Will paying the piper change the tune? Innovations in financing health services

Reinhard Busse, Prof. Dr. med. MPH FFPH
Department of Health Care Management, Berlin University of Technology (WHO Collaborating Centre for Health Systems Research and Management) & European Observatory on Health Systems and Policies
Agenda

• Paying hospitals
• Paying GPs (and other ambulatory care physicians)
• Paying for chronic care
## Advantages and disadvantages of different forms of hospital payment

<table>
<thead>
<tr>
<th>Payment mechanism</th>
<th>Patient needs (risk selection)</th>
<th>Activity</th>
<th>Expenditure control</th>
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<th>Transparency</th>
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</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Number of services/case</td>
<td>Number of cases</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Fee-for-service</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Global budget</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
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<td>-</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DRG based case payment</td>
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<td>-</td>
<td>+</td>
<td>0</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Global budget</td>
<td>-</td>
<td>-</td>
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</tr>
</tbody>
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Advantages and disadvantages of different forms of hospital payment

- “dumping“ (avoidance), “creaming“ (selection) and “skimming“ (undertreatment)
- up/wrong-coding, gaming

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<td>+</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
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<td>0</td>
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</table>

**USA 1980s**

**European countries 1990s/2000s**
Empirical evidence (I):
hospital activity and length-of-stay under DRGs

<table>
<thead>
<tr>
<th>Country</th>
<th>Study</th>
<th>Activity</th>
<th>ALoS</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA, 1983</td>
<td>US Congress - Office of Technology Assessment, 1985</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>Guterman et al., 1988</td>
<td>▼</td>
<td>▼</td>
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<tr>
<td></td>
<td>Davis and Rhodes, 1988</td>
<td>▼</td>
<td>▼</td>
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<tr>
<td></td>
<td>Kahn et al., 1990</td>
<td>▼</td>
<td>▼</td>
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<tr>
<td></td>
<td>Manton et al., 1993</td>
<td>▼</td>
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<td></td>
<td>Muller, 1993</td>
<td>▼</td>
<td>▼</td>
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<tr>
<td></td>
<td>Rosenberg and Browne, 2001</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

Cf. Table 7.4 in book
## Empirical evidence (II)

<table>
<thead>
<tr>
<th>Country, Year</th>
<th>Study</th>
<th>Activity</th>
<th>ALoS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden, early 1990s</td>
<td>Anell, 2005</td>
<td>▲</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>Kastberg and Siverbo, 2007</td>
<td>▲</td>
<td>▼</td>
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<tr>
<td>Italy, 1995</td>
<td>Louis et al., 1999</td>
<td>▼</td>
<td>▼</td>
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<tr>
<td></td>
<td>Ettelt et al., 2006</td>
<td>▲</td>
<td></td>
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<tr>
<td>Spain, 1996</td>
<td>Ellis/ Vidal-Fernández, 2007</td>
<td>▲</td>
<td></td>
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<tr>
<td>Norway, 1997</td>
<td>Biørn et al., 2003</td>
<td>▲</td>
<td></td>
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<tr>
<td></td>
<td>Kjerstad, 2003</td>
<td>▲</td>
<td></td>
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<tr>
<td></td>
<td>Hagen et al., 2006</td>
<td>▲</td>
<td></td>
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<tr>
<td></td>
<td>Magnussen et al., 2007</td>
<td>▲</td>
<td></td>
</tr>
<tr>
<td>Austria, 1997</td>
<td>Theurl and Winner, 2007</td>
<td>▼</td>
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<tr>
<td>Denmark, 2002</td>
<td>Street et al., 2007</td>
<td>▲</td>
<td></td>
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<tr>
<td>Germany, 2003</td>
<td>Böcking et al., 2005</td>
<td>▲</td>
<td>▼</td>
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<tr>
<td></td>
<td>Schreyögg et al., 2005</td>
<td>▼</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hensen et al., 2008</td>
<td>▲</td>
<td>▼</td>
</tr>
<tr>
<td>England, 2003/4</td>
<td>Farrar et al., 2007</td>
<td>▲</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>Audit Commission, 2008</td>
<td>▲</td>
<td>▼</td>
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<tr>
<td></td>
<td>Farrar et al., 2009</td>
<td>▲</td>
<td>▼</td>
</tr>
<tr>
<td>France, 2004/5</td>
<td>Or, 2009</td>
<td>▲</td>
<td></td>
</tr>
</tbody>
</table>

**European countries 1990/2000s**

Cf. Table 7.4 in book

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So then, why DRGs?

