Payment systems for contracting family doctors in primary care

Voluntary Exchange with Cyprus
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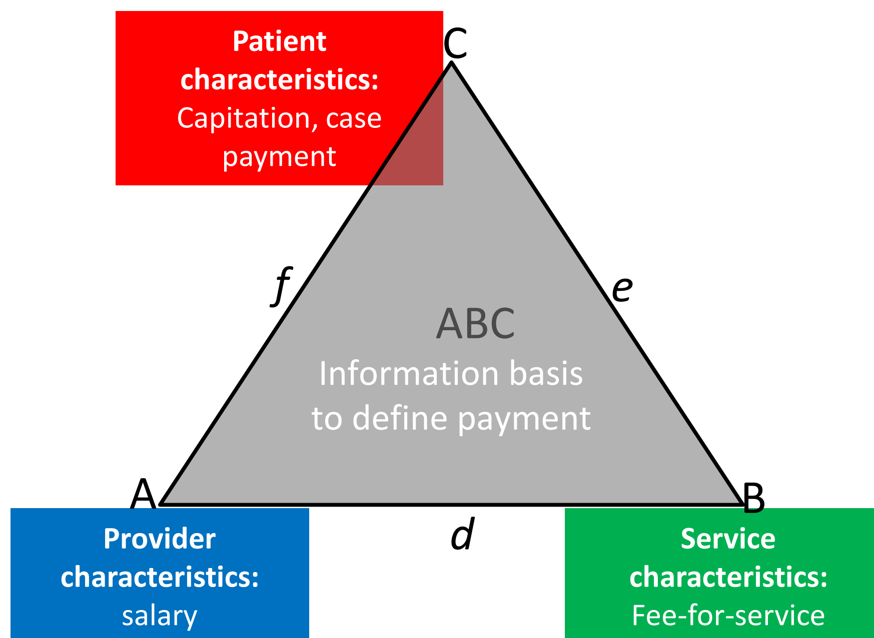
Advantages and disadvantages of different payment mechanisms

Payment mecha-nism	Patient needs (risk selection)	Activity		Expendi-ture control	Technical efficiency	Trans-parency	Quality	Admini-strative simplicity
		Number of cases	Number of services/ case					
Fee-for-service	+	+	+	—	0	0	0	—
Capi-tation	— (if not risk-adjusted)	+	—	+	+	—	0	0
Salary	0	—	—	+	0	—	0	+

A framework for analysis of payment systems



Source: based on Ellis and Miller, 2009

Primary care payment: overview

		Germany	Netherlands	England	Sweden
Objective: appropriateness & outcomes	Quality payment		P4P & bundled payments (10-15%)	QOF bonus (10-15%)	Bonus and/or Malus (max. +/-3%)
Objective: productivity & patient needs	Extra service payment	FFS - uncapped FFS (with caps per service type)	FFS (per visit & out-of-hours), (35-40%)	FFS ("enhanced services"), (15-20%)	FFS (per visit), 10-20%, Stockholm 60%)
Objective: admin. simplicity & cost-containment (& geogr. equity)	Basic service payment	"RLV" (capped FFS) (60-70%)	Capitation (45-50%)	Capitation (70-75%)	Capitation (80-90%, Stockholm 40%)

Information basis: GP payment England: details

	GP costs (in million GBP)
Other (replacements, trainees, IT, admin)	7%
Prescribing	9%
Total Enhanced Services	12%
QOF	8%
Premises	9%
Global Sum and PMS	54%

Y-axis: in million GBP; scale - to 10.000,00

NHS Digital

NHS Payments to General Practice

England, 2016/17

Published 20 September 2017

A framework for analysis of payment systems

too generous

Adequacy of payment

too small (not cost-covering)

