framework

Financial pooler \rightarrow Payer/ purchaser

(Re-)Allocation

Resource generation: taxes, contributions, premiums

Financing of chronic care/ DM

Cost-sharing & direct payments

Population/ patients

Provider payment/ reimbursement

GP
Specialist Nurse
Hospital Providers

A
B
C
D
„Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism (2006)

Avg. 5.20€/ day
The well-known 20/80 distribution – actually the 5/50 or 10/70 problem
14% meet threshold of > 1.5fold avg. expenditure
Chronic patients’ cost-sharing – traditional approaches

• no co-payments for services related to their disease, e.g. ‘ALD’ (30 mainly chronic diseases) in France

• lower annual limits on co-payments

• certain drugs require lower cost-sharing if the indication is deemed serious
Chronic patients‘ cost-sharing – newer approaches

- ‘ALD’ exemption only if care protocol is established for each patient by their GP and signed by patient (France since 2004)
- cost-sharing may be reduced or waived if patients enrol in DMPs
- patients with chronic conditions/complex needs managed via a care plan/ inscribed in DMP receive rebates (Australia) or additional services (Germany)
- ‘ALD’ exemption only if protocol is presented to every treating physician at each visit (France)
- lower cost-sharing limit applies only if patient is compliant (Germany from 2007)
“Risk-adjusted” capitation: What is risk? Can risk be measured by treatment parameter (hospitalization, drug prescriptions)? Should DMP participation increase or decrease capitation?

Financial pooler → Payer/ purchaser

Non-risk related contribution/ premium
Bonus for DMP participation?

Fee-for-service/ DRGs: Bad outcomes = more money?
Outcome-/ quality-based compensation: Does it work? What is the right balance?

Financing chronic care: political and research agenda

Population/ patients

Cost-sharing: Reduction? Specific limits? Only for compliant patients?

GP
Specialist
Hospital
Nurse
Providers
Chapter 9: Paying for chronic disease care
Reinhard Busse and Nicholas Mays