Capturing the potential of “pay-for-performance” within national health financing arrangements

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Incentives matter, but can do harm as well as good: handle with care


Source of slide: Dr. Phusit Prakongsai, IHPP, Thailand
COUNTRIES AROUND THE WORLD ARE TRYING TO “PAY FOR RESULTS”
<table>
<thead>
<tr>
<th>Country</th>
<th>Program Name</th>
<th>Measures</th>
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</thead>
<tbody>
<tr>
<td>Australia</td>
<td>“Practice Incentives Program (PIP)”</td>
<td>13 incentive areas in 3 domains—quality of care, capacity, rural support</td>
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<tr>
<td>Brazil</td>
<td>“Programa de Incentivo para a Melhoria do Desempenho na Saude da Familia (PIMESF)”</td>
<td>6 indicators of health service coverage addressing specific health gaps in the municipality</td>
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<tr>
<td>France</td>
<td>“Contracts to Improve Individual Practice (CAPI)”</td>
<td>16 indicators in 3 domains—prevention, chronic disease management, cost-effective prescribing</td>
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<tr>
<td>New Zealand</td>
<td>“PHO Performance Programme”</td>
<td>10 indicators in 4 domains—service coverage, quality, efficiency, capacity to improve performance</td>
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<tr>
<td>U.K.</td>
<td>“Quality and Outcomes Framework (QOF)”</td>
<td>129 indicators in 4 domains—clinical care, organizational, patient experience, additional services</td>
</tr>
<tr>
<td>U.S.</td>
<td>“Premier Hospital Quality Improvement Demonstration (HQID)”</td>
<td>34 indicators for 5 acute clinical conditions: acute myocardial infarction, coronary artery bypass graft, heart failure, community-acquired pneumonia, and hip/knee replacement</td>
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</tbody>
</table>

And in low-middle income countries

- Spreading rapidly under labels of “RBF” and “PBF”

- Supported from the “Health Results Innovation Trust Fund” managed by World Bank and funded by Norway and the UK, with particular focus on MDGs 4 and 5. Many others now engaged
  - Focus on supply-side incentives and demand-side barriers
  - Link to targeted “free care” initiatives

- Has diffused rapidly
  - Initially in Benin, DR Congo, Eritrea, Ghana, Rwanda, Zambia
  - Later in Afghanistan, Argentina, Burundi, Cambodia, Kyrgyzstan, Nigeria, Sierral Leone, and many more
  - See (http://www.rbfhealth.org/rbfhealth/)
  - CoP PBF: https://groups.google.com/forum/?fromgroups#!myforums
SOME WHO REFLECTIONS ON THESE DEVELOPMENTS
Many ideas are being peddled in countries around the world. How to ensure that choices will actually solve problems rather than simply being "faith-based policy"?
Overall, these “incentive” initiatives are a positive development with good potential:

- Recognizes system obstacles that must be addressed to get priority services to those who need them.

- Can also help change the culture where (especially public sector) service provision is rigid and unresponsive.

- If done right, has great potential to build capacity for national health (and health financing) policy, and purchasing in particular.

- If done wrong, can be a purely donor-driven initiative that raises expectations, under-delivers, and leaves little behind after the project ends.
A part of health financing policy

- Getting “more health for the money” a WHR main message
  - More efficiency, more equity, from existing resources

- Health financing policy consists of 4 functions/policies
  - Collection (sources of funds and collection modalities)
  - Pooling (accumulation of prepaid funds on behalf of population)
  - Purchasing (allocation of resources to providers/interventions)
  - Benefits/rationing (entitlements and obligations of the population)

- Financial incentives are in the domain of purchasing
Just paying the provider’s bill can result in poor quality and inefficiency

Tonsillectomy rate in different counties of Hungary (age group of 0-14)

Source: MOH/ESKI, Hungary

Source of slide: Tamás Evetovits, WHO/EURO
Financial incentives are the focus of the purchasing function

● Generic definition: allocation of resources to providers
  – All systems do it, consciously or not
  – The way this is done generates incentives, which in turn influence provider behavior