Source: based on Ellis and Miller, 2009

Assuring payment adequacy requires cost/expenditure data

GP Earnings and Expenses Estimates

Time Series 2002/03 to 2016/17

£400 000
£350 000
£300 000
£250 000
£200 000
£150 000
£100 000
£50 000
£ 0

GBP 338 300

10%
40%
9%
6%
32%

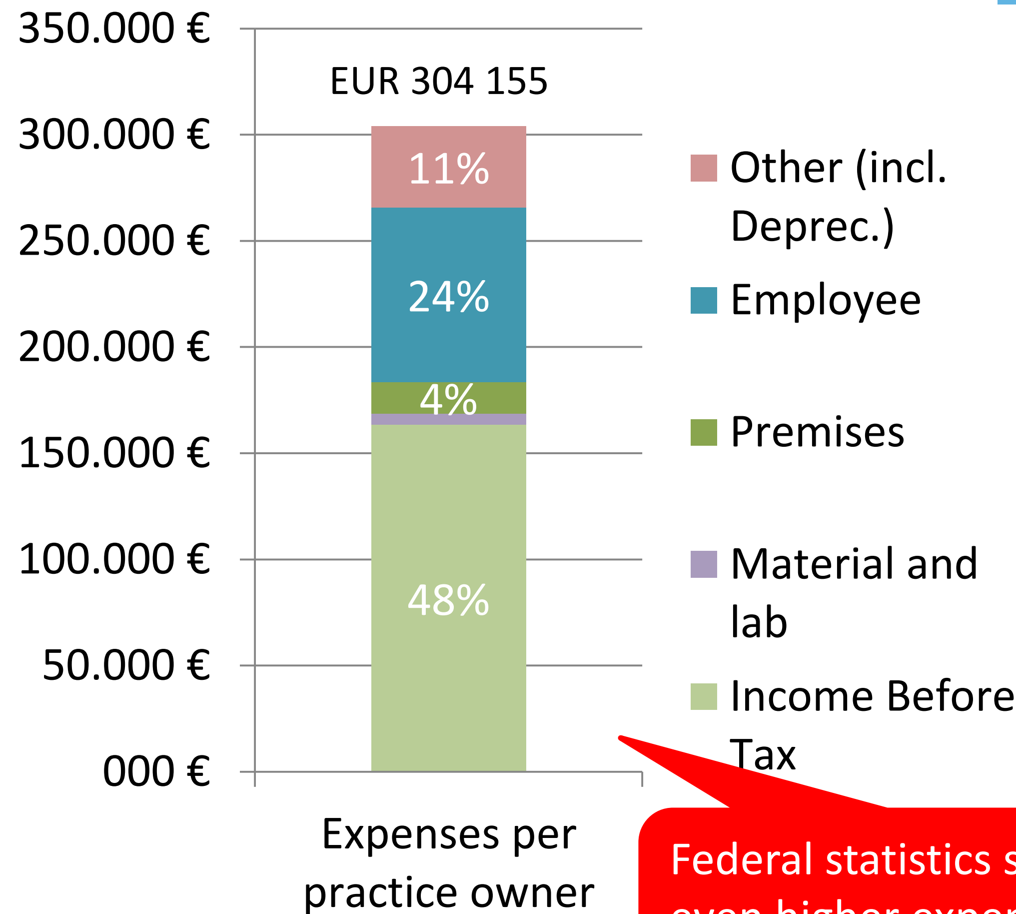
2016/17

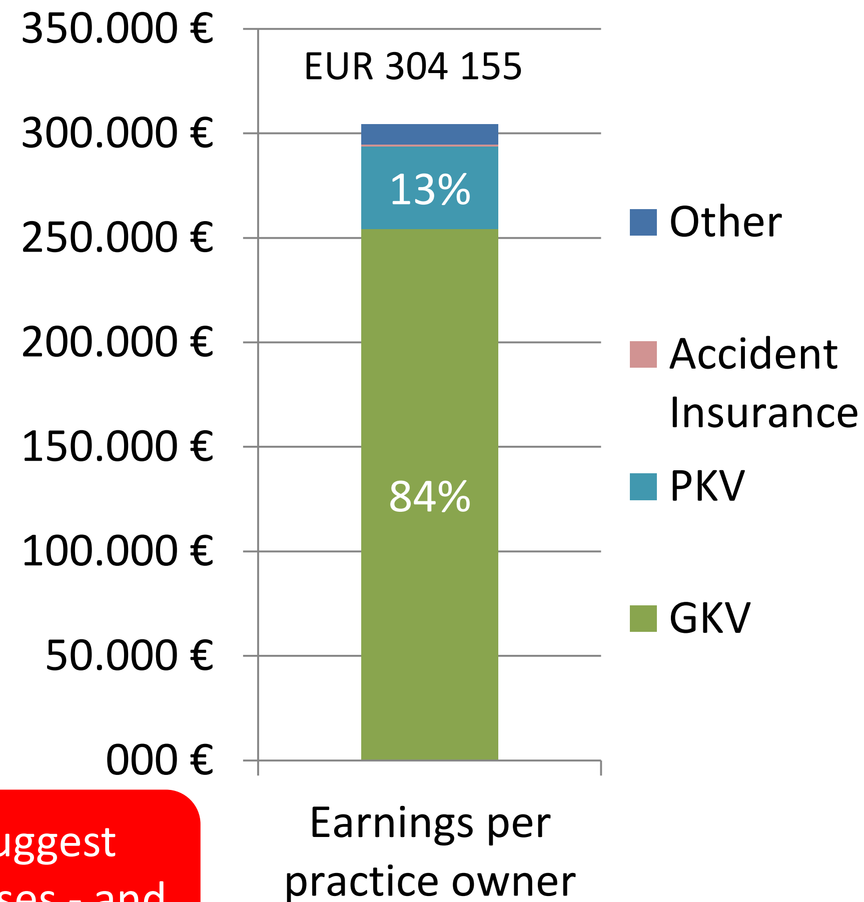
GP gross earnings and expenses

Net Capital Allowance
Other (incl. Depreciation)5
Interest3
Car and Travel
Employee
Premises
Office & General Business2
Income Before Tax

Assuring payment adequacy requires cost/expenditure data

Germany





Federal statistics suggest even higher expenses - and higher incomes

A framework for analysis of payment systems

Scope of payment

(What services, costs, and time are included?)

narrow broad

too generous

Adequacy of payment

too small (not cost-covering)

Patient characteristics: Capitation, case payment

C

f *e*

ABC

Information basis to define payment

A B

d

Provider characteristics: salary

Service characteristics: Fee-for-service

Source: based on Ellis and Miller, 2009

Points to consider concerning scope of payment

- Is the content (in terms of services, costs, time period) of the payment category clearly defined?
- Do additional FFS payments incentivize desired/priority services?
- Is it easy for providers to game the system?

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Source: based on Ellis and Miller, 2009

How fine is the risk-adjustment of capitation

Impossible to adequately adjust capitation payments without cost and utilization data

England:

- age and sex structure of the patient population
- proportion of population in nursing and residential homes
- additional care needs of the population (measured by survey data)
- additional work effort related to new patients (require more work)
- factors outside the control of providers, e.g. higher wage costs and rurality

BUT very different weightings exist across countries
→ Even Scotland is very different!

Age-sex workload index (males aged 5-14 = 1) for UK except Scotland

	0–4	5–14	15–44	45–64	65–74	75–84	85+
Male	3.97	1	1.02	2.15	4.19	5.18	6.27
