Can (economic) incentives promote better quality?

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Fundamental questions

- Do the existing institutional infrastructure and economic incentives promote quality?
  - Hospital remuneration using DRG
- Should quality be promoted with (financial) incentives? And can we find effective incentives?
- Should we pay for higher quality?
- Should we penalize poor quality with (economic) incentives?

Hospital reimbursement

EXISTING INFRASTRUCTURE & INCENTIVES

DAGENS Medicin

Per Okkels så gerne, at det danske sundhedssystem belønnede effekten og ikke produktiviteten. — Foto: Region Nordjylland

Hospitaler tjener penge på at påføre patienter infektioner

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Det er tid til en kritisk gennemgang af drg-systemet. Effektivitet skal belønnes frem for produktionen i sig selv, siger Danske Regioners administrerende direktør, Per Okkels.

Når en patient bliver fejlopereret og skal igennem en reoperation, får sygehuset i virkeligheden dobbelt drg-takst for behandlingen af patienten. Det samme gør sig gældende, når patienten er så uheldig at pådrage sig et liggesår eller en infektion under indlæggelsen og derfor må behandles for dette.

Danske Regioners administrerende direktør, Per Okkels, mistænker ikke sygehusene for at spekulere i re-operationer og infektioner, men mener, at drg-systemet belønner ud fra forkerte parametre.

På Dansk Selskab for Patientsikkerheds årsmøde i København i mandags sagde han direkte, at »drg har korrumperet os«.

blå bog

Per Okkels, 56

2008-: Administrerende direktør i Danske Regioner

2007-2008: Regionsdirektør i Region Nordjylland

1998-2006: Amtsdirektør i Nordjyllands Amt

Hospitals earn from infecting patients

Hospital reimbursement

- Activity-based reimbursement using DRG
  - ”you get what you pay for”

- However;
  - Professional norms and routines
  - Incentivizes higher quality with patients’ free choice (if patients make strategic use of free choice)
  - Incentivizes better patient safety that will reduce LOS
  - Other non-financial incentives: public reporting of quality, accreditation, reputation, etc.

Hospital reimbursement

- Empirical literature – experiences with introduction of DRG
  - Remember that economic incentives are always present – always a comparative analysis of the effects of different incentives!

  - Ambiguous, but no strong evidence that DRG have harmed quality
  - Some, but ambiguous, evidence of increased readmission rates
  - However, clear evidence of reduced LOS (which some have claimed to be equal to reduced quality)

P4P suggested by Institute of Medicine (2001): *Crossing the quality chasm* due to lack of incentives to deliver quality

SHOULD WE PAY FOR QUALITY?

Paying for quality

Two considerations

- Is higher quality more costly?
  - No, not necessarily
  - But there, however, still be good reasoning for paying despite quality being less costly
- How do we incentivize providers to provide the best possible quality?
  - (financial) Incentives may be one solution
  - Quality control, clinical databases .....
  - Public reporting
  - Patients' free choice
  - Tenders of services with quality as one of the choice parameters

Paying for quality – knowledge from economic theory

Fundamentals for design of payment mechanisms

1. Does the (third party) buyer have perfect understanding of the medical processes that improve health?
2. Do providers have perfect understanding of the medical process that improve health?
3. Can the third party buyer measure patients' risk adjusted health

Fundamentals cont'

Ad 1: Buyer's understanding of the medical process

- If the buyer have complete understanding (and information) of the medical process – The optimal medical conduct can (in theory) be implemented by
  - Providing clinical guidelines that are enforced
  - Set optimal fee-for-service scheme with fees reflecting relative importance of the services

- If the buyer does not have complete understanding of the medical process
  - The buyer have to incentivise appropriate conduct and effort by rewarding outcome rather than input

Fundamentals cont'

Ad 1: Buyer's understanding of the medical process

- A mixed strategy may also be optimal
  - FFS for known evidence-based effective procedures combined with P4P for quality to encourage use of processes that providers believe will improve quality

Fundamentals cont'

Ad 2: Provider's understanding of the medical process

- When providers know more about the appropriate medical process than the buyer (and have no incentive to completely reveal this to the buyer)
  - Shift to paying for quality (outcome) relative to paying for inputs may be optimal

- If buyer and provider have equally little understanding, paying for outcome may give the provider an inoptimal degree of risk sharing

