Global Review of Pay for Performance and Financing Systems

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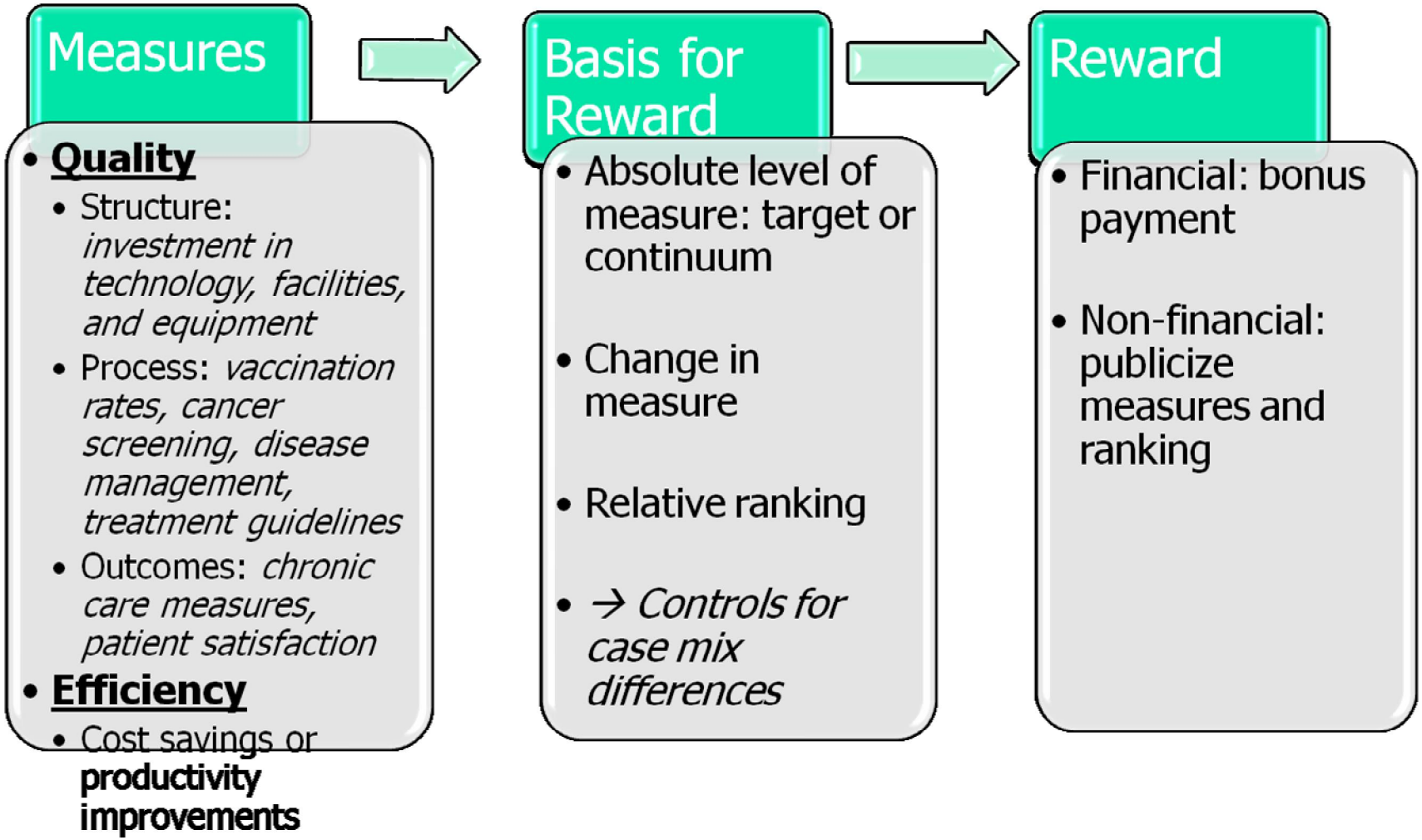
The First Pay for Performance Program: Emperor Qin Shi Huang's

