Technische Universität Berlin

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

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European Observatory on Health Systems and Policies

World Congress

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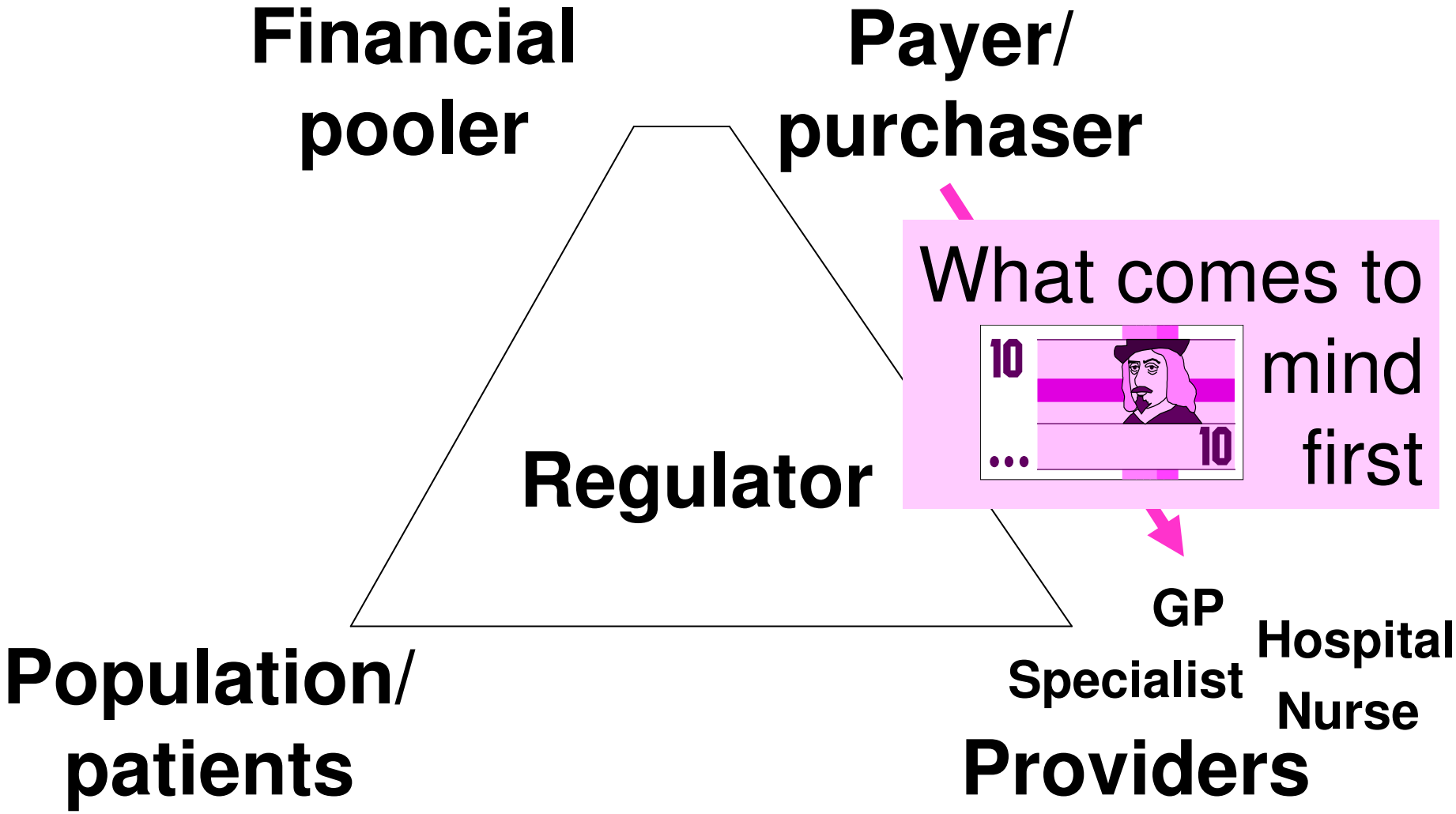
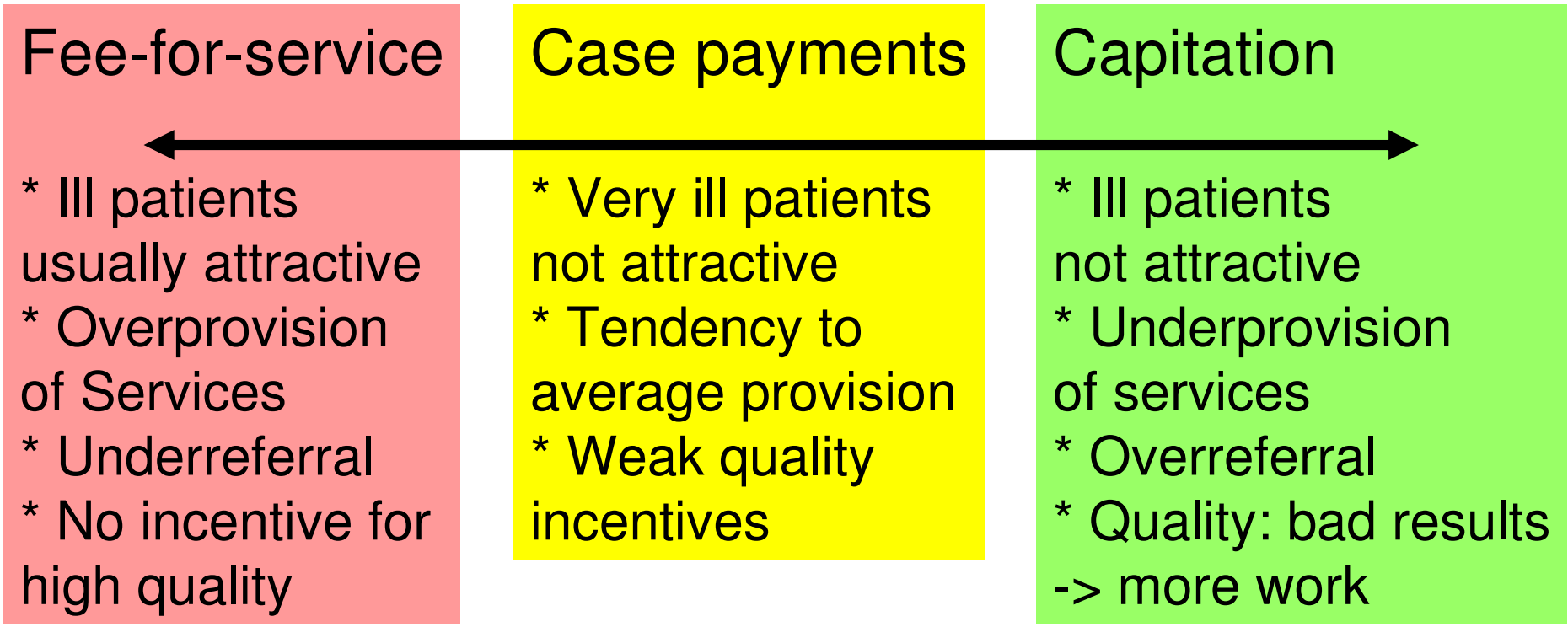

