

## **Financial incentives to stimulate integration of care**

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# Content

- Background
- Why financial incentives to integrated care
- What are the existing models
- Barriers and facilitators
- Impact
- Future of financial incentives in Europe



# Types of incentives

- Existing (dis)incentives may be identified at several levels targeting at different stakeholders
- Incentives for healthcare professionals:
  - Financial incentives
  - Professional ethics (intrinsic motivations)
  - Organizational cultures
  - Policies and governance



# The goal of financial incentives

- The underlying goal of incentives is not simply rewarding good performance or punishing bad performance.
- The goal of using incentives is to support the change in the status quo by:
  - stimulating both immediate and long-term improvements in performance
  - creating alignment between expectations and rewards
  - removing financial barriers that perversely effect desired performance



# Financial incentives vs intrinsic motivation?

- Debate whether incentives well targeted or whether they might even undermine intrinsic motivations of staff (Elovainio, 2010).
- Especially in health and social care, financial incentives may even result in ‘crowding out’ intrinsic motivators such as purpose or altruism (Woolhandler & Arieli, 2012; Harrison & Marshall, 2005).
- Glasziou checklist whether financial incentives via P4P would be beneficial rather than harmful (Glasziou et al. 2012, BMJ)



# Financial self-interest: is it wrong?



- Physicians in Ancient Greece:
  - Had an interest in money to make a living
  - Were not ashamed of admitting it
  - The medical ethics ordained that a physician should not be preoccupied by money, but **NOT** that he should be indifferent to money
- If the self-interest of suppliers **matched** by the self-interest of consumers leads to an optimal outcome for society as ‘man is led, as if by an invisible hand, to promote ends which were not part of his original intention’ (Smith, 1776)
- Due to market failures in health care, governments took up the role of matching-self interests and became the ‘visible hand’



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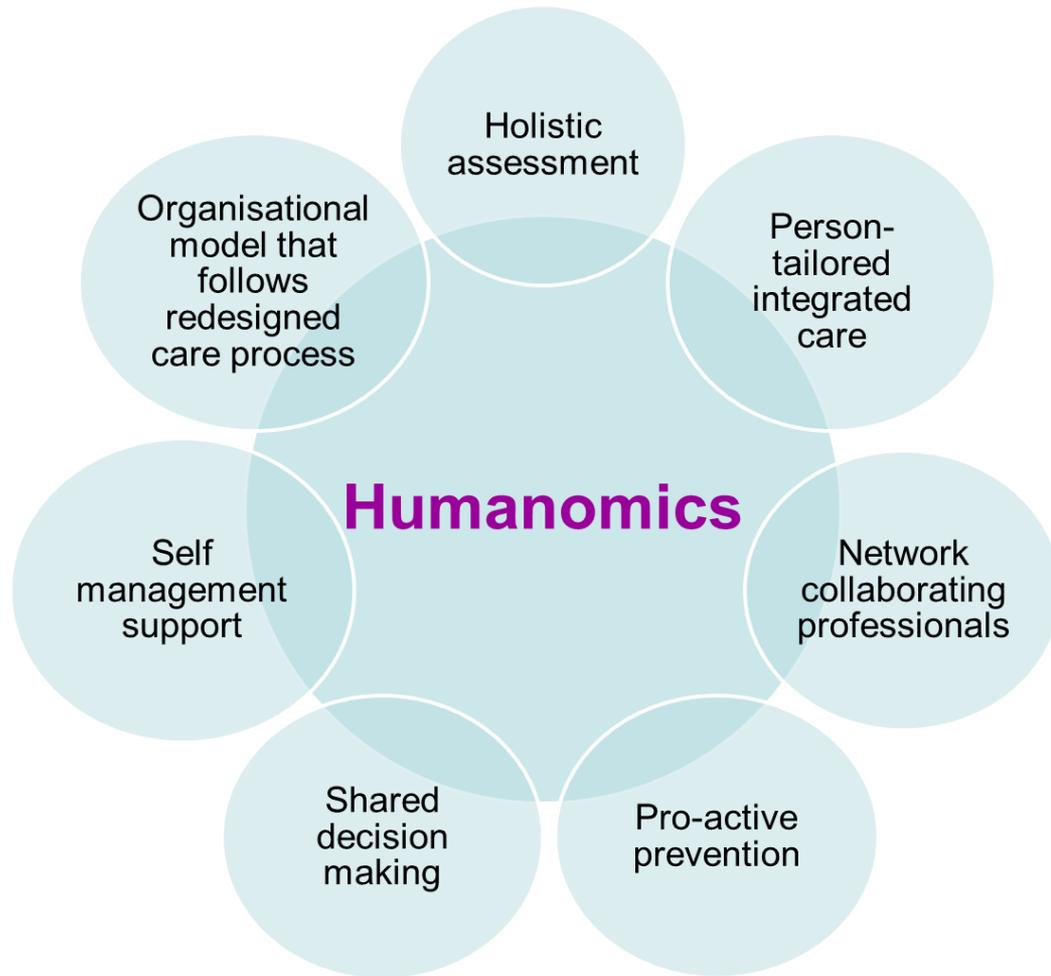