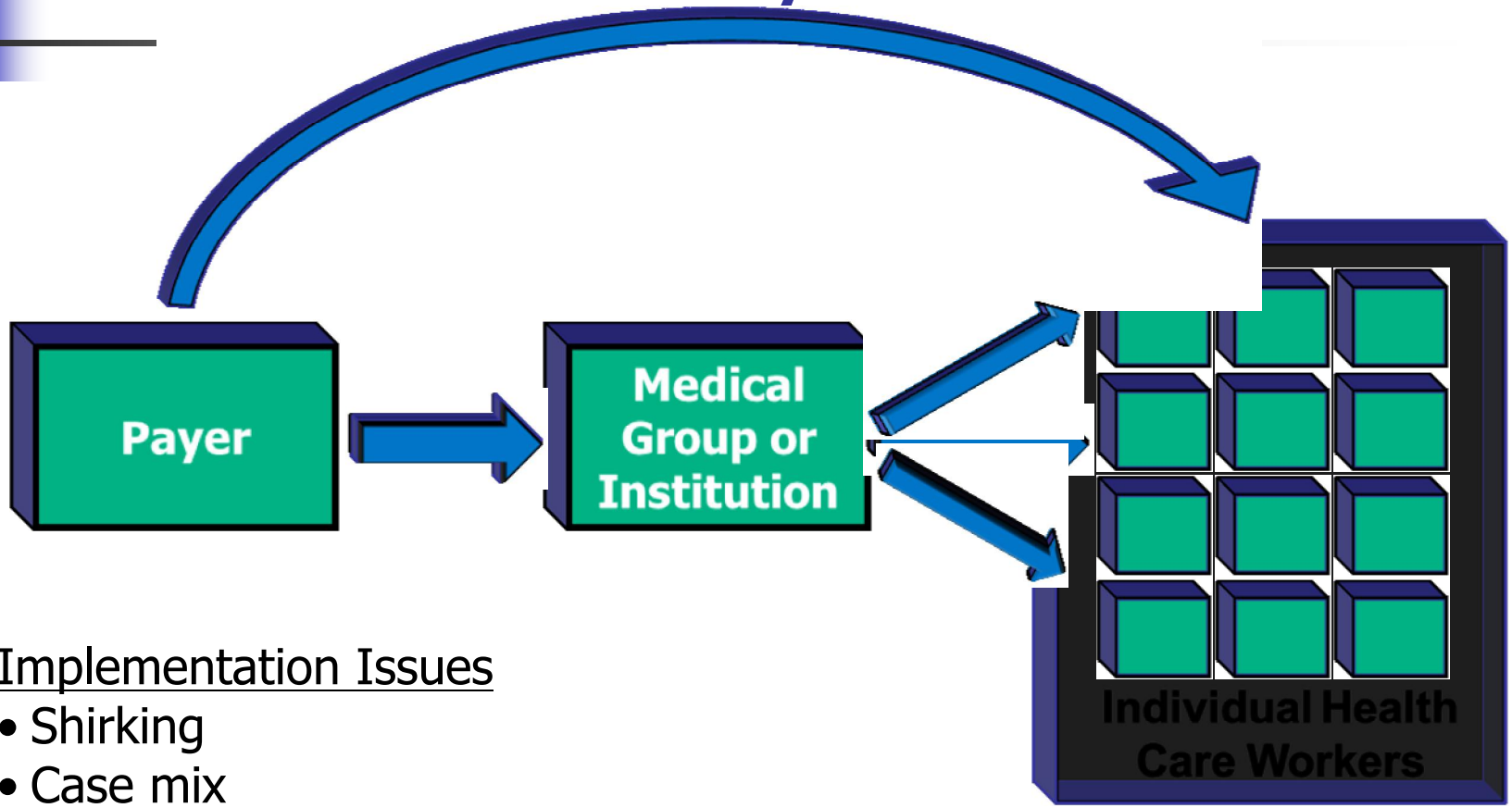
Emperor of Qin Dynasty
(259 BCE – 210 BCE)

Framework of P4P Programs



Source: Adopted from Scheffler RM: *Is There a Doctor in the House? Market Signals and Tomorrow's Supply of Doctors*, Stanford University Press, 2008.

