Financial incentives - the role of provider payment mechanisms in relation to the quality of mental health care

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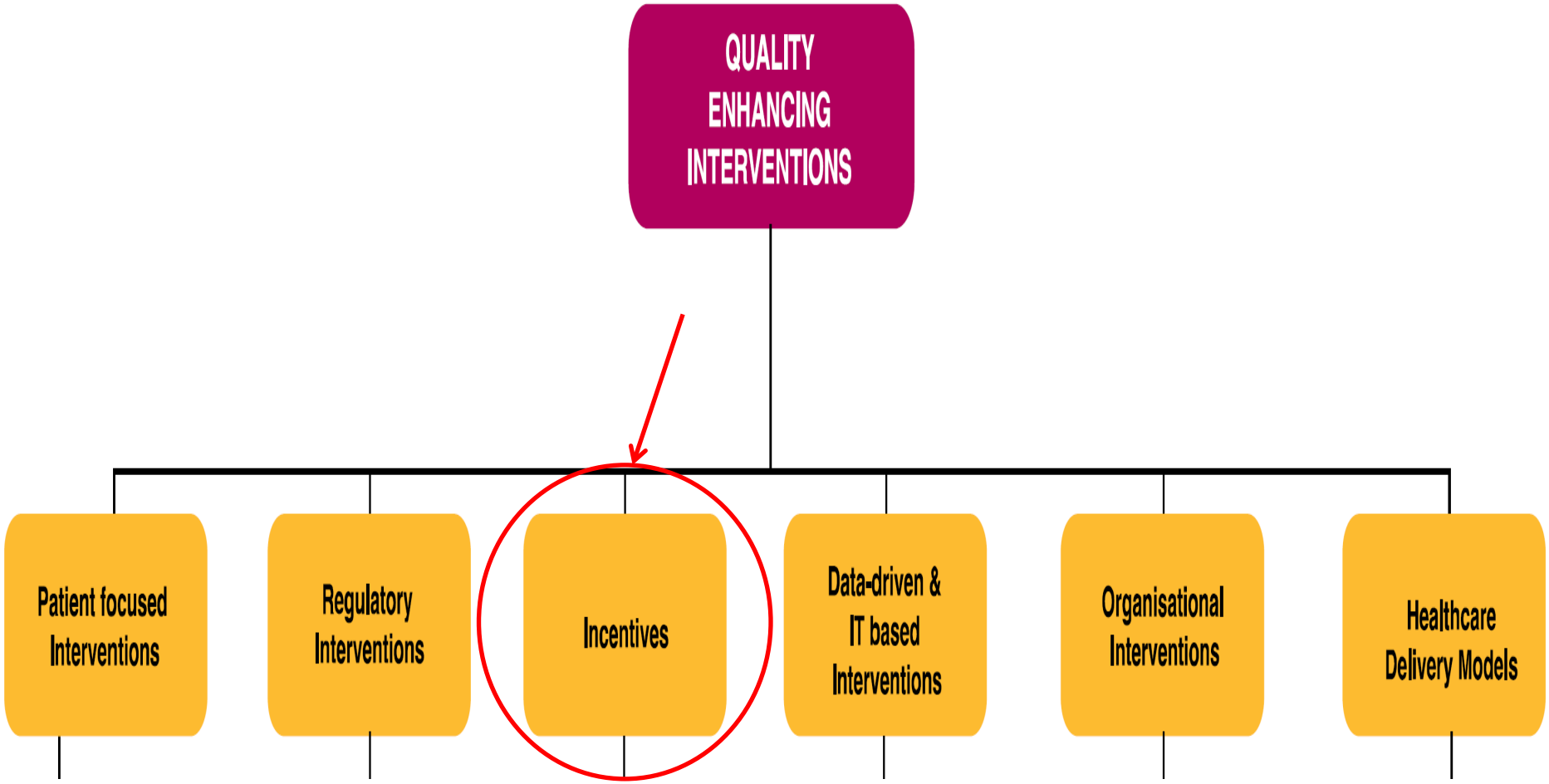
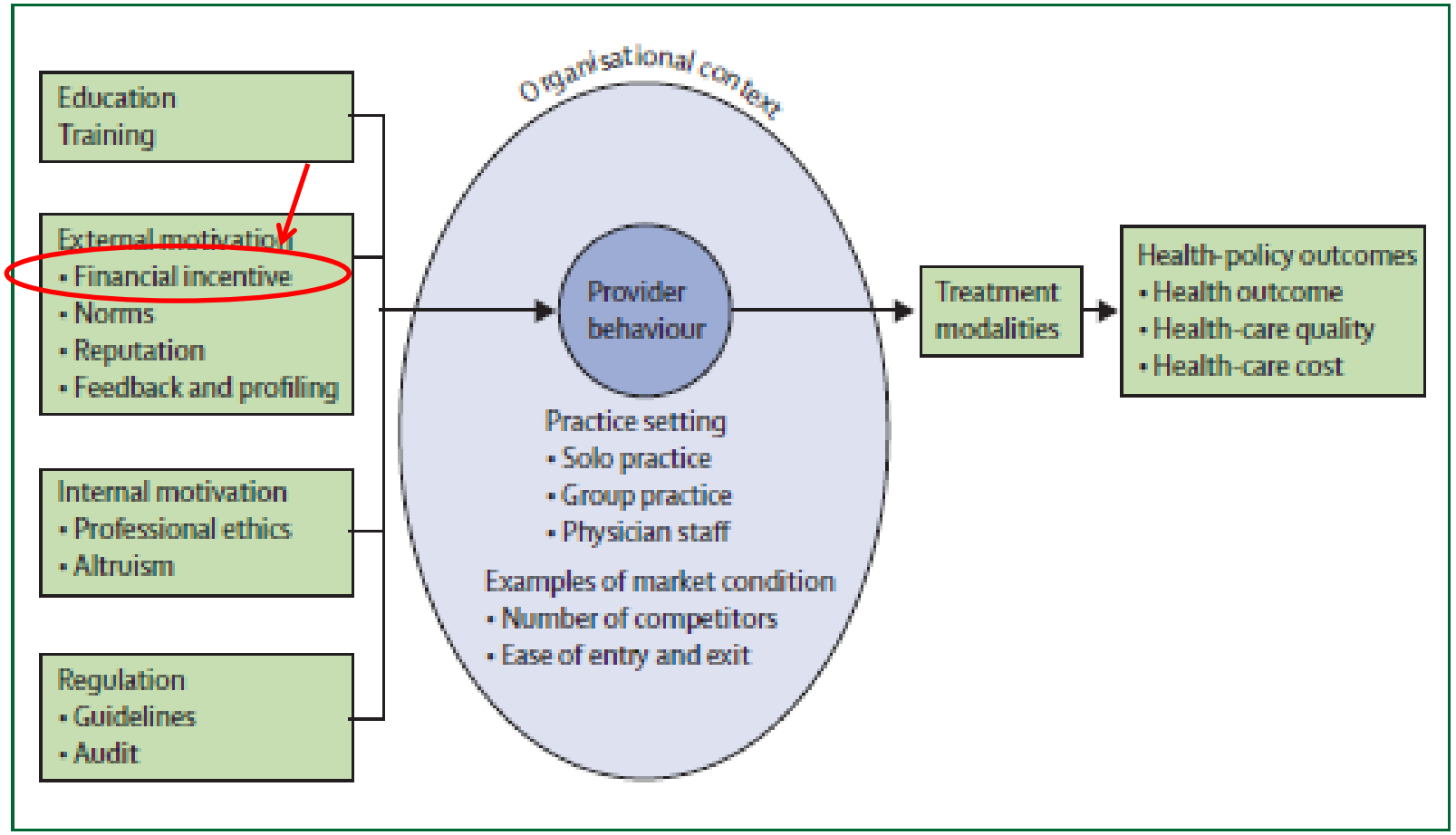
Outline