Fundamentals cont'

Ad 3: Buyer's ability to risk adjust patients' health

- Potentials for unintended selection in P4P programmes when the buyer imperfectly adjust for patient health status
  - The more imperfect risk adjustment; the lower payment from P4P and targeted to organisational levels rather than individuals

Fundamentals cont'

(the left side of table 3) is imperfect, performance payr
be small and targeted whenever possible at the physicians
health system level in order to reduce providers' risk and
upward pressure on costs. In most cases, providers' performa
measured by patients' outcomes or changes in their outcom
basing P4P payments on process measures may be helpful
processes cannot be easily removed from bundled payment
of the P4P programs described in table 2 use process measu
high-performing providers, and the discussion nationally i

Nicholson et al. 2008. Getting Real Performance Out of Pay-for-Performance. The Milbank Quarterly, 86(3): 435-457.

P4P: Specific design parameters

Rewarding quality performance

- Who will be paid?
- What will they be paid for?
  - Type and degree over coverage of indicators which are rewarded
- Criteria for reward (or punishment)
  - Absolute or relative performance; or changes in performance
  - Absolute minimum standards
  - Relative performance with implicit competition
  - Risk adjustments; how?
- Size of the rewards/punishments?
- Public reporting of performance?
- Frequency of assessment of performance, rewards and changes in the rewarding system

Example of a national P4P from UK

BEST PRACTICE TARIFFS

Purposes of BPT

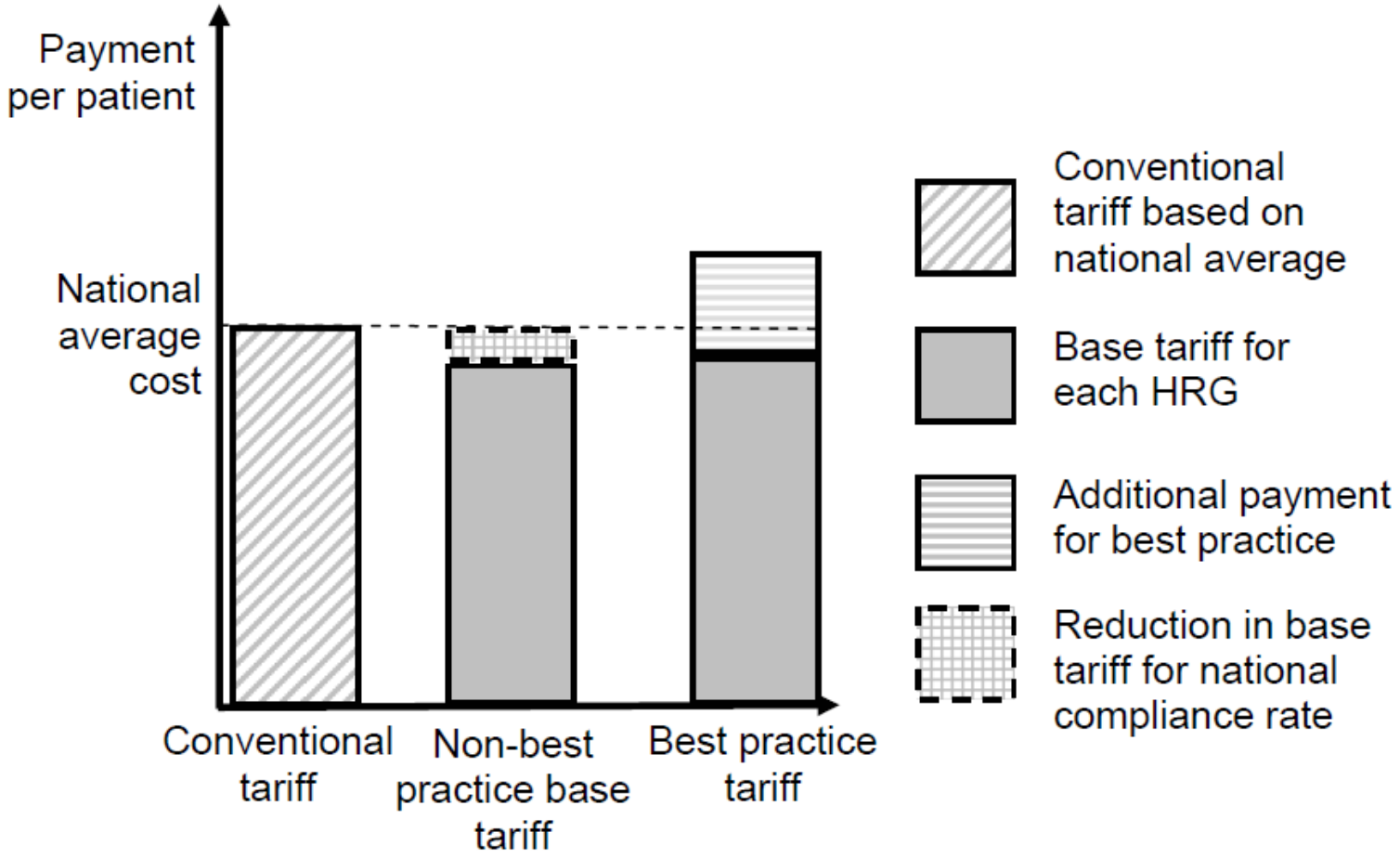
- Promote clinical engagement in best practice
- Improve quality
- Improve contracting of health care services
- Increase efficiency and strategic management of health care