# Burden of chronic conditions

- Chronic conditions are related to:
  - 60% of all DALYs
  - 75% of total health care expenditure
  - Other costs: disability, premature mortality, work absence, reduced productivity, early retirement, informal care
- This threat increases due to:
  - increasing prevalence
  - multi-morbidity



# Integrated care



To incentivize cooperation, communication and joint visions a number of preconditions have to be:

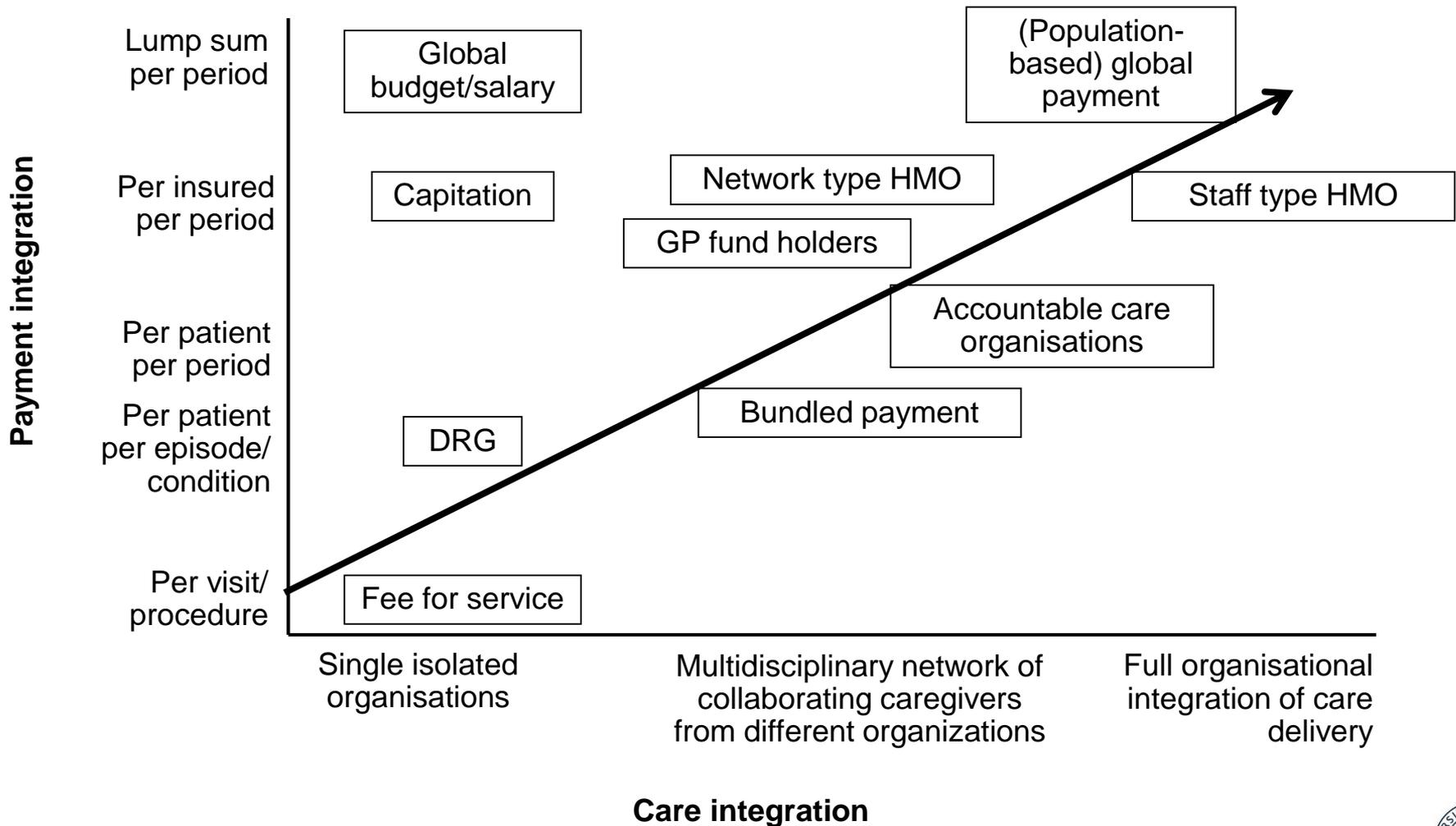
- Adequate leadership and governance at various levels in the system
- Adequate ICT support
- Adequate (financial) incentives for providers, patients, payers
- Tools to assess and monitor performance as well as unintended effects