To get a common “currency” of hospital activity for

- transparency $\rightarrow$ efficiency benchmarking & performance measurement (protect/improve quality),
- budget allocation (or division among providers),
- planning of capacities,
- payment ($\rightarrow$ efficiency)

Exact reasons, expectations and DRG usage differ among countries – due to (de)centralisation, one vs. multiple payers, public vs. mixed ownership.
### Scope of DRGs within set of hospital activities

<table>
<thead>
<tr>
<th>Excluded costs</th>
<th>(e.g. for infrastructure; <em>in U.S. also physician services</em>)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments for non-patient care activities</td>
<td>(e.g. teaching, research, emergency availability)</td>
</tr>
<tr>
<td>Payments for patients not classified into DRG system</td>
<td>(e.g. outpatients, day cases, psychiatry, rehabilitation)</td>
</tr>
<tr>
<td>Additional payments for specific activities for DRG-classified patients</td>
<td>(e.g. expensive drugs, innovations), possibly listed in DRG catalogues</td>
</tr>
<tr>
<td>Other types of payments for DRG-classified patients</td>
<td>(e.g. global budgets, fee-for-service)</td>
</tr>
<tr>
<td><strong>DRG-based case payments</strong>, <strong>DRG-based budget allocation</strong></td>
<td>(possibly adjusted for outliers, quality etc.)</td>
</tr>
</tbody>
</table>
Essential building blocks of DRG systems

1. Patient classification system
   - Diagnoses
   - Procedures
   - Severity
   - Frequency of revisions

2. Data collection
   - Demographic data
   - Clinical data
   - Cost data
   - Sample size, regularity

3. Price setting
   - Cost weights
   - Base rate(s)
   - Prices/tariffs
   - Average vs. “best”

4. Actual reimbursement
   - Volume limits
   - Outliers
   - High cost cases
   - Quality
   - Innovations
   - Negotiations
Choosing a PCS: copied, further developed or self-developed?

Patient classification system
- Diagnoses
- Procedures
- Severity
- Frequency of revisions

The great-grandfather

The grandfathers

The fathers

France Spain USA Portugal USA Ireland Australia Germany USA Finland Estonia Scandinavia Sweden England Poland Austria Netherlands

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Basic characteristics of DRG-like PCS in Europe

<table>
<thead>
<tr>
<th></th>
<th>AP-DRG</th>
<th>AR-DRG</th>
<th>G-DRG</th>
<th>GHM</th>
<th>NordDRG</th>
<th>HRG</th>
<th>JGP</th>
<th>LKF</th>
<th>DBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRGs / DRG-like groups</td>
<td>679</td>
<td>665</td>
<td>1,200</td>
<td>2,297</td>
<td>794</td>
<td>1,389</td>
<td>518</td>
<td>979</td>
<td>≈30,000</td>
</tr>
<tr>
<td>MDCs / Chapters</td>
<td>25</td>
<td>24</td>
<td>26</td>
<td>28</td>
<td>28</td>
<td>23</td>
<td>16</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Partitions</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>-</td>
</tr>
</tbody>
</table>

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Main questions relating to data collection

Clinical data
→ classification system for diagnoses and
→ classification system for procedures

Cost data
→ imported (not good but easy) or
→ collected within country (better but needs standardised cost accounting)

Sample size
→ entire patient population or
→ a smaller sample

Many countries: clinical data = all patients; cost data = hospital sample with standardised cost accounting system
How to calculate costs and set prices fairly

- Based on good quality data (not possible if cost weights imported)
- “Cost weights x base rate” vs. “Tariff + adjustment” vs. Scores
- Average costs vs. “best practice”
## Incentives and hospital strategies