- Are not supposed to be lasting tariffs

BPTs

- 2010/11
  - (a) cataracts
  - (b) cholecystectomy (gall bladder removal)
  - (c) fragility hip fracture
  - (d) stroke care.
- 2011/12 expanded with
  - (a) adult renal dialysis
  - (b) interventional radiology
  - (c) paediatric diabetic medicine
  - (d) primary total hip and knee replacements
  - (e) transient ischaemic attacks (mini-strokes)

Structure in BPT



BPT: Acute stroke example

Table 16: Stroke care best practice tariff prices

Tariff elements	AA22Z	AA23Z
Conventional tariff*	£4,348	£4,411
Base tariff **	£4,095	£4,158
Best practice additional payments		
Timely brain imaging	£133	£133
Acute stroke unit	£342	£342
Best practice tariff	£4,570	£4,633
Alteplase adjustment ***	£828	-

* 2010-11 price prior to non-best practice adjustments
** National tariff less an adjustment to reflect current compliance to the criteria and deduction of £133 for brain imaging
*** Alteplase not applicable for AA23Z as patients in this HRG have a haemorrhagic stroke rather than ischaemic

The case management scheme [Kontaktpersonordningen]

Results from Søren Rud Kristensen's work

PAY FOR PERFORMANCE: A DANISH EXAMPLE

Background

Year	Event
1998-2000	Media reports of success stories of providing patients with case managers locally
2001	A national right to having a case manger is agreed upon
2004	A performance indicator is introduced
2005-2008	Media reports of patients lacking case mangers
2009	Having a case manager is made a legal right
2009	The region of Southern Denmark introduces a P4P scheme in relation to the case management scheme