Financial pooler
Payer/ purchaser
What comes to mind first
10
10
Regulator
GP
Specialist
Hospital
Nurse
Population/ patients
Providers

# Weaknesses of traditional ways of paying providers for chronic care




* 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

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

# Examples of new payment measures

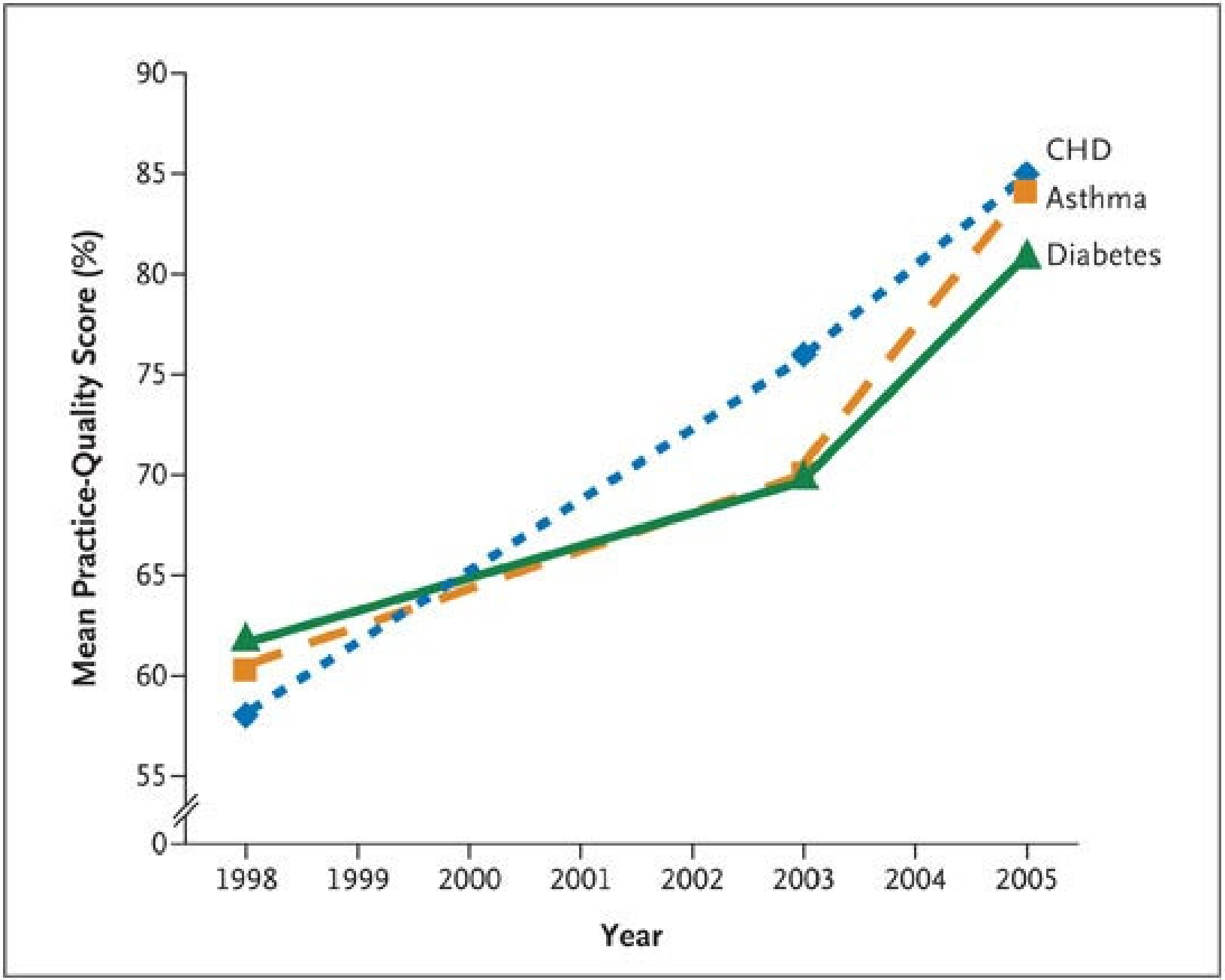
- ‘year of care’ payment for the complete service package required by individuals with chronic conditions (DK)
- Per patient bonus for physicians for acting as gatekeepers for chronic patients and for setting care protocols (F)
- bonus for DMP recruitment and documentation (D)
- 1% of overall health 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