<table>
<thead>
<tr>
<th>Incentives of DRG-based hospital payment</th>
<th>Strategies of hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Reduce costs per patient</strong></td>
<td>a) Reduce length of stay</td>
</tr>
<tr>
<td></td>
<td>• optimize internal care pathways</td>
</tr>
</tbody>
</table>
|                                        |   • inappropriate early discharge (‘bloody discharge’)
|                                        | b) Reduce intensity of provided services |
|                                        |   • avoid delivering unnecessary services |
|                                        |   • withhold necessary services (‘skimming/undertreatment’)
|                                        | c) Select patients |
|                                        |   • specialize in treating patients for which the hospital has a competitive advantage |
|                                        |   • select low-cost patients within DRGs (‘cream-skimming’)
| **2. Increase revenue per patient**     | a) Change coding practice |
|                                        |   • improve coding of diagnoses and procedures |
|                                        |   • fraudulent reclassification of patients, e.g. by adding inexistent secondary diagnoses (‘up-coding’)
|                                        | b) Change practice patterns |
|                                        |   • provide services that lead to reclassification of patients into higher paying DRGs (‘gaming/overtreatment’)
| **3. Increase number of patients**      | a) Change admission rules |
|                                        |   • reduce waiting list |
|                                        |   • admit patients for unnecessary services (‘supplier-induced demand’)
|                                        | b) Improve reputation of hospital |
|                                        |   • improve quality of services |
|                                        |   • focus efforts exclusively on measurable areas

**Positive and negative consequences are closely related**

24 January 2012

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How European DRG systems reduce unintended behaviour: 1. long- and short-stay adjustments

- Short-stay outliers
- Inliers
- Long-stay outliers

Actual reimbursement
- Volume limits
- Outliers
- High cost cases
- Quality
- Innovations
- Negotiations

Deductions (per day)

Revenues

Surcharges (per day)

LOS

Lower LOS threshold

Upper LOS threshold

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How European DRG systems reduce unintended behaviour: 2. Fee-for-service-type additional payments

<table>
<thead>
<tr>
<th>Actual reimbursement</th>
<th>England</th>
<th>France</th>
<th>Germany</th>
<th>Netherlands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments per hospital stay</td>
<td>One</td>
<td>One</td>
<td>One</td>
<td>Several possible</td>
</tr>
<tr>
<td>Payments for specific high-cost services</td>
<td>Unbundled HRGs for e.g.: • Chemotherapy • Radiotherapy • Renal dialysis • Diagnostic imaging • High-cost drugs</td>
<td>Séances GHM for e.g.: • Chemotherapy • Radiotherapy • Renal dialysis Additional payments: • ICU • Emergency care • High-cost drugs</td>
<td>Supplementary payments for e.g.: • Chemotherapy • Radiotherapy • Renal dialysis • Diagnostic imaging • High-cost drugs</td>
<td>No</td>
</tr>
<tr>
<td>Innovation-related add’l payments</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (for drugs)</td>
</tr>
</tbody>
</table>
How European DRG systems reduce unintended behaviour: 3. adjustments for quality

- England/ Germany: no extra payment if patient readmitted within 30 days/ length-of-stay threshold
- Germany: deduction for not submitting quality data
- England: up 1.5% reduction if quality standards are not met
- France: extra payments for quality improvement (e.g. regarding MRSA)
### 4. Frequent revisions of PCS and payment rates