# Traditional payments unable to facilitate integration

- Salary: fails to stimulate integration of care because there are potential incentives to accept only healthy patients (cream skimming) and to refer complex cases to more costly secondary services (dumping)
- Capitation: chronically ill are financially unattractive as they require more time and services to treat, at the expense of the physician
- FFS: little incentive to provide high quality of care and adequately address the needs of patients with chronic diseases.



# Integrated care requires integrated payment



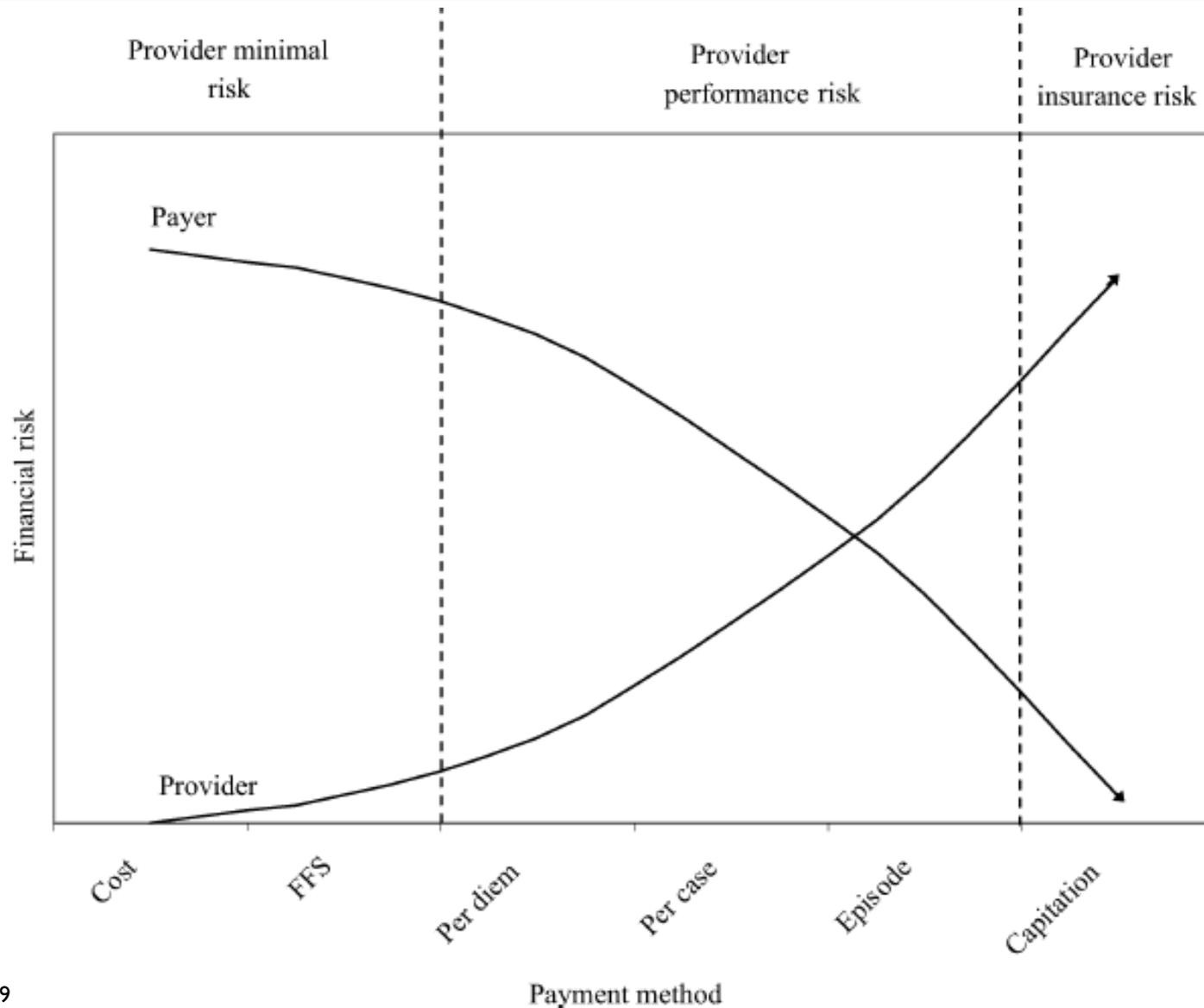
# Financial risk



Source: UHCHRM, 2012 and KPMG, 2014.



# Who bears the financial risk?



# Incentivize different stakeholders

- **Purchasers/payers:**
  - What: the allocation of resources towards coordination and more integrated care delivery
  - Examples: 'Accountable Care Organizations' with population based payment or earmarked payments
- **Providers:**
  - What: provision of coordinated/integrated care
  - Examples: global payments, pooled funds, bundled payments, pay-for-coordination, pay-for-performance
- **Patients:**
  - What: patient compliance, prevention and self-management
  - Examples: personal health budgets or waivers/reductions of out-of-pocket contributions
  - Supplemented by preventive and health promoting measures such as discount for gym membership and privileged access to physicians outside normal hours
- **Incentives for different stakeholders should be aligned!**



# Alternative payments in the U.S.

- Aim: to contain costs and improve quality of care.
- Examples: global payment, accountable care organizations with shared savings, PFP, bundled payment, and PFC.
- They introduced:
  - financial risk to providers,
  - explicit measures of quality improvement driven by financial incentives to providers,
  - efforts towards patient-centred care through integration and coordination of care
  - financial incentives for patient safety.



# The European version of payments

- Adapted to be “transferable” to the European context
- Accompanied by broader reforms in the European health care systems
- The adoption (i.e. which) and adaptation (i.e. how) were based on the structure of its health care system
- Combined (e.g. global payment with PFC in Germany) or provided on top of traditional payment schemes (e.g. PFP on top of capitation and FFS in England).
- Targeted those stakeholders who were expected to adjust their behaviour and provided them with adequate financial incentives.



