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Health Care Funding, Cost-Containment, and Quality

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Pay-for-Performance — What is it?

The explicit use of targeted financial incentives to encourage specific behaviors intended to improve quality of care.

Ontario Preventive Care Bonus Payment Scheme:

Pap smear	Proportion of FP's rostered female patients aged 35-69 who received a Pap smear for cervical cancer screening during the previous 30 months[c]	• 60% of target population: $220 • 65% of target population: $440 • 70% of target population: $660 • 75% of target population: $1,320 • 80% of target population: $2,200

Ontario Diabetes Management Assessment Fee Code ($37.00)

- encourage the regular, comprehensive management of diabetic patients the regular, comprehensive management of diabetic patients
- maintain a diabetes flow sheet that tracked cholesterol, haemoglobin, retinal eye examination, blood pressure, weight, and other parameters relevant to diabetes management
- bill the code up to three times per year per diabetic patient

Ontario Preventive Care Bonus Scheme *(Hurley et al. 2011)*

Preventive Service	Baseline Coverage Rate
Senior Flu Shot	0.554
Toddler Immunization	0.543
Pap Smear	0.589
Mammogram	0.646
Colorectal Cancer Screening	0.150

Ontario Preventive Care Bonus Scheme *(Hurley et al. 2011)*

Preventive Service	Baseline Coverage Rate	Absolute Increase	Percentage Increase
Senior Flu Shot	0.554	0.028	5.0%
Toddler Immunization	0.543	0.011	2.0%
Pap Smear	0.589	0.041	6.9%
Mammogram	0.646	0.018	2.7%
Colorectal Cancer Screening	0.150	0.085	56.7%

Ontario Diabetes Management Assessment Fee *(Kiran et al. 2012)*

- uptake of the code was low (25% of diabetic patients)
- the code was not associated with increased compliance with three evidence-based services (retinal eye exam, HbA.sub.1c and cholesterol measurement)
- the code rewarded those already providing good care while having little or no effect on other physicians

Pay-for-Performance: Does it Improve Quality?

Systematic Reviews (Giuffrida et al. 1999; Armour et al. 2001; Town, Kane, and Johnson 2005; Rosenthal and Frank 2006; Christianson et al. 2008; Scott et al. 2011)

Rosenthal and Frank (2006): *". . . the empirical foundations of pay for performance in health care are rather weak."*

Christianson et al. 2007: *the evidence is not sufficient to inform the effective design and implementation of pay-for-performance*

Scott (2011): *". . . there is insufficient evidence to support or not support the use of financial incentives to improve the quality of primary health care."*

Pay-for-Performance: Does it Save Costs?

- Little or no evidence regarding net impact on costs
- Cost-per-unit change in service provision is high
  - windfall gain to all those already meeting targets

Pay-for-Performance: Can't Play a Substantial Role

- Little evidence to indicate that pay-for-performance is effective in improving quality or controlling costs
- A bit of reflection reveals that, even if effective, it could never serve as the foundation for a concerted, comprehensive initiative to improve system quality
  - only a small share of provider activity can be targeted in this way
  - this approach requires creating a parallel "fee-schedule" of bonus payments linked a dozens of specific actions/diseases

Funding Matters

- Distinguish the use of targeted financial incentives from funding *per se*
- Funding schemes unavoidably create financial incentives
  - fee-for-service vs. case-based funding vs. capitation vs. global budgets
- Decades of research confirm that these incentives importantly shape provider behavior, system costs and (less well documented) quality
  - increased "prospectiveness" associated with greater cost control and no lower quality
  - alternative payment methods offer differing scope for innovative delivery arrangements and, consequently, non-financial initiatives to improve quality

Directions in Funding Reform

- increased prospectiveness of funding with link to quality (but not necessarily specific actions)
- increase funding linkages across primary, secondary, and institutional care
- joint design of funding models and delivery models

Some Examples

- *Bundled Payment Models*

  Episode-based payment that integrate payment for hospital and non-hospital services
- *"Shared Savings" Models*

  FFS but providers eligible for share of savings if costs stay below target level and the providers meet quality targets.

  Integrated with Accountable Care Organizations (ACOs) and versions of Medical Homes

Directions for Canada

- Funding reform is an important part of reforms to improve quality and control costs, BUT it only one part of coordinated set of policies
- Move toward blended payment models for primary care

  practices funded by a mix of capitation, FSS, programmatic funding
- Build a foundation for better linking funding across physician, hospital and other sectors

  bundled payments?

  gainsharing?
- Virtue in simplicity and transparency

Thank You