<table>
<thead>
<tr>
<th>Country</th>
<th>PCS</th>
<th>Payment rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency of updates</td>
<td>Time-lag to data</td>
</tr>
<tr>
<td>Austria</td>
<td>Annual</td>
<td>2–4 years</td>
</tr>
<tr>
<td>England</td>
<td>Annual</td>
<td>Minor revisions annually; irregular</td>
</tr>
<tr>
<td></td>
<td></td>
<td>overhauls about every 5–6 years</td>
</tr>
<tr>
<td>Estonia</td>
<td>Irregular (first update</td>
<td>1–2 years</td>
</tr>
<tr>
<td></td>
<td>after 7 years)</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>Annual</td>
<td>1 year</td>
</tr>
<tr>
<td>France</td>
<td>Annual</td>
<td>1 year</td>
</tr>
<tr>
<td>Germany</td>
<td>Annual</td>
<td>2 years</td>
</tr>
<tr>
<td>Ireland</td>
<td>Every 4 years</td>
<td>Not applicable (imported AR-DRGs)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Irregular</td>
<td>Not standardized</td>
</tr>
<tr>
<td>Poland</td>
<td>Irregular – planned</td>
<td>1 year</td>
</tr>
<tr>
<td></td>
<td>twice per year</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>Irregular</td>
<td>Not applicable (imported AP-DRGs)</td>
</tr>
<tr>
<td>Spain</td>
<td>Biennial</td>
<td>Not applicable (imported 3-year-old CMS-DRGs)</td>
</tr>
<tr>
<td></td>
<td>(Catalonia)</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>Annual</td>
<td>1–2 years</td>
</tr>
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</table>
Conclusions

• DRG-based hospital payment is the main method of provider payment in Europe, but systems vary across countries
  – Different patient classification systems
  – DRG-based budget allocation vs. case-payment
  – Regional/local adjustment of cost weights/conversion rates

• To address potential unintended consequences, countries
  – implemented DRG systems in a step-wise manner
  – operate DRG-based payment together with other payment mechanisms
  – refine patient classification systems continuously (increase number of groups)
  – place a comparatively high weight on procedures
  – base payment rates on actual average (or best-practice) costs
  – reimburse outliers and and high cost services separately
  – update both patient classification and payment rates regularly

• If done right (which is complex), DRGs can contribute to increased transparency and efficiency – and quality
## DRG payment – the way forward

**Integrate all relevant cost categories into DRGs**

**Separate priority activities not related to a particular patient from DRG payments**

**Pay separate for patient-related activities which you want to incentivize (upon prior authorization, 2nd opinion?)**

- Define clinically meaningful groups (constant updating),
- which are cost-homogeneous (on average or “best practice”),
  - measure quality and
  - adjust payment

### Excluded costs

- (e.g. for infrastructure; *in U.S. also physician services*)

### Payments for non-patient care activities

- (e.g. teaching, research, emergency availability)

### Payments for non-patient care activities

- (e.g. output-based or “bundled” system)

### Develop intersectoral “bundled” DRGs based on care pathways

### Additional DRG-specific activities for DRG-classified patients (e.g. expensive drugs, innovations), possibly listed in DRG catalogues

### Other types of payments for DRG-classified patients

- (e.g. global budgets, fee-for-service)

### DRG-based case payments, DRG-based budget allocation

- (possibly adjusted for outliers, quality etc.)

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Theory and Practice in the Design of Physician Payment Incentives

JAMES C. ROBINSON

University of California, Berkeley

There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of "ping-pong" referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem. But American medicine exhibits numerous interesting compensation systems that blend elements of retrospective and prospective payment, of fee-for-service, salary, and capitation. These innovations seek a middle ground between high- and low-intensity incentives, between piece rates and straight salary. Payment systems are becoming more complex and their design and implementation require an understanding of motivation and behavior.
## Advantages and disadvantages of different forms of GP payment

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<td></td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>+</td>
<td>+</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Capitation</td>
<td>- (if not risk-adjusted)</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Salary</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>0</td>
<td>-</td>
<td>0</td>
<td>+</td>
</tr>
</tbody>
</table>
Traditional forms of paying GPs (until early 2000s)

France    Germany    Netherlands    England    Sweden
Germany – 2-step payment of physicians

Sickness fund X

Sickness fund Y

Sickness fund Z

Capitation based on previous year's utilisation, increase factor, adjustments

Physicians' association (KV)

GP budget (ca. 1/3)

Specialists' budget (ca. 2/3)

FFS up to specialty- and patient-adj. caps for basic and groups of special services

GP 1  GP 2  GP 3  Spec1  Spec2  Spec3

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Payment components in GP care today