P4P Reward Payment Models



Implementation Issues

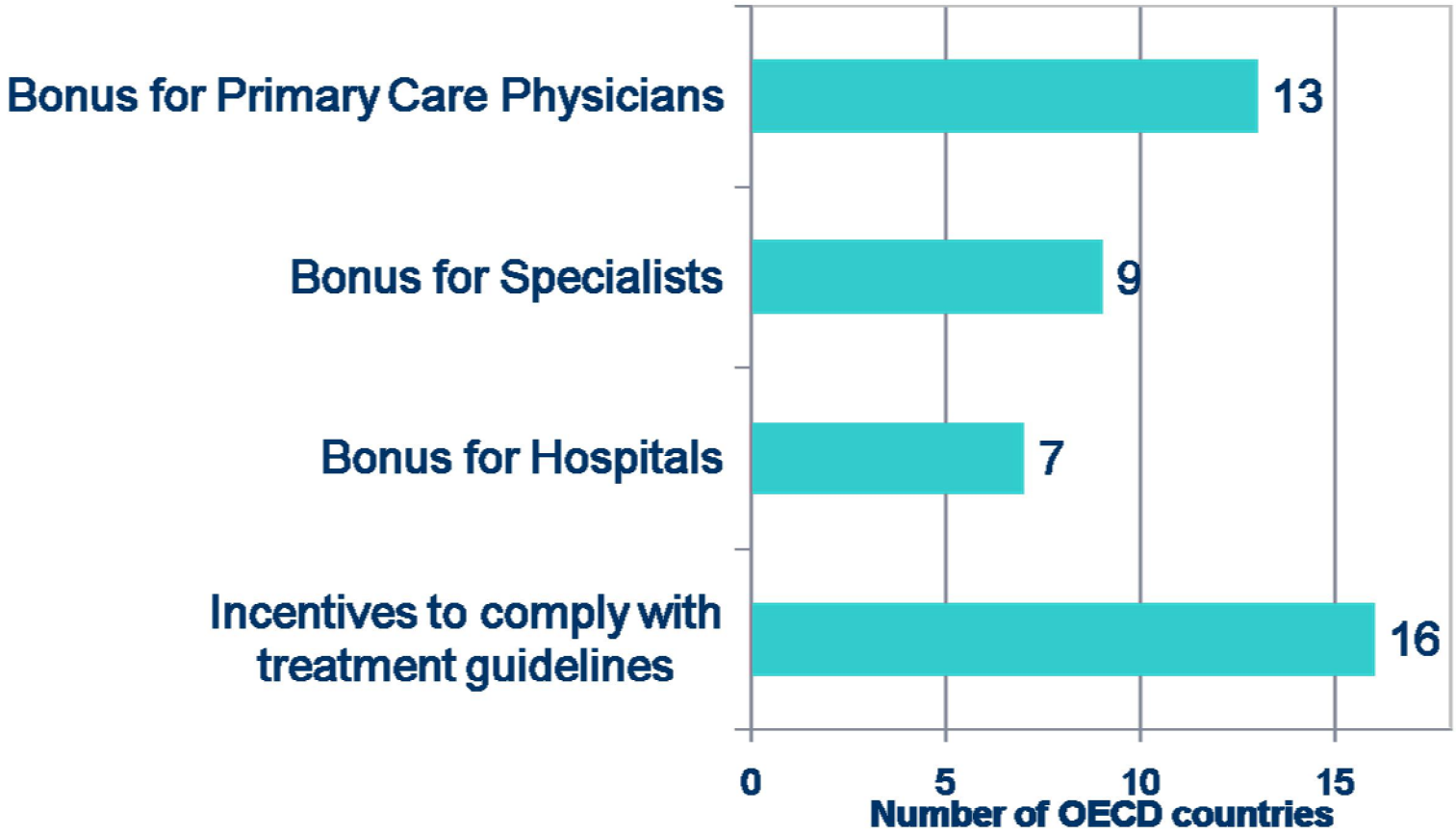
- Shirking
- Case mix
- Medical groups and institutions have multiple payers

Source: Adopted from Scheffler RM: *Is There a Doctor in the House? Market Signals and Tomorrow's Supply of Doctors*, Stanford University Press, 2008.

OECD Survey on Health System Characteristics 2008-2009

- All OECD countries, except the United States replied to the survey
- Questions related to P4P
  - Whether country had bonus payments for primary care physicians, specialists, and hospitals
  - Proportion who earn bonuses and size of bonus
  - Types of measures: preventative care, chronic disease, patient satisfaction, clinical outcomes

OECD P4P Survey Results



Source: OECD Survey on Health System Characteristics 2008-2009 (including the United States). Data for Sweden not available.

