PAYING FOR INTEGRATED CARE: AN OVERVIEW

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Summary: Population ageing and the rising prevalence of chronic diseases challenge health care systems, underscoring the need for new approaches to population health management, such as integrated care. Financial incentives are used in many countries to encourage the implementation of integrated care schemes. Here, we review innovative integrated care schemes, payment models and financial incentives implemented in several countries at the forefront of integrated care. The review shows that further assessment of the effectiveness of these incentives is required; caution also should be taken when translating cost-effective incentives from one country to another, as they may not be transferable.

Keywords: Integrated Care, Financial Incentives, Payment Models, Pay-for-performance

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Introduction

Increasing health expenditure is a matter of great concern in many countries, with the percentage of Gross Domestic Product (GDP) devoted to health rising substantially over the last two decades (see Figure 1). This trend is expected to increase in the coming years with the ageing of the world’s population and the rising prevalence of chronic diseases. New models of chronic care and approaches to population health management have been developed to respond to the changing burden of disease. In recent years, the use of integrated care models has gained renewed attention as an important mechanism to promote the on-going viability and sustainability of health care systems.

A key factor in the integration of care is the adoption of payment systems that incorporate appropriate financial incentives. In many countries, financial incentives are used to encourage the implementation of integrated care schemes, recruit and enrol patients into these schemes, implement better systems of data collection, mandate the use of clinical practice guidelines and ensure that they are followed, and reach process and outcome targets. Indeed, financial incentives can be used to influence the structure, processes, and outcomes of care.
of integrated care. Presently, the vast majority of payment schemes used in most high-income countries focus on the structure and processes of care, with some exceptions, such as in the United Kingdom (UK) where certain payment incentives for general practitioners (GPs) are linked to specific patient health outcomes. While most incentives and payment systems in integrated care schemes have targeted health care providers, various financial incentives have also focused on health insurers and patients as well.

An assessment of the effectiveness of these incentives and payment models in integrated care remains crucial, however. In particular, several empirical questions need to be addressed: Are financial incentives able to improve the integration of care, and if so, in which contexts? Are some incentives more effective than others? To whom should they be directed? Here, we review some of the existing evidence on payment systems and incentives for integrated care services, in an attempt to determine the extent to which the available evidence currently allows for these questions to be addressed.

In particular, this review focuses on innovative integrated care schemes, payment models, and financial incentives in some countries at the forefront of integrated care, including Australia, Canada, Denmark, France, Germany, the Netherlands, the UK, and the US. Country-specific case studies complement this article but caution should be taken regarding the evidence available as it is descriptive and may be difficult to translate to other settings due to cultural and organisational differences among health systems.

**Incentives and payment mechanisms for providers**

We first describe various types of financial incentives that reward providers with additional (performance-based) payment for participating in integrated care schemes and/or achieving certain integrated care goals but that do not substantially alter provider remuneration (e.g. fee-for-service, capitation, etc). Subsequently, we present several innovative integrated payment models that more fundamentally change the ways health care providers are paid.

**Financial incentives**

Pay-for-performance (P4P) schemes are widely used to incentivise health care providers to develop appropriate structures and processes for integrated care and chronic care delivery.

One example is the Quality and Outcomes Framework (QOF) that was introduced in England in 2004, with the main aims of improving the quality of primary care, embedding preventive measures in the health system and stimulating an improvement in chronic disease management. The QOF rewards GP practices with financial incentives for meeting quality targets, with more than half of all indicators referring directly to the management of common chronic diseases. However, the current evidence base for the impact of the QOF remains patchy and inconclusive and there is no consensus on whether the QOF has changed the underlying overall rate of quality improvement, despite some significant, albeit small, improvements for some conditions such as diabetes, asthma and cardiovascular care for diabetic patients (see case study article).