Female	3.64	1.04	2.19	3.36	4.9	6.56	6.72

Source: (BMA/NHS Employers, 2007)

A framework for analysis of payment systems

Scope of payment
(What services, costs, and time are included?)

narrow

broad

too generous

Adequacy of payment

too small (not cost-covering)

coarse

Fineness of payment

fine

Patient characteristics: Capitation, case payment

C_q

C

Quality

f

e

ABC
Information basis to define payment

A_q

B_q

A

B

d

Provider characteristics: salary

Service characteristics: Fee-for-service

Source: based on Ellis and Miller, 2009

Points to consider for P4Q

- Development of meaningful indicators
  - Focusing on high impact areas,
  - Involving stakeholders and aligning with professional norms
- Data on quality of care:
  - Availability, completeness
  - Reliability, resitance to gaming
  - Risk-adjustment, exclusion reporting
- Designing appropriate incentives:
  - targets (absolute or relative?);
  - level of the payment adjustment (Individual, group, institution?);
  - form of the incentive (bonus or penalty?)

A framework for analysis of payment systems

Source: based on Ellis and Miller, 2009

Proposed payment for primary care in Cyprus

- Service provision: 500 GPs + 200 pediatricians; (public health centres?)
- Information basis:
  - Patient-based (capitation per registered patient)
  - Service based (FFS)
  - KPI = Quality?
- Scope:
  - Capitation: differs depending on provider (GP, pediatrician): everything except services paid FFS.
  - FFS: chronic care services, home-visits, vaccinations, screening
  - Including all costs of running the practice (assistants, equipment, rent…)?
- Adequacy:
  - Calculated based on available budget, taking into account total number of physicians
- Fineness
  - capitation: 6 age groups
  - FFS?

To be paid with the same system?

What about practice costs (assistants, materials, depreciation)?

Is cost or income data avilable?

Is this fine enough to account for differences in patient complexity?

Thank you!

If you have further questions:

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OK to make slides available?

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