1. **Why this topic?**
2. FINCENTO – a tool for assessing systems of financing mental health care and their inbuilt incentives
3. Outlook: Provider payment mechanisms for treatment of people with SPMI



www.health.org.uk/qquip 2010

Factors that affect practice behaviour of physicians (Yip et al 2010)



The European Mental Health Action Plan (WHO-EURO) 2013

"analyse and if required rectify health financing to create **incentives** for the development of community based mental health services"

Çeşme Izmir, Turkey, 16–19 September 2013

Understanding financing mechanisms matters for improving the quality of mental health care

in addition to understanding other factors such as

- Effectiveness of mental health interventions („efficacy“ and „efficiency = cost/effectiveness“)
- Professional guidelines
- Ethics
- User and carer experience/involvement
- Training of professionals
- Stigma and discrimination
- Organization of services
- State regulations
- etc etc….

All of these are, of course, also related to financing issues

Purpose of this presentation 1

(1) Sensitize mental health care planners and politicians

to the fact that it is **not only the total amount of money** spent that matters for the **quality of mental health care** but also the **mechanisms how the money is spent** and which **intended and unintended incentives** are contained in provider payment mechanisms.

Quality of Care

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are **consistent with current professional knowledge**

Institute of Medicine

Quality of Care (cont.)

However 1:

In psychiatry there is less agreement than in other medical disciplines about the current professional knowledge and the „desired outcomes“ to which quality of care would be related and for which payers would spend money.

This complicates our communication with health care planners and polititians, also with the general public, by whom polititians want to be elected

Some of us are happy with the medical model

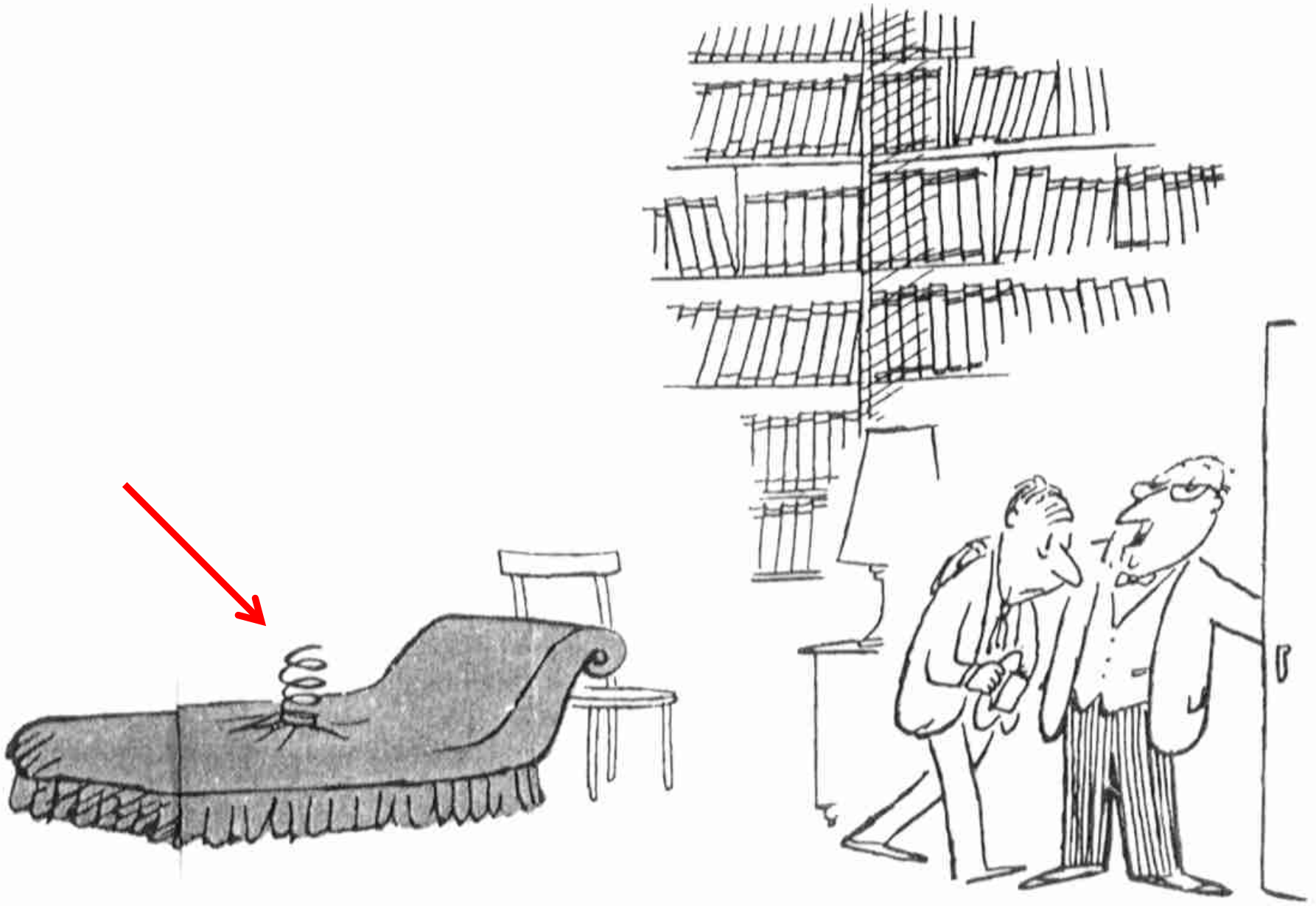
Depression is nothing more than a simple chemical imbalance in the brain.