Performance-based incentives are also used in the ‘Gesundes Kinzigtal’ Integrated Care initiative in Germany, a population-based integrated care system introduced in 2005 that covers all sectors and indications of care for members of two sickness funds (see case study article). While health care providers continue to be reimbursed by health insurers, providers participating in the scheme are given additional P4P reimbursement for services not normally covered but considered important to achieve better quality of care. In addition, all providers are given a share of the company’s profit on the basis of individual provider performance. While an overall evaluation of the system is still underway, various safeguards to mitigate the potential for risk selection have been put in place, which have been shown to be successful not only in preventing traditional risk selection, but in achieving an “inverted” risk selection, such that the scheme has primarily enrolled members with above average morbidity and costs (see case study article).

In 2005, the Australian Government also introduced a series of additional financial payments for health care professionals if they created Team Care Arrangements (TCAs) for chronically ill patients who require on-going care from at least three health care providers (see case study article). Under this scheme, health professionals are paid for performing activities related to an individual’s care plan. While a comprehensive evaluation of this initiative has not been carried out...
as yet, the initiative has been criticised as being too prescriptive and cumbersome, potentially discouraging health care professionals from creating, reviewing or contributing to a TCA (see case study article).

In Denmark, for example, the government introduced payment innovations for physicians who use EMRs and for primary care practices that conduct telephone and email consultations. From 2003 to 2004, GPs and pharmacists in the Italian region of Lombardy also received financial incentives for actively promoting and using the region’s electronic health and social care information system in patient consultations. Similarly, while rewarding primary care providers for both quality measurement and quality improvement, the QOF in England also incentivises the adoption and use of health care IT.

Payment models
Beyond the use of additional financial incentives that can augment providers’ regular sources of income, several countries are currently experimenting with various innovative integrated care payment models that more fundamentally change the ways in which health care providers are paid.

For example, the Medicare Severity Diagnostic Related Groups (MS-DRGs) that the Centers for Medicare and Medicaid Services (CMS) adopted in 2007–2008 in the US was a new scheme replacing the existing 538 DRGs in Medicare’s Inpatient Prospective Payment System (IPPS) for acute care inpatient hospital stays with 745 DRGs that were adjusted for severity of illness (see case study article). Each MS-DRG now has a flat payment weight that is assigned to each inpatient stay using the principal diagnosis, up to eight secondary diagnoses, the main procedure performed, up to six additional procedures, age, sex, and discharge status. By reimbursing providers at a higher rate for more severe cases, MS-DRGs provide a financial incentive for hospitals to improve the clinical integration of health care.

However, an evaluation assessing whether this change has increased clinical integration has not been conducted. It has been argued that the cost-control incentives created by DRGs may present an obstacle for the integration of care in that hospitals only have an incentive to work towards clinical integration, rather than more general integration of care, and to collaborate with physicians inside the hospital rather than those working outside of the hospital.

For outpatient care, various countries, including Denmark, the Netherlands and the UK, have piloted innovative schemes providing an annual payment for the complete package of care required by patients with chronic diseases. Under the bundled payment scheme for diabetes care in the Netherlands, for instance, health insurers are able to purchase all of the health care services needed to manage diabetes through the payment of a single fee to newly created contracting entities called “care groups” (see case study article). Comprised of multiple health care providers, care groups are clinically and financially responsible for all assigned patients in the diabetes care programme. In principle, this payment structure incentivises the care groups to achieve greater value for money, thereby potentially resulting in lower use of more expensive specialist and hospital services. Preliminary evaluation of bundled payments for diabetes care indicated that these had higher cost increases than for patients not enrolled in a disease management programme (DMP) (see case study article). Nevertheless, it is still too early to draw definitive conclusions about the long-term impact of bundled payment schemes on the costs and quality of diabetes care.