● In financing policy, we aim for “active” or “strategic” purchasing:
  – Linking the allocation of resources to information on provider performance or population health needs
  – Seek to promote efficiency, use of desired services, and quality
RBF/PBF/P4P are examples of strategic purchasing

- They link payment to information
  - Often, fee-for-service targeted to specific aims like immunizing a child or delivering a baby in a health facility
  - Can be very sophisticated or quite simple (e.g. certifying that the providers meet minimum standards, or a shift from historical budgeting to simple capitation)
  - Can be used for both public and private sector providers (but may require changes in some administrative rules in the public sector)
Strategic purchasing and the Universal Coverage agenda

- Efficiency (more health for the money) as one of the key pathways to Universal Coverage identified in WHR2010

- Using purchasing more effectively is a demonstrated mechanism to enhance provider efficiency

- RBF/PBF/etc. is one pathway to developing more strategic purchasing (and strategic purchasing builds capacity!!)
  - People have to analyze and use information on what is actually happening with health services, and use it for decision-making
  - Changes the culture of the system, shakes up bureaucratic inertia

- The alternative (passive budgeting or unmanaged fee-for-service) does not promote efficiency
Managing expectations: most results-based financing does not really finance results

- It is rare that anyone is paying for “results” or for “performance”
  - We economists are great at measuring quantity, and have developed methods to pay for it.
  - Not so great at quality

- So frequently, "RBF" means paying for reporting, or paying for processes that are believed to be associated with good quality
Financial incentives are more effective for some things (routine, mechanical) than others (cognitive)

www.youtube.com/watch?v=u6XAPnuFjJc
But the “mechanical” processes may still be important (e.g. Australia diabetes P4P)

- Existence of a diabetes register and patient recall/reminder system
  - One-off signing award that depends on the size of the practice

- At least 20% of diabetes diagnosed patients complete a cycle of care
  - For practices with at least 2% of their patients diagnosed with diabetes mellitus
  - GP gets a AUS$20 reward per patient

- Absolute number of diabetes treatment cycles completed
  - Every completed treatment cycle is awarded AUS$40
More generally, that's okay

- If the problem is lack of activity, especially for interventions for which there is not a lot of quality variation (e.g. immunizations, directly observing a TB patient taking their medicines), paying for it can still give you better performance.

- If low utilization/productivity is the problem, paying for outputs can help.
  - Some good experiences linking RBF to “free care” (e.g. Burundi).

- And payment incentives can drive efficiency gain, which is also important.

- An instrument to bring systems and “programs” together.
  - Effective use of these mechanisms requires technical/clinical input.
  - Don’t let economists like me decide what the “good processes” are!!

- Need to monitor reporting sufficiently.
  - Verification of data essential, but can be costly and difficult.
But care and humility are warranted

- Targeted payment incentives work best for mechanical, repetitive tasks

- Effects of payment incentives are less clear for more complex tasks requiring greater cognitive assessment by the provider

- Requires a tailored approach

- And recognize as well that the ability of financial incentives to "drive quality improvement" may be quite limited (our dose of humility); so need a comprehensive approach to quality improvement
Don't overdo it

- We don't want a totally (or even predominantly) fee-for-service system (i.e. lessons from China)

- Marginal vs average: may well be that a small payment incentive is all that's needed to get response we want

- Careful not to overwhelm management capacity
  - How many special incentive programs can the purchaser manage (one of the concerns of the English QOF)?
  - That is a risk of “project-izing” the RBF rather than treating it as part of a wider system intervention
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<td>Australia</td>
<td>PIP</td>
<td>Average payment to a practice in 2009-2010 A$57,800 (4-7% of total practice income)</td>
</tr>
<tr>
<td>Brazil</td>
<td>PIMESF</td>
<td>20% of individual salary</td>
</tr>
<tr>
<td>France</td>
<td>CAPI</td>
<td>The payment to a physician is EUR 3,100 per year (2% of average total earnings)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>PHO Perf</td>
<td>Less than 1% of government PHC expenditure</td>
</tr>
<tr>
<td>U.K.</td>
<td>QOF</td>
<td>The average payment to a GP practice was £74,300 in 2004-05 (30% of average total earnings) and £126,000 in 2005-06.</td>
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<tr>
<td>U.S.</td>
<td>HQID</td>
<td>2% of Medicare payment for only 5 clinical conditions but often &gt; $100,000 per hospital</td>
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Link to main payment mechanism