I'll send you away with a prescription for these little pills and very soon a pleasant sense of confidence, control and normality will return to the situation.

Thankyou. I'm
so grateful. You're
so marvellous.
Thankyou.
Goodbye.


Leunig

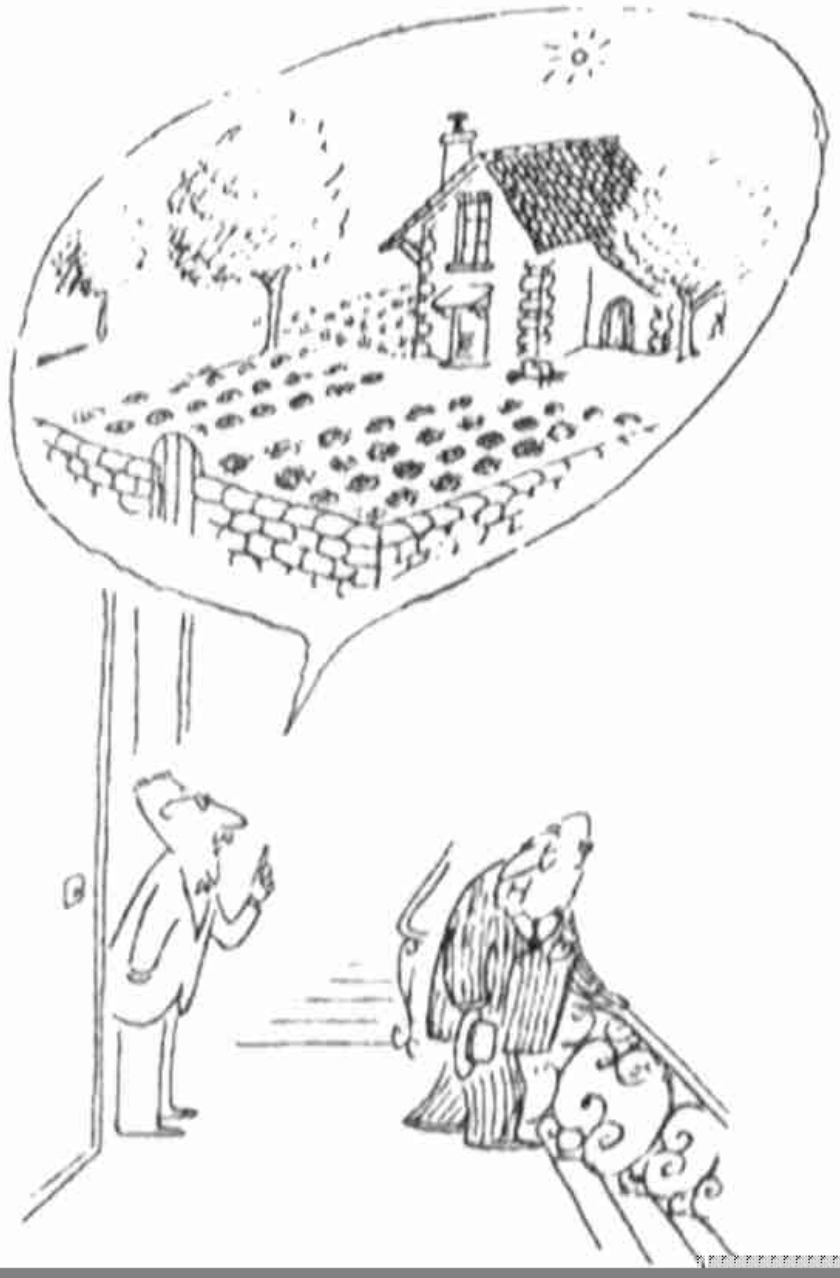
Some focus on the personality and neglect the real world