**Examples of indicators, targets and point values in the GP contract**

| Type | Indicator | Points | Target Range |
|---|---|---|---|
| Structural | 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. | 1.5 | yes/no |
| Structural | The practice establish a register for patients with stroke or TIA | 4 | yes/no |
| Process | The percentage of patients with history of myocardial infarction who are currently treated with an ACE inhibitor. | 7 | 25%-70% |
| Process | Patient Survey: The practice will have undertaken an approved patient survey each year | 40 | yes/no |
| Outcome | The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less. | 17 | 25%-55% |
| Outcome | 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 | 6 | 25%-70% |


Mean Practice-Quality Score (%)
90
85
80
75
70
65
60
55
0
1998
1999
2000
2001
2002
2003
2004
2005
Year
CHD
Asthma
Diabetes

# 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

TECHNICAL REVIEW SUMMARY

# Strategies To Support Quality-based Purchasing: A Review of the Evidence

Agency for Healthcare Research and Quality

2004

www.ahrq.gov

## Introduction

Deficiencies in quality have been widely documented in the U.S. health care system. A recent component of purchaser response to these data has been the pursuit of quality-based purchasing (QBP). However, purchasers have been uncertain both

In this report,[1] we sought to describe and evaluate the evidence regarding the effectiveness and potential of QBP strategies to improve the quality of care provided in the U.S. health care system. For this report, QBP is defined as payment or reputational strategies aimed at providers that individual employers, employer coalitions, or

Very few well conducted trials (9!) –
mainly on prevention and only one on chronic care!