- Need to ensure that main payment mechanism is aligned with objectives
- Need to ensure sufficient facility autonomy for providers to respond
- Sequencing is important for P4P to make an impact

“... simply attaching targets, indicators and bonuses to underlying payment systems that do not create the right incentives seems to be expensive and ineffective.”

Cheryl Cashin
Message: use these initiatives to build the system, not just to “prove they work”

- RBF should not be run like a "scheme" or "project", but as a step in the process of moving systems towards more strategic purchasing
  - Long-term capacity building for the purchaser (and investing in understanding by the providers) is much more important than trying to "prove" whether or not it works (because we know that passive budgeting or unmonitored fee-for-service does not work)
A bad RBF project…

…is run by donors (or institutionalizes the idea that the money for these incentives will be managed separately)

…overdoes the financial incentives in a way that can't be sustained by the government

…is only interested in "proving it works" in the short run, rather than always acting with the intent to move from scheme to system

…overwhelms domestic capacity with too many new things to monitor

…does not address the institutional platform that will, in the future, be required to attract and retain the people with the necessary skills to be good purchasers
Using performance-based payment for system-building: the case of Burundi

- 2006: President declares abolition of user fees for pregnant women and under-5's
  - Initial large increase in utilization, as desired
  - But absence of fee revenues led to rapid depletion of inputs, complaints from health workers about increased workload, and then informal payments
  - Problems led to development of a solution…a more comprehensive approach to reform
Making the promise real in Burundi

- Linking (“performance-based”) payment to benefits
  - Initial pilots not linked to free care initiative, but then came together
  - Payment linked to facility-level indicators on services for under-five's and pregnant women
  - Linking benefits to payment kept the benefits of fee revenue for providers (flexible and rapid use) while eliminating access barriers
  - This comprehensive approach only went national in mid-2010 \( \rightarrow \) too early to know the full impact
  - It reflects a move towards real strengthening of the national health financing system: central MOH-linked agency managing and analyzing the data, asking questions, making the payments
Lessons illustrated by this experience

- Declaring a package without first having (or concurrently introducing) a mechanism to pay for it results in an unfunded mandate
  - Undermines transparency and confidence in the system
  - Sequencing matters: need a payment mechanism before you can successfully realize and sustain entitlements

- Making an explicit link between benefits and purchasing reflects “systems thinking”, and moves beyond the simple accounting logic often applied to “packages”
  - Also links to public sector financial management issues, if these new mechanisms are to become part of the wider system
SUMMARY MESSAGES
Our perspective on all of this: it has great potential, but manage expectations

- "RBF" can be entry point to strengthening the purchasing function of health financing systems
  - As such, it is part of our Universal Coverage agenda
  - Perhaps most important is that it has the potential to build real capacity for evidence-informed decision making

- It’s not a “magic bullet” – must be part of an overall approach to system reform
  - just “free care” or just “results-based payment” unlikely to work
  - it takes coordination among the pieces to make things work
  - don’t let fascination with the latest fad take too much attention away from the “heavy lifting” that real reform requires
  - And more generally, we don’t believe in magic
Towards Universal Coverage requires moving from scheme to system

- Whatever exists in the country today is the starting point
  - a foundation on which to build (and from where to move)

- Principles to guide progress
  - Explicit complementarity of different funding sources
  - Focus on reducing fragmentation and expanding pool size (more prepayment, not more prepayment schemes)
  - Recognize that real progress will require an explicit role (and for most of your countries, increased levels) for general revenues
  - Create unified information platform across all schemes to lay foundation for universal financing system
  - More money and larger pools not enough: need to move towards strategic purchasing to address inefficiencies and make progress on defined, measurable objectives by linking payment to core benefits