Objective: appropriateness & outcomes
- Quality payment
- CAPI bonus

France

Objective: appropriateness & outcomes
- Extra service payment
- ADL payment

Germany

Objective: activity & patient needs
- Extra service payment
- FFS DMP payment
- FFS with caps per service type

Netherlands

Objective: activity & patient needs
- Extra service payment
- FFS (per service type)

England

Objective: cost-containment (& geographic equity)
- Basic service payment
- FFS
- “RLV” (capped FFS)

Sweden

Objective: cost-containment (& geographic equity)
- Basic service payment
- Capitation
- Capitation

Bonus and/or Malus

FFS (per visit & out-of-hours)
FFS (per visit)
FFS (per service type)
FFS (per service type)
FFS (per service type)
FFS (per service type)
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Determination

- **England**: sex and 7 age bands = 14 categories (1.0 = males 5-14 → 8.9 females 85+) *plus* adjustments for long-term illness and standardised mortality ratio *plus* adjustment for cost (GP, staff, land, buildings)
- **Germany**: based on actual utilisation in previous year
- **Netherlands**: 3 age bands plus deprivation in area = 6 categories
- **Sweden**: several age bands and/or morbidity factors (plus socio-economic factors)
### Percentage of total payment per component (estimates)

<table>
<thead>
<tr>
<th>Objective: appropriateness &amp; outcomes</th>
<th>France</th>
<th>Germany</th>
<th>Netherlands</th>
<th>England</th>
<th>Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td>max.</td>
<td>5%</td>
<td>25%</td>
<td>25%</td>
<td>max. 25-30%</td>
<td>+/- 3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective: activity &amp; patient needs</th>
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</thead>
<tbody>
<tr>
<td>1%</td>
<td>&lt;5%</td>
<td>40-45%</td>
<td>&lt;10%</td>
<td>10-20%</td>
<td>60%</td>
</tr>
<tr>
<td>30%</td>
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<td>(Stockholm 40%)</td>
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<th>Objective: cost-containment (&amp; geographic equity)</th>
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<tr>
<td>60-70%</td>
<td>55-60%</td>
<td>65%</td>
<td>80-90%</td>
<td>(Stockholm 40%)</td>
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28 February 2012  CHSPR Health Policy Conference, Vancouver
The challenge for paying for chronic care

• Care for people with chronic conditions is an issue with increasing importance in all industrialized countries

• Countries have been experimenting and working towards care models in response to the fact that chronic diseases can rarely be treated in isolation

• These models try
  ➢ to coordinate and potentially integrate care
  ➢ with the aim of providing higher quality of care
  ➢ while also being efficient

• Challenge: to pay providers in a way that incentivizes these objectives
## Advantages and disadvantages of different forms of payment

<table>
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<tr>
<th>Payment mechanism</th>
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<th>Activity</th>
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<tr>
<td>Capitation</td>
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Three observations stand out:

1) all payment mechanisms provide conflicting incentives for “activity” and “expenditure control”, with capitation and DRGs best for efficiency;

2) **none** provide incentives for producing high quality outcomes;

3) **none** provide incentives for care coordination.
First strategy: Paying for quality of care

_for Structure_, e.g. access time, provider’s function as a gatekeeper or for including patients in registers

_for Processes_, i.e. for treating chronically ill according to established practice, e.g. adherence to guidelines

_for Outcome of care_, i.e. short- or long-term clinical outcomes or patient satisfaction
Framework

Capitation

or

Case-based

and

Documentation bonus

Bonus for structural quality (e.g. waiting)

Bonus for process quality (e.g. guidelines adherence)

Bonus for outcome quality

Paying for quality

Quality-relation

Structure  Process  Outcome

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February 2012
Financial incentives to (primarily) improve quality of care