# Issues in Pay-for-Performance (P4P) design

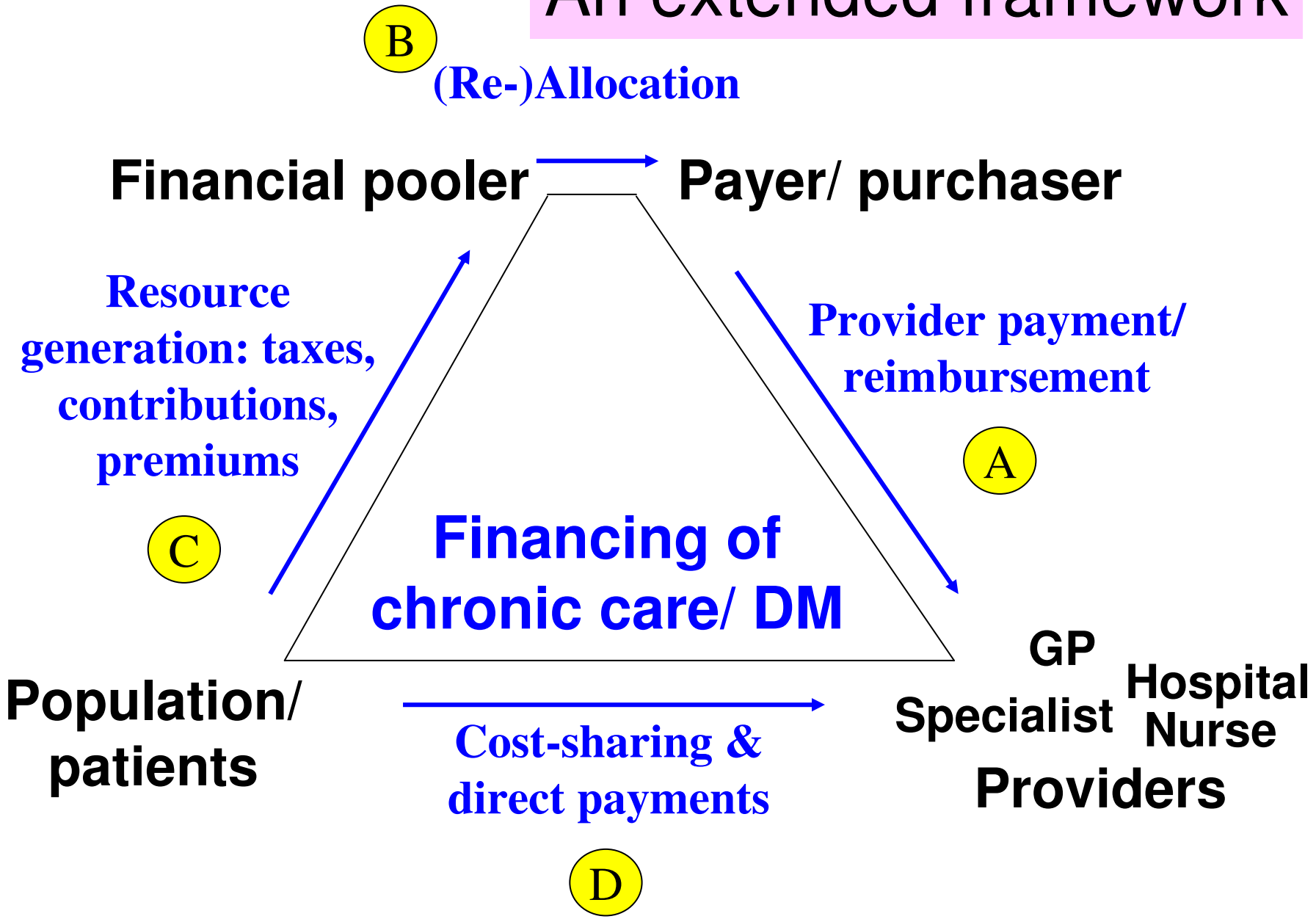
- Individuals vs. groups (institutions, all physicians in one department)
- Paying the right amount (US: 9% of income)
- Selecting the right performance measures
- Paying for improvement vs. reaching threshold (US: 70% threshold, 25% improvement)
- Priority for quality improvement of underserved populations?