Similarly, a pilot programme introduced in Denmark in 2007 offered GPs additional remuneration for coordinating care for diabetes patients. Upon joining the scheme, GPs are paid a relatively high up-front annual fee of £125 (€156) per diabetic patient listed, with the practice to cover the various elements of disease management (see case study article). Importantly, entering into this new form of reimbursement is voluntary and the GPs are free to stay under the traditional fee-for-service reimbursement scheme. The implementation of the scheme is not complete and has therefore not yet been evaluated.

Incentives for purchasers
While most financial incentives flow from purchasers of care (i.e. sickness funds and health insurers) to health care providers,
financial incentives can also be targeted at purchasers of care. In practice, few such incentives exist, but some noteworthy examples include the use of funding allocation formulas that account for patient enrolment in DMPs as well as morbidity criteria. In Germany, for instance, sickness funds receive an additional flat rate (€180) for patients enrolled in DMPs, providing sickness funds with an incentive to develop such programmes.

Incentives for patients

With regard to patients, several financial incentive schemes have been introduced throughout Europe. In Germany, co-payments may be reduced or waived for patients enrolled in certain DMPs, who are also given access to additional services for which non-DMP patients are not eligible. In the ‘Gesundes Kinzigtal’ Integrated Care model, for instance, while there are no direct financial incentives offered to patients, enrolled patients receive a number of enhanced services such as improved care coordination across all sectors, individualised treatment plans, additional health check-ups relative to normal care and discounts for gym memberships. Meanwhile, in France, co-payments are waived for DMP care if patients bring their care protocol to every physician visit.

Also fundamentally changing the nature of paying for integrated care is the implementation of personal health budgets (PHB) in the Netherlands and the UK, which incentivised patients to take charge of their care needs. Seeking to improve the integration of social care, these programmes provide patients with cash or vouchers that they can use for home care, with patients able to choose what care is most appropriate for them (see case study article). In the Netherlands, PHBs were introduced in 1996 for the older people and for people with disabilities to empower them and provide more flexibility as they receive a set amount of money that they can use for health care at their convenience within a regulated framework. The major challenges of the scheme, however, are that the number of PHBs has increased exponentially over time and cases of fraud have been reported. By January 2014, the government expects to reduce the number of PHBs by 90% and to restrict the scheme to people who would otherwise move to a nursing or residential home. In theory, PHBs may increase competition between service providers and increase quality; however, little evidence is available, and the available evaluations show a high level of patient satisfaction but a weak impact on health improvement.

In the UK, as the result of a series of pilot projects starting in 2005, PHBs were also introduced throughout the country. Individuals are able to spend a discretionary allowance on a variety of services, which allows them to determine the quantity and type of service appropriate for their own needs. Evaluations in 2008 and 2012 have shown positive results, concluding that PHBs can be used as a vehicle to promote better integration and that further integration may lead to additional changes in the balance of services used by individuals. Although the results indicate that PHBs change the use of primary and secondary care, no change was found in the use of social care services.

Discussion

At present, there is limited evidence on the effects and effectiveness of financial incentives and other payment models in integrated care. Most of the incentives have been applied in very specific settings or at an early stage of implementation, with little or no evaluation available as yet. Countries should therefore take a cautious approach when designing and implementing integrated care schemes with the use of financial incentives and innovative payment models, particularly as success in one setting may not be transferable elsewhere due to different cultural and organisational contexts across systems.

A key requirement for the development of effective payment schemes is the availability of information systems that can be used to measure and assess the structure, processes, and outcomes of care. If used, financial incentives need to be designed carefully so as to reduce the likelihood of unintended negative consequences. This requires careful selection of incentive-linked, risk-adjusted performance measures, which should be closely associated with improvements in health. A combination of both process and outcome measures may represent the best approach. In addition, the size of the incentive is likely to be important in influencing provider behaviour in integrating care. Given the dearth of research in this area, it seems prudent not to offer very large financial incentives.

Ultimately, however, financial incentives in isolation are unlikely to be a sufficient condition for success. The successful uptake and on-going viability of integrated care models is more likely to depend on the complementary use of financial and non-financial incentives.

References