<table>
<thead>
<tr>
<th>... targeting <strong>structures</strong> of care</th>
<th>... targeting <strong>processes</strong> of care</th>
<th>... targeting <strong>outcomes</strong> of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per patient bonus for physicians for acting as gatekeepers for chronic patients and for setting care protocols or providing patient education (FR)</td>
<td>Points for reaching process targets (UK: QOF; FR: CAPI; AUS: PIP)</td>
<td>Points for reaching outcome targets (UK: QOF)</td>
</tr>
<tr>
<td>Bonus for DMP / PIP recruitment and documentation (GER; AUS)</td>
<td>P4P (mainly hospitals, US)</td>
<td>P4P (mainly hospitals, US)</td>
</tr>
<tr>
<td>Points for reaching structural targets (UK: QOF; FR: CAPI)</td>
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</tbody>
</table>
Second Strategy: Paying for care coordination

1st level: separate payment for coordination or extra effort

2nd level: bundled payment across services (for one provider but incl. referrals/prescriptions)

3rd level: bundled payment across providers (but restricted to a set of activities, e.g. only those related to one disease)

4th level: bundled payment across services and providers

Main incentive: be efficient and keep savings!
Paying for care coordination

Separate provision

Full integration

Linkage

Coordination

Integration

Capitation and/or Case-based

Coordination/extra effort payment

Bundled payment for one provider across services (incl. referrals/prescriptions)

Bundled payment for group of providers for specific services

Documentation bonus

Bundled payment across providers and services

February 2012

CHSPR Health Policy Conference, Vancouver
## Financial incentives used to (primarily) improve care coordination

<table>
<thead>
<tr>
<th>... for coordination/extra effort</th>
<th>... for bundling across services</th>
<th>... for bundling across providers</th>
<th>... for bundling across services and providers</th>
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</thead>
<tbody>
<tr>
<td>“Year of care” payment for the complete package of chronic disease management (UK) or service incentives (AUS)</td>
<td>“fundholding” (UK)</td>
<td>1% of overall health budget available for integrated care → majority of integrated care (GER)</td>
<td>1% overall health budget available for integrated care → population-based integrated care (Kinzigtal; GER)</td>
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<tr>
<td>Per patient bonus for physicians acting as gatekeepers for chronic patients/ for setting care protocols/ providing patient education (FR)</td>
<td></td>
<td>Payment for professional cooperation and diagnostic-related bundled payment (FR)</td>
<td>Shared savings for Accountable Care Groups; tested in Physician Group Practice demonstration (US)</td>
</tr>
<tr>
<td><strong>Bonus for DMP recruitment and documentation</strong> (GER) or initial payments (AUS)</td>
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<td>Integrated Care Groups (NL)</td>
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<tr>
<td>Service outcome payments (AUS)</td>
<td></td>
<td>Bundled payment for acute-care episodes (US)</td>
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</tr>
</tbody>
</table>

28 February 2012  
CHSPR Health Policy Conference, Vancouver  
39
Paying for care coordination

Separate provision

Full integration

Coordination

Integration

Linkage

Bundled payment for one provider across services (incl. referrals/ prescriptions)

Bundled payment for group of providers for specific services

Paying for quality and coordination

Capitation

and/or

extra effort payment

or

Case-based

and

Bonus for structural quality (e.g. waiting)

Bonus for process quality (e.g. guidelines adherence)

Bonus for outcome quality

Quality-relation

Structure

Process

Outcome

Paying for quality

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Very few integrated care contracts (GER)

A few Care Groups (NL) only if there are savings (US: PGP)

Quality is taken into account

Bundled payment for one provider across services

Paying for quality and coordination

Bonus for structural quality (e.g. waiting)

Bonus for process quality (e.g. guidelines adherence)

Bonus for outcome quality

Quality-relation

Linkage

Coordination

Integration

Capitation

or

Case-based

and/or

and
Conclusions: paying for chronic care

• A shift from incentives which simply take into account the presence of chronically ill towards incentives designed to improve structural and process indicators
  ➢ Although a trend towards more quality-related payment can be observed, financial incentives for the delivery of quality outcomes are still limited
  ➢ A separate trend towards more bundling of payments across providers, services or both (“integrated care”) can be observed (main incentive: profit-sharing for efficiency)

• The challenge – paying for successful coordination AND quality (rather than just efficiency) – still remains
  ➢ The current rare approaches need to be evaluated
  ➢ Further models need to be developed