# BUT

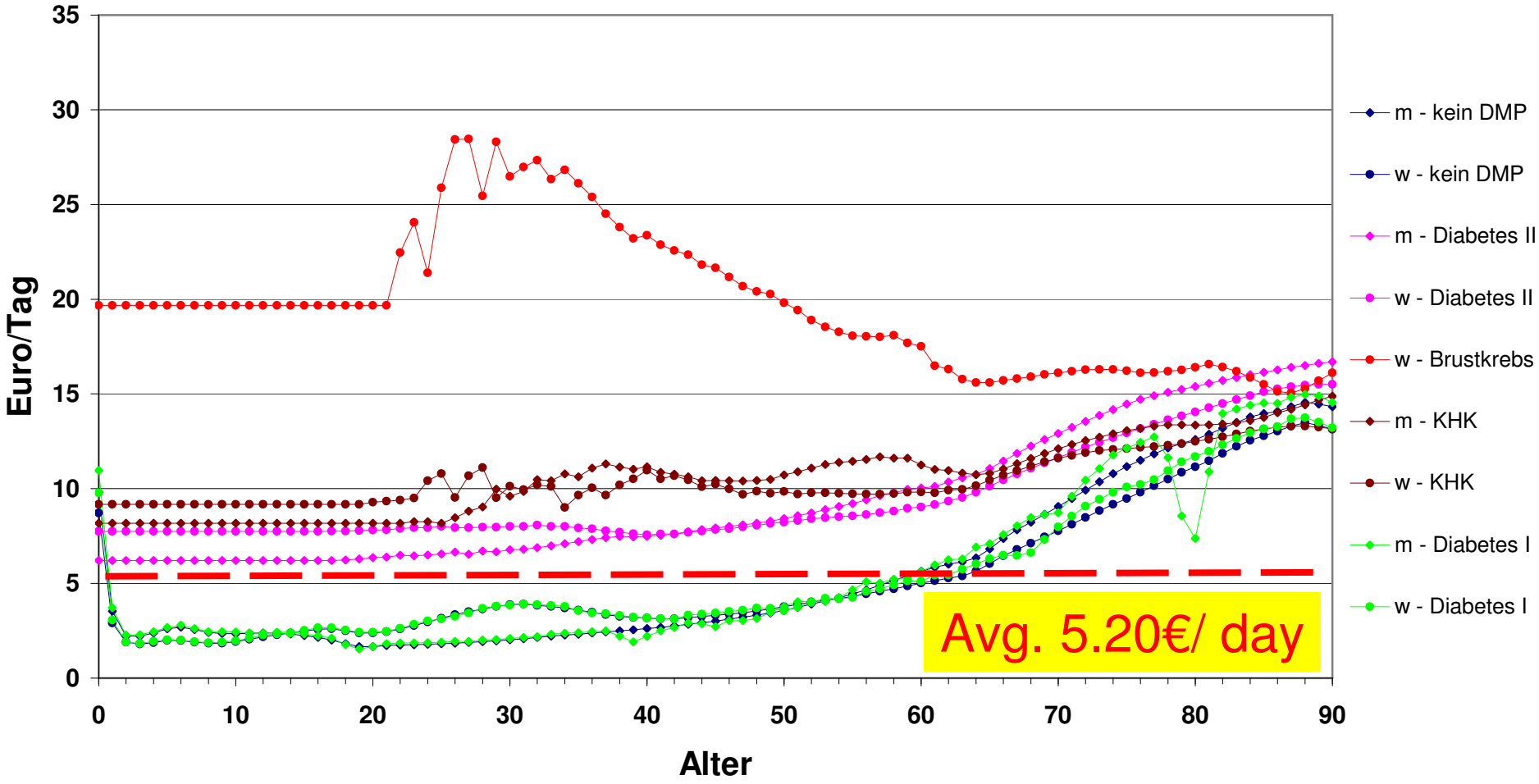
If third-party payers/ purchasers spend appropriately more for chronically ill, then they will

