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OECD Expert Meeting on Payment Systems
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Recent developments in provider payment models aim to achieve value for money in OECD countries

- Rising burden of chronic diseases and increasing health spending in OECD countries
- Traditional payment models are inadequate
- Many OECD countries are experimenting with new methods of paying health care providers to improve the quality of health care and coverage of priority services (Pay-for-Performance or “P4P”)

**Total health expenditure as a share of GDP, 1995-2007**
Selected OECD countries

Source: OECD Health Data 2009.
P4P has widespread appeal but does it work?

- Very few programs evaluated.
- Evidence of effect on outcomes is weak—no “breakthrough” performance improvement.
- Performance measures tied to incentives tend to improve, but often marginally.
- Even less evidence on design and implementation and whether P4P is a cost-effective way to achieve various objectives.

Source: Campbell SM et al; National Primary Care Research and Development Centre
The objectives are to:

- Better understand the elements of the design and implementation of P4P programs
- Assess to what extent the programs meet their objectives
- Identify factors that contribute to or limit success
- Generate lessons for low- and middle-income countries

<table>
<thead>
<tr>
<th>Programs from a variety of contexts</th>
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<tbody>
<tr>
<td><strong>Socioeconomic context</strong></td>
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<tr>
<td>High income (10)</td>
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<td>Middle income (2)</td>
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<td><strong>Program coverage</strong></td>
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<td>National programs (8)</td>
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<td>Regional (3)</td>
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<td>Pilot (1)</td>
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<td><strong>Program focus</strong></td>
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<td>Primary care (8)</td>
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<td>Hospitals (4)</td>
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</tbody>
</table>
## Case Study P4P Programs

<table>
<thead>
<tr>
<th>Program Focus</th>
<th>Country</th>
<th>Programme</th>
<th>Year Program Began</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Australia</td>
<td>PIP Practice Incentives Program</td>
<td>1998</td>
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<tr>
<td></td>
<td>Estonia</td>
<td>PHC QBS Primary Health Care Quality Bonus System</td>
<td>2005</td>
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<tr>
<td></td>
<td>France</td>
<td>ROSP* Payment for Public Health Objectives</td>
<td>2009</td>
</tr>
<tr>
<td></td>
<td>Germany</td>
<td>DMP Disease Management Programs</td>
<td>2002</td>
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<tr>
<td></td>
<td>New Zealand</td>
<td>PHO Performance Program</td>
<td></td>
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<tr>
<td></td>
<td>Turkey</td>
<td>FM PBC Family Medicine Performance Based Contracting Scheme</td>
<td>2003</td>
</tr>
<tr>
<td></td>
<td>U.K.</td>
<td>QOF Quality and Outcomes Framework</td>
<td>2004</td>
</tr>
<tr>
<td>Hospitals</td>
<td>Brazil--Sao Paolo</td>
<td>OSS** Social Organizations in Health</td>
<td>1998</td>
</tr>
<tr>
<td></td>
<td>Korea</td>
<td>VIP Value Incentive Programme</td>
<td>2007</td>
</tr>
<tr>
<td></td>
<td>U.S.-Maryland</td>
<td>MHAC Maryland Hospital Acquired Conditions Program</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>U.S. National</td>
<td>HQID Hospital Quality Incentive Demonstration</td>
<td>2004</td>
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</tbody>
</table>
P4P Program Design

Performance Measures

- Performance domains
- Indicators

Basis for Reward or Penalty

- Absolute level of measure: target or continuum
- Change in measure
- Relative ranking

Reward/Penalty

- Size of bonus payment or penalty
- Paid to individual or organization
- Non-financial incentives (e.g. publicize measures and ranking)

Data Reporting and Verification

- Information systems

## P4P Program Design Decisions

<table>
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<tr>
<th>Aspect of Design</th>
<th>OECD Experience</th>
<th>General Observations</th>
</tr>
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<tr>
<td>Performance Measures</td>
<td>7 (Korea VIP) – 142 (UK QOF)</td>
<td>Performance measures are highly inadequate Non-clinical/coverage indicators of dubious value</td>
</tr>
<tr>
<td></td>
<td>Most programs use 10-30 indicators</td>
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<tr>
<td>Basis for reward/penalty</td>
<td>Absolute (targets)—7 programs</td>
<td>Most programs reward improvement not only achieving targets</td>
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<td></td>
<td>Relative ranking—3</td>
<td></td>
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<tr>
<td></td>
<td>Varies by purchaser—2</td>
<td></td>
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<tr>
<td>Size of reward/penalty</td>
<td>1 – 30% of provider income</td>
<td>What is a “meaningful” incentive depends on income/margins of providers</td>
</tr>
<tr>
<td></td>
<td>Most programs &lt; 10%</td>
<td></td>
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<tr>
<td>Data/reporting</td>
<td>Claims/administrative data sources—9</td>
<td>Claims data good starting point but most programs need to add new data sources</td>
</tr>
<tr>
<td></td>
<td>New data source—3</td>
<td></td>
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</tbody>
</table>
Incentive structures reflect priorities

Distribution of points in U.K. QOF

- Clinical (655 points) 65%
- eHealth 33%
- After-hours 19%
- Practice Nurse 18%
- Diabetes, Asthma and Cervical Screening 11%
- Rural loading 9%
- Teaching 3%
- Quality prescribing 1%
- Domestic Violence <1%
- Aged Care Access 3%
- Procedural 3%
- Education and training 3%
- Coverage of priority services 4%
- Records and information about patients 9%
- Patient experience 11%
- Coordinated care 2%
- Practice management 2%
- Patient communication 0%

Source: ANAO 2010.

Distribution of payments in Australia PIP
Main Conclusions

Overall the P4P programs
- are typically costly (even when payments are low)
- have some obvious shortcomings in design/implementation

The results show
- only modest impacts on quality measures
- no impact on outcomes
- mixed results for efficiency and equity
  - direct incentives for efficiency have not been effective
  - direct incentives for equity have mixed results
- no serious unintended consequences

Unclear role/importance of incentives—but they often do not reach front-line providers.
Main Conclusions

- BUT, most programs contribute to:
  - Greater focus on health system objectives
  - Better generation and use of information
  - More accountability
  - In some cases a more productive dialogue between health purchasers and providers.

More effective health sector governance and strategic health purchasing
(1) Programmes are most effective when:

- They are aligned with and reinforce overarching strategies, objectives and clinical guidelines that are accepted by stakeholders
- They focus on specific performance problems that require broad-based approaches for improvement
- The incentive is integrated into and complements the underlying payment system.

(2) The structure of service delivery is important for whether or not providers can and do respond to the incentives

- Autonomy of providers is a critical pre-requisite
- Programs tend to favour larger, more urban providers.
What do Avoid

• Complex and non-transparent programme structure.
• Selective participation in programme domains
• Specific incentives to improve the organization of service delivery.
Questions to ask before “jumping” to P4P

• Do the diagnostics--what are the real barriers to performance improvement? Can they be resolved in other ways?

• How would P4P relate to and complement the underlying provider payment systems?

• Is there sufficient infrastructure and capacity (data, verification teams) to implement P4P effectively?

• Will problems with (administrative burden, transparency, gaming) be exacerbated or improved?

• What will happen to poor performers and the populations they serve?
Thank You.