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# Financial incentives in Europe

	Reform	Target group	Elements of integrated care	Financial incentives	Uptake
Austria	Health Reform Act 2005	Social health insurers and regional governments	DMPs across primary and secondary care	Budget pool of 1-2% for ICPs	Low
		GPs	DMPs	€53 initial + €25 quarterly to coordinate care	
Denmark	Administrative Reform 2007	Region	Multi-disciplinary teams, continuity and coordination of care	€70 million for ICPs	High
		Municipalities		<ul style="list-style-type: none"> <li>• 15% of a regional healthcare budget to reduce inpatient care</li> <li>• Co-financing of inpatient care</li> </ul>	
France	Health Insurance Act 2004	GPs	DMPs in primary care for 30 chronic diseases	€40 per patient for coordination	Medium
	CAP1 2009	GPs	Integrated care related performance indicators	up to €6,000 annual reward for high performance	High
Germany	Risk Structure compensation Act 2002	Social health insurers	DMPs across primary and secondary care	<ul style="list-style-type: none"> <li>• Benefit to €1,000 per patient per year</li> <li>• €153 annually per patient for coordination</li> </ul>	Medium/High (but mainly in primary care)
		GPs	Care coordination and documentation	€75 annually per patient	NA
Netherlands	Bundled payment	Mainly primary care providers	DMPs for diabetes, COPD and CVRM in primary care	Price negotiated between insurer and care group (bundled); Performance is a factor in price negotiations	Medium/High
United Kingdom	Quality and Outcomes Framework 2004	GPs	Integrated care related performance indicators	reward up to 30% of salary	High
Portugal	Performance compensations 2006	Multi-disciplinary primary care teams	Multidisciplinary high quality care, continuity of care	NA	NA
Hungary	Act of Social Health Insurance Fund's Budget 1998	Care providers	Coordinate primary, secondary tertiary care	amount per patient per year	NA
	Performance based payment 2009	GPs	Integrated care related performance indicators	€10.9 million budget for GP bonuses	NA
Estonia	Performance based payment 2009	GPs	Integrated care related performance indicators	up to €255 per month on top of capitation	NA

# Payment schemes for ICC

- Pay-for-coordination (PFC): payment for coordination of care provided by different care providers (AUS, DEN, FRA, GER)
- Pay-for-performance (PFP): payment or financial incentive associated to improvements in the process and outcomes of chronic care (ENG, FRA)
- All-inclusive payments including:
  - Bundled payment for a group of services for a specific disease involving multiple providers (NL)
  - Global payment, risk-adjusted payment for the full range of services related to specified group of people (GER)



# Evidence in the literature

- PFC can be cost-saving (Berry et al., 2013)
- PFP can potentially be effective (de Bruin et al., 2011; Eijkenaar et al., 2013) and cost-effective (Walker et al., 2010)
- Bundled payment may reduce health care utilization (Hussey et al., 2009)
- Global payment may improve quality and reduce health care expenditure (Song et al., 2014).



# Facilitators and barriers

	<b>Facilitators</b>	<b>Barriers</b>
Pay-for-coordination	<ul style="list-style-type: none"> <li>Stakeholder cooperation (AUS, GER)</li> <li>Patient demand (AUS)</li> <li>Adequate financial incentive for GP engagement in DMPs (DEN)</li> </ul>	<ul style="list-style-type: none"> <li>Gaming (GER)</li> <li>Misaligned incentives between stakeholders (AUS)</li> <li>GP Opposition (AUS,GER, FRA)</li> <li>Virtual budget (AUS)</li> <li>Inflexible task allocation (AUS)</li> </ul>
Pay-for-performance	<ul style="list-style-type: none"> <li>Adequate financial incentive for GPs (ENG, FR)</li> </ul>	<ul style="list-style-type: none"> <li>Gaming (ENG)</li> <li>Defining performance indicators (ENG)</li> </ul>
Bundled Payment	<ul style="list-style-type: none"> <li>Stakeholder cooperation (NL)</li> <li>Flexible task allocation (NL)</li> </ul>	<ul style="list-style-type: none"> <li>Gaming (NL)</li> <li>Lack of transparency (NL)</li> <li>Lack of comprehensive means to address multi-morbidity (NL)</li> </ul>
Global Payment	<ul style="list-style-type: none"> <li>Adequate financial incentive for engagement (GER)</li> <li>Stakeholder cooperation (GER)</li> </ul>	<ul style="list-style-type: none"> <li>Misaligned incentives in short versus long-term(GER)</li> <li>Gaming (GER)</li> <li>Political investment (GER)</li> </ul>