OECD P4P Country-Level Survey Results (continued)

Bonus payments to:	Country Name
Primary care physicians (PCP)	Australia, Hungary, Italy, New-Zealand, Portugal
Hospitals	Luxembourg
PCP and specialists	Czech Rep., Poland, Spain
Specialists and hospitals	Slovak Rep.
PCP, specialists, and hospitals	Belgium, Japan, Turkey, UK, USA

Source: OECD Survey on Health System Characteristics 2008-2009 (including the United States). Data for Sweden not available.

OECD Survey Findings

- Pay for performance programs reported in 19 OECD countries
- Number of countries that had bonuses for:
  - Primary care physicians (15)
  - Specialists (10)
  - Hospitals (7)
- Most bonuses are for quality of care targets such as:
  - Preventive care
  - Management of chronic diseases

Goal of Provider Pay for Performance

- Principal-agent problem and asymmetric information
  - Principal (payer) hires agent (provider); they have different objectives
  - Provider has more information about health production function than payer
- P4P's goal is to better align provider's objective with payer's
  - Provider's information advantage
  - Provider is risk averse

Incentives are design to change mix of services and inputs

- Health care service mix
  - Chronic disease management to avoid inpatient stays
- Input mix used to produce those services
  - Health workforce mix

Six Factors to Assess Provider P4P's Effect on Health

- 1. Health-increasing substitution (+)
  - Incentives' goal is for new mix of services and inputs to increase health
- 2. Health-decreasing substitution (-)
  - Incentives can be perverse, where providers substitute away from unrewarded, yet important, dimensions because they are unobserved or unmeasurable

Six Factors to Assess Provider P4P's Effect on Health (cont.)

- 3. Provider surplus extraction (e.g., increased provider effort) (+)
  - Provide incentives to increase workers' effort, where increased effort could be for output (LICs) or quality (HICs)
  - Example
    - Before P4P: \$100,000 salary with effort e_1
    - After P4P:
      - \$90,000 salary plus bonus \$0 to \$20,000, with expected value of \$10,000 with effort e_2, where $e_2 > e_1$
    - Impacts
      - Some workers will quit
      - Remaining workers willing to expend effort e_2

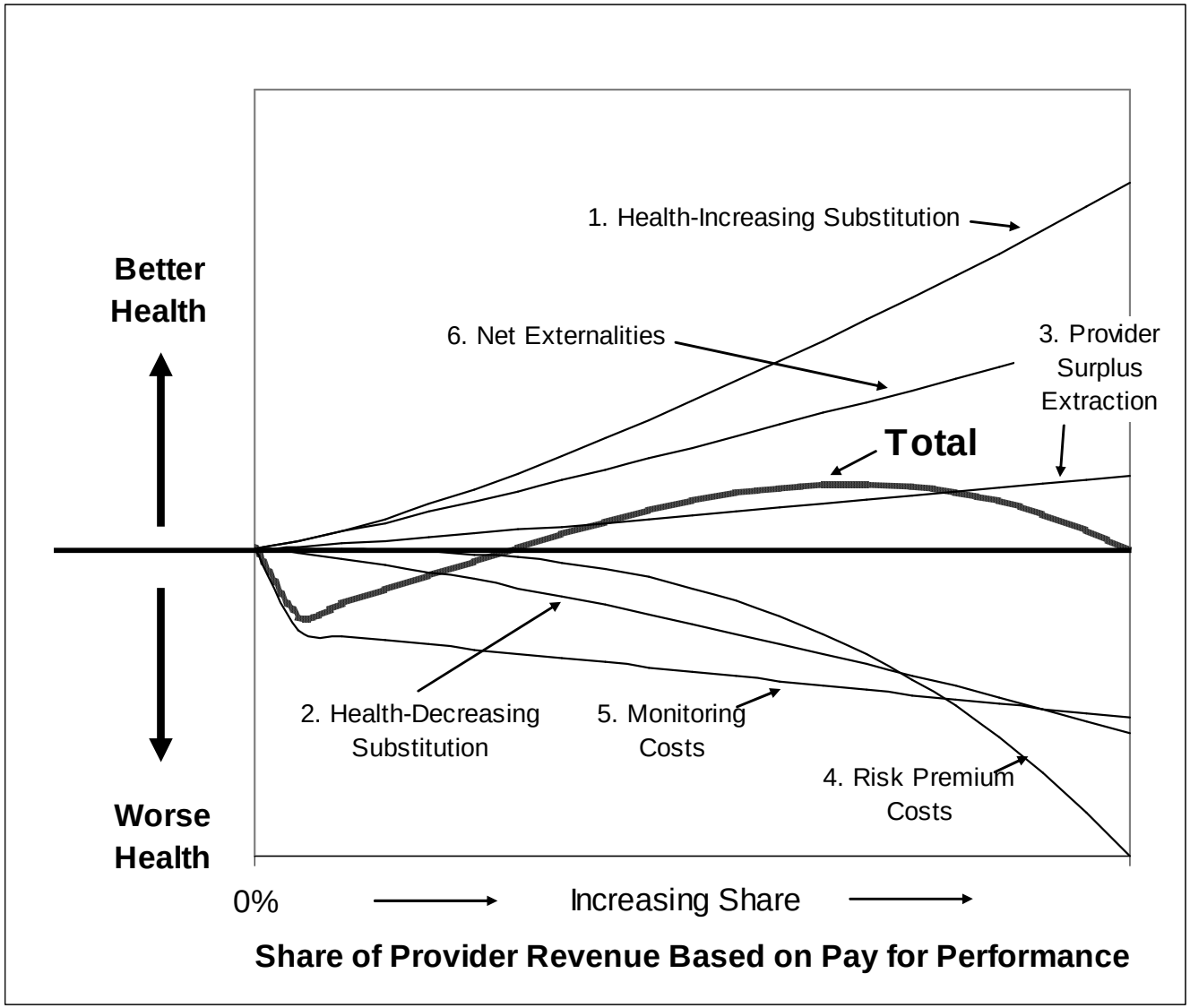
Six Factors to Assess Provider P4P's Effect on Health (cont.)