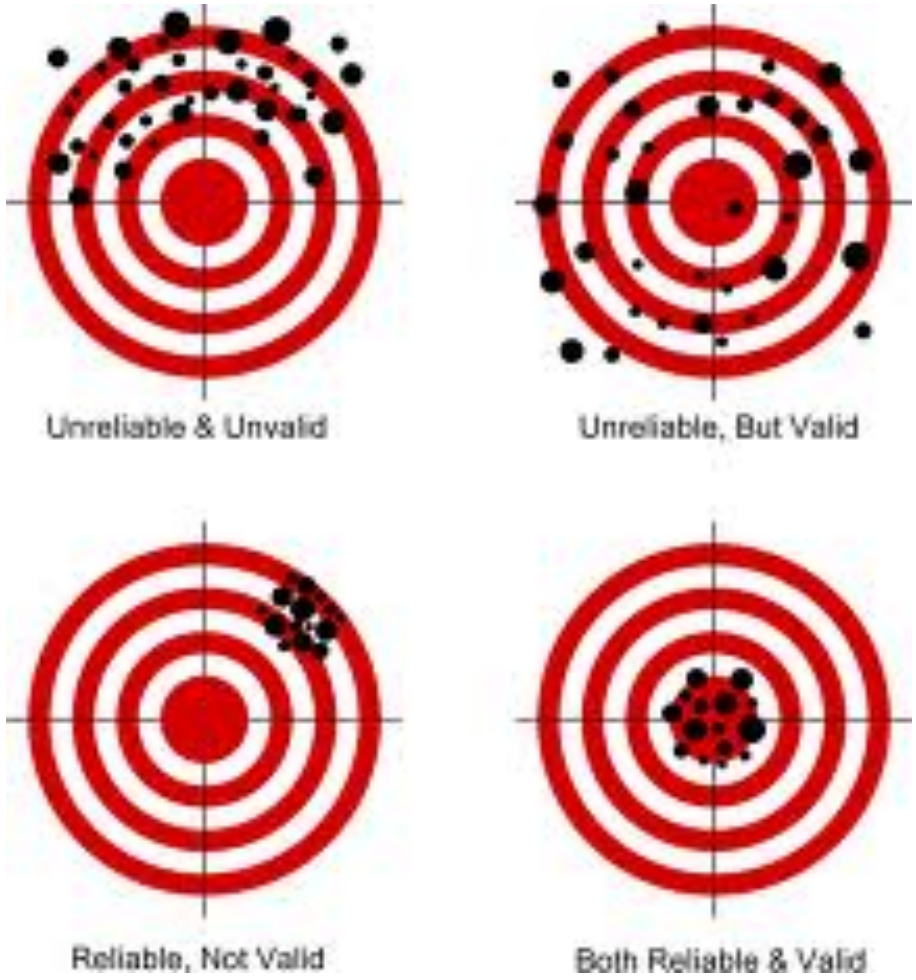
Case managers: The indicator (2004)

- The medical record indicator [journalauditindikatoren]
  - Quarterly observations at ward level
  - Draw minimum 15 medical charts randomly at each ward
  - Check to see if a case manager has been assigned

Case managers: What do we know?

- Significant increase in performance when payment is redistributed to ward level rather than central hospital level
- Only 25 % of patients who according to their medical record have a case manager are aware of that (Lindegaard & Qvist, 2010)
- Does the strengths of incentive induce hospitals to misreport performance?
  - Stronger incentives seem to increase gap between reported journal indicator and actual patient experienced contact with case manager

Aim, indicator – validity and reliability



Punishment of poor quality

NON-PAYMENT FOR PERFORMANCE

Movement to non-payment

- From 2001 – P4P
- New trend from around 2007 – non-payment or payment restrictions based on quality (or lack of)
- Use information from existing reimbursement schemes
  - DRG
- Hold back existing reimbursement as an incentive to report quality

- Example: Region of Southern Denmark – Payment only for achieved goals in cancer packages

Examples

- No-pay restrictions and never events
- 'Never Events'
  - "Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers" (NPSA, 2009, p. 3).

- US
  - Reduce Hospital Acquired Conditions (HAC)
  - Complications which
    - Are costly
    - Can be prevented by the hospitals
    - Harm the patients
    - Lead to a higher DRG tariff (before)
  - Hospital will no longer get the higher DRG tariff for HAC
    - Example: Catheter-associated urinary tract infections

NOT PAYING FOR READMISSIONS IN ENGLAND

Renewed policy interest in readmission rates

- Internationally, new policies aim at reducing readmissions by holding hospitals financially responsible for readmission rates
  - US: Medicare hospitals will face overall reductions in payments if their risk adjusted readmission rates are higher than expected from 2012
  - UK: No payment for emergency readmissions occurring within 30 days from an elective admission since April 1st 2011

The new English readmission policy

- Hospitals will not be reimbursed for
  - Emergency readmissions that have a national tariff within 30 days of discharge following a day case, ordinary elective admission, regular day or night admission
- PCTs are to put savings in a fund for improving post-discharge care

The new English policy: Exemptions

- Readmission without a national tariff
- Maternity and childbirth
- Children under 4 at the time of readmission
- Cancer, chemotherapy and radiotherapy
- Some multiple trauma (HRG VA14 or VA15)
- When the readmission is due to a transport accident
- Patients who are readmitted having self-discharged against clinical advice
- Emergency transfers of an admitted patient from another provider
- Cross border activity

Concluding remarks

- Financial incentives do influence behaviour
- Optimal designs (should) rely on thorough and sound theoretical considerations
- No perfect incentive scheme exist – there are always trade-offs and unintended consequences