# Impact on expenditure

- Immediate impact on outpatient (PFC, ALL), hospital care, administrative (PFP)
- Volatile implementation of financial agreements
- Sustainable impact had only PFP and ALL
- Concerns:
  - PFC - suitable as start-up
  - PFP - may jeopardize quality of non-rewarded services
  - ALL - supply induced demand
- Blended payment scheme:
  - Basis: a yearly risk-adjusted population-based global payment
  - Additional: pay-for-coordination and pay-for-performance
  - Shared savings to avoid “gaming”, align incentives, support prevention, and reward patients



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# Ongoing payment reforms

## ■ Germany

- 2004: Health Care Modernization Act providing **PFC** and a **global payment**
- 2015: Health Care Strengthening Act created a large **pooled budget** across sectors

## ■ England

- 2004: **Pay-for-performance** in GP care
- 2015/2016: Year of care **capitated model** for a range of services for a defined time period
- 2015/2016: Better Care Fund is a single **pooled budget** to integrate health and social care

## ■ The Netherlands

- 2010: **Bundled payment** for chronic conditions
- 2013: Regional experiments with **population-based payment** including shared savings
- 2015: **3-tiers payment system** for primary care including pay-for-coordination/collaboration and pay-for-performance/innovation



# Designing financial incentives

- Comprehensive, evidence-based incentives attuned to norms of medical professionalism
- Reward risk with premium
- Balance of rewards and penalties depending on context
- Offering providers a choice among schemes
- A blend of group and individual-level incentives
- Combination of absolute and relative targets differentiated across groups
- Right-sized incentives with payoff rules known in advance
- Timely payment schedule, minimized time-lag
- Incentives to be sustained over the long run



# Conditions for success

- A clearly defined population
- Sufficient and relevant data to compensate for high risk patients
- Unambiguous and measurable goals to determine success
- Broadly accepted, sensitive, and clinically relevant indicators
- Transparency and willingness to record results
- Involved parties share commitment and goals
- Insight into costs of the population
- High degree of organization in primary care
- An integrated ICT system
- Long-term scope: sufficient time allowed to wait for the first results



# Future evaluation

- More rigorous study designs need to:
  - Account for the selection of physicians into incentive schemes
  - Disentangle the effect from other reforms
  - Infer causality (natural experiments or quasi-experimental designs?)
  - Examine the potential unintended consequences of incentive
- Studies should more consistently describe:
  - the type of payment scheme at baseline or in the control group
  - how payments were used and distributed
  - the size of the new payments
- Further research:
  - Find optimal mixture (type and size) of financial incentives
  - compare financial incentives with other behaviour change interventions



# Future policy-making

- Financial incentives are potentially powerful tools to stimulate integration of care
- They should be used as a means to extend the cost-reducing potential of integrated chronic care rather than as cost-containment policies
- Consider experiences from countries that have comparable health care systems and context
- Strong willingness and commitment of the health authorities to re(design) financial incentives
- Re-positioning financial incentives and changing behaviour in the health care sector, which requires a large share of a country's GDP and workforce, is not an easy task



Thank you for joining the webinar!

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