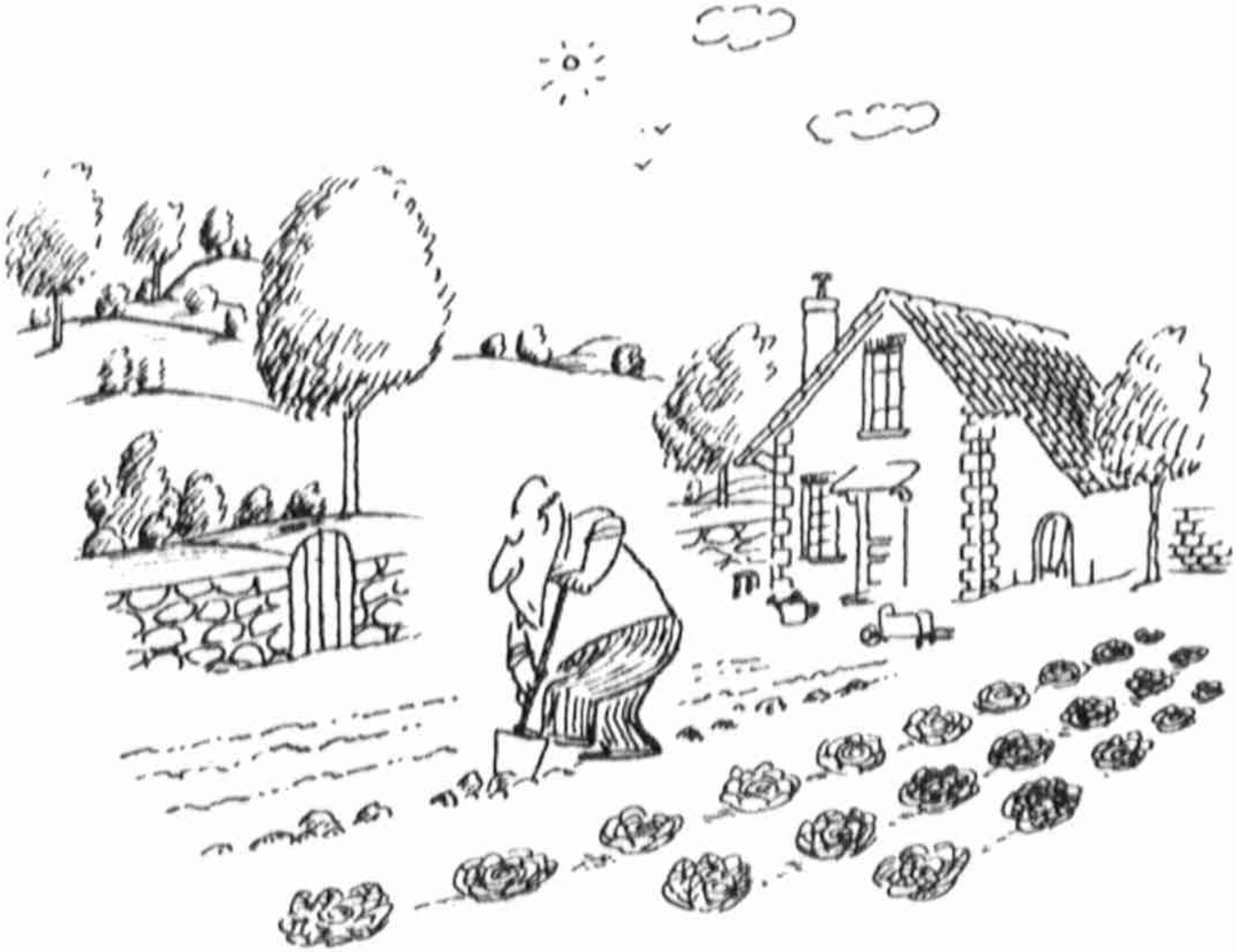