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

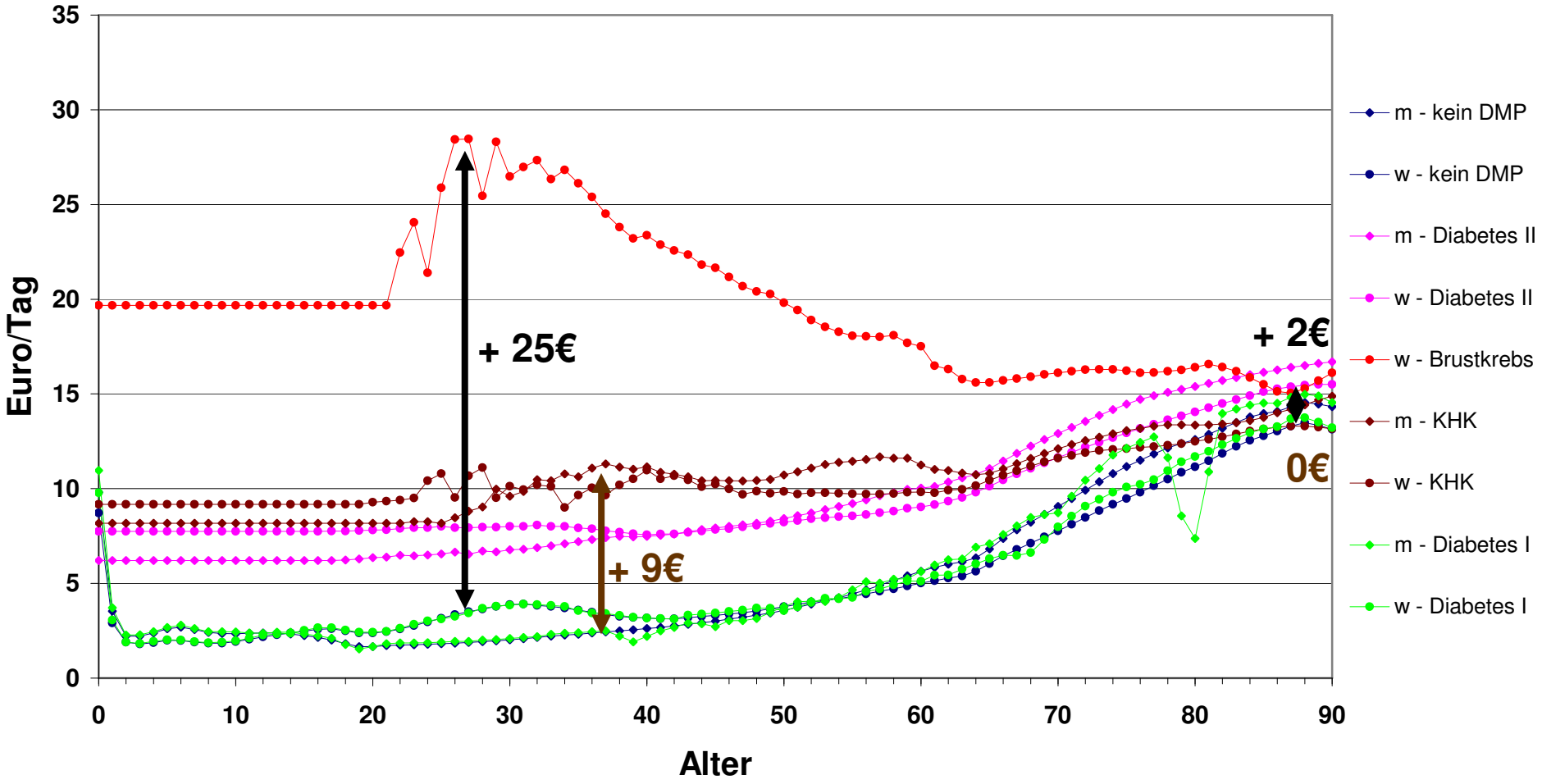
# An extended framework



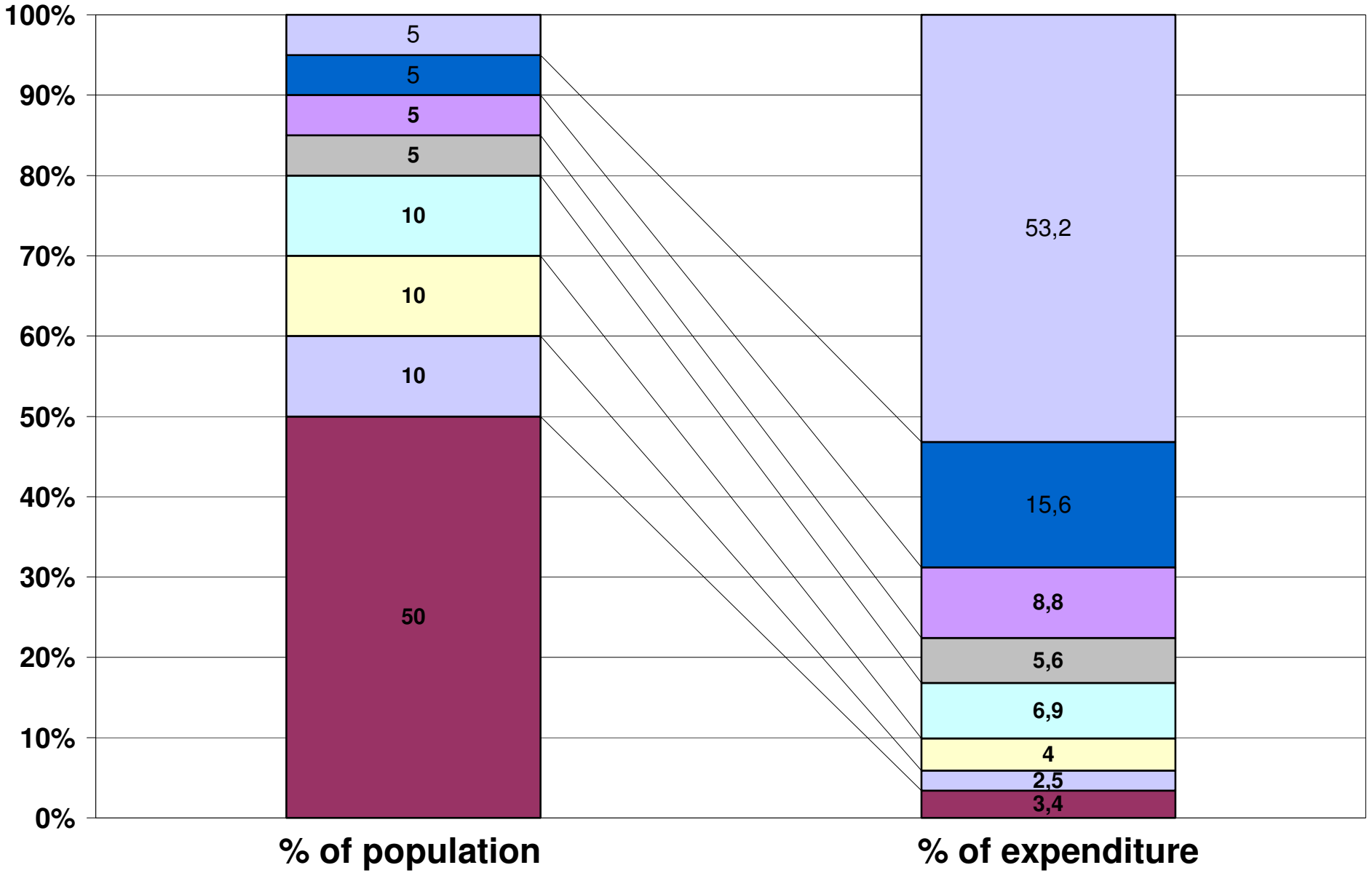
# „Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism (2006)