- 4. Risk premium costs (-)
  - Need to compensate provider for taking on risk, i.e., for being rewarded for factors beyond its control
  - Risk premium costs decrease health, because less budget available for health care services

Six Factors to Assess Provider P4P's Effect on Health (cont.)

- 5. Monitoring costs (-)
  - Monitoring costs decrease health, because less budget available for health care services
- 6. Net externalities (+ or -)
  - Positive or negative effects on health, beyond the explicit P4P measures
    - Positive – better governance and information systems
    - Negative – workers become less team-oriented

Six Factors to Assess Provider P4P's Effect on Health



California Pay for Performance Program

- Overview
  - Eight commercial HMO health plans, covering 11.5 million enrollees, and approximately 230 physician groups with 35,000 physicians
  - 68 measures in five domains: clinical quality, patient experience, information technology-enabled systemness, coordinated diabetes care, and resource use and efficiency (gain sharing)
- Key Factors to Assess
  - Health-increasing substitution: likely low because bonuses represented 2% of physician groups' revenues (1)
  - High monitoring costs (5)

United Kingdom Quality and Outcomes Framework

- Overview
  - 134 indicators in four domains: clinical, organizational, patient experience, and additional services
- Key Factors to Assess
  - Increase in provider effort was low, because targets set too low (3)
  - Paid too much for moderate risk exposure (4)
  - High monitoring costs (5)

New Zealand Primary Health Organization (PHO) Performance Programme

- Overview
  - Incentives paid to Primary Health Organization
  - Maximum bonus adds only $8.24 to capitated payment
  - 10 performance indicators, including cardiovascular disease screening and diabetes follow-up
- Key Factors to Assess
  - Health-increasing substitution and increase in provider effort both low, because bonuses were too low and they did not reach workers (1, 3)
  - Net externalities may be large because of better governance and data systems, as a result of P4P (6)

Zambian Health Results Based Financing

- Overview
  - Pilot began in 2009
  - Fee for service payments to increase utilization (e.g., antenatal care visits, institutional deliveries by skilled birth attendant, immunizations)
  - FFS payments adjusted based on quality measures
  - FFS payments up to 20% of facility's routine funding
    - Facility may allocate up to 30% of its FFS payment to worker salary bonuses
- Key Factors to Assess
  - Expect provider surplus extraction/increase in provider effort, similar to Rwanda (3)
  - Risk premium costs may be moderate to high (4)

Conclusion

- The 6 factors that we identified can be used to better design P4P programs
- P4P programs are growing rapidly in the OECD countries
- Well designed impact evaluations of P4P in the OECD are lacking

THANK YOU VERY MUCH!

QUESTIONS?