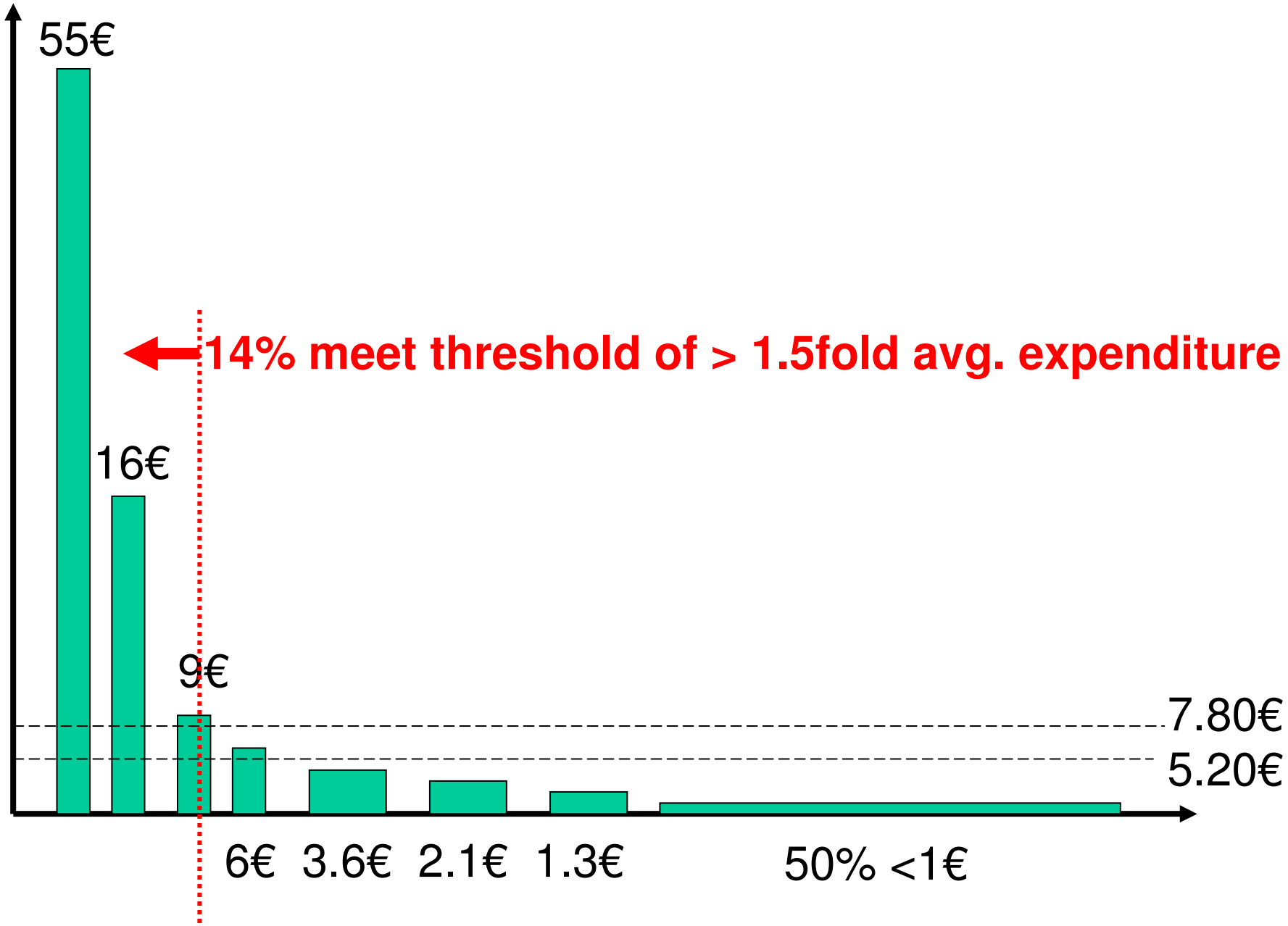


# Effect of „illness“ by age differs greatly (2006)



# The well-known 20/80 distribution – actually the 5/50 or 10/70 problem




55€
14% meet threshold of > 1.5fold avg. expenditure
16€
9€
7.80€
5.20€
6€
3.6€
2.1€
1.3€
50% <1€

# 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

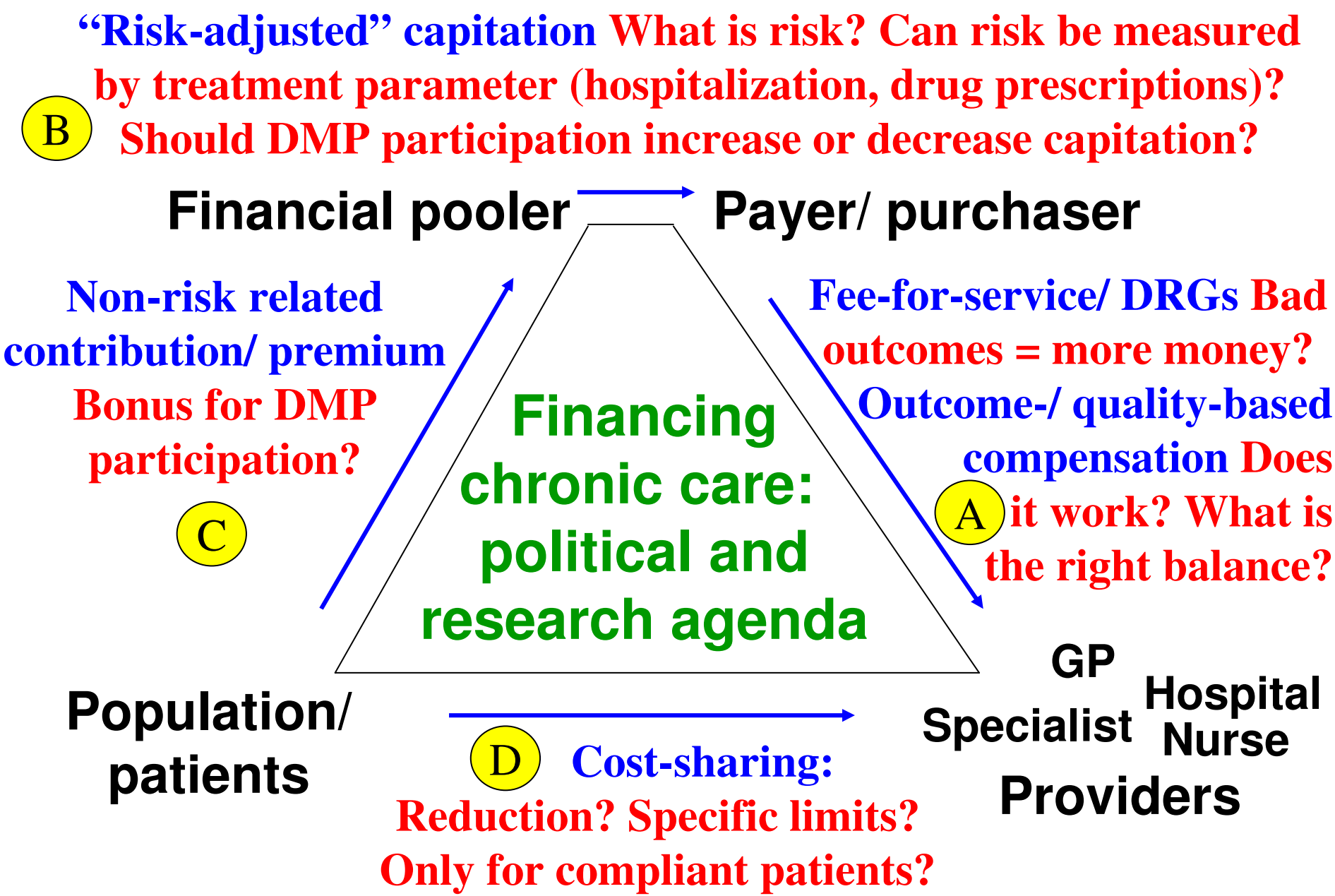
# Chronic patients‘ cost-sharing – newer approaches

- ‘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)

STRUCTURAL QUALITY

- ‘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)

PROCESS QUALITY


"Risk-adjusted" capitation What is risk? Can risk be measured by treatment parameter (hospitalization, drug prescriptions)?
B
Should DMP participation increase or decrease capitation?
Financial pooler
Payer/ purchaser
Non-risk related contribution/ premium
Bonus for DMP participation?
C
Financing chronic care: political and research agenda
Fee-for-service/ DRGs Bad outcomes = more money?
Outcome-/ quality-based compensation Does
A
it work? What is the right balance?
Population/ patients
D
Cost-sharing:
Reduction? Specific limits?
Only for compliant patients?
GP
Specialist
Hospital
Nurse
Providers

# Full text:

**Chapter 9: Paying for chronic disease care**

Reinhard Busse and Nicholas Mays

In: Nolte E, McKee M, eds. *Caring for people with chronic conditions: a health system perspective*. Maidenhead: Open University Press, 2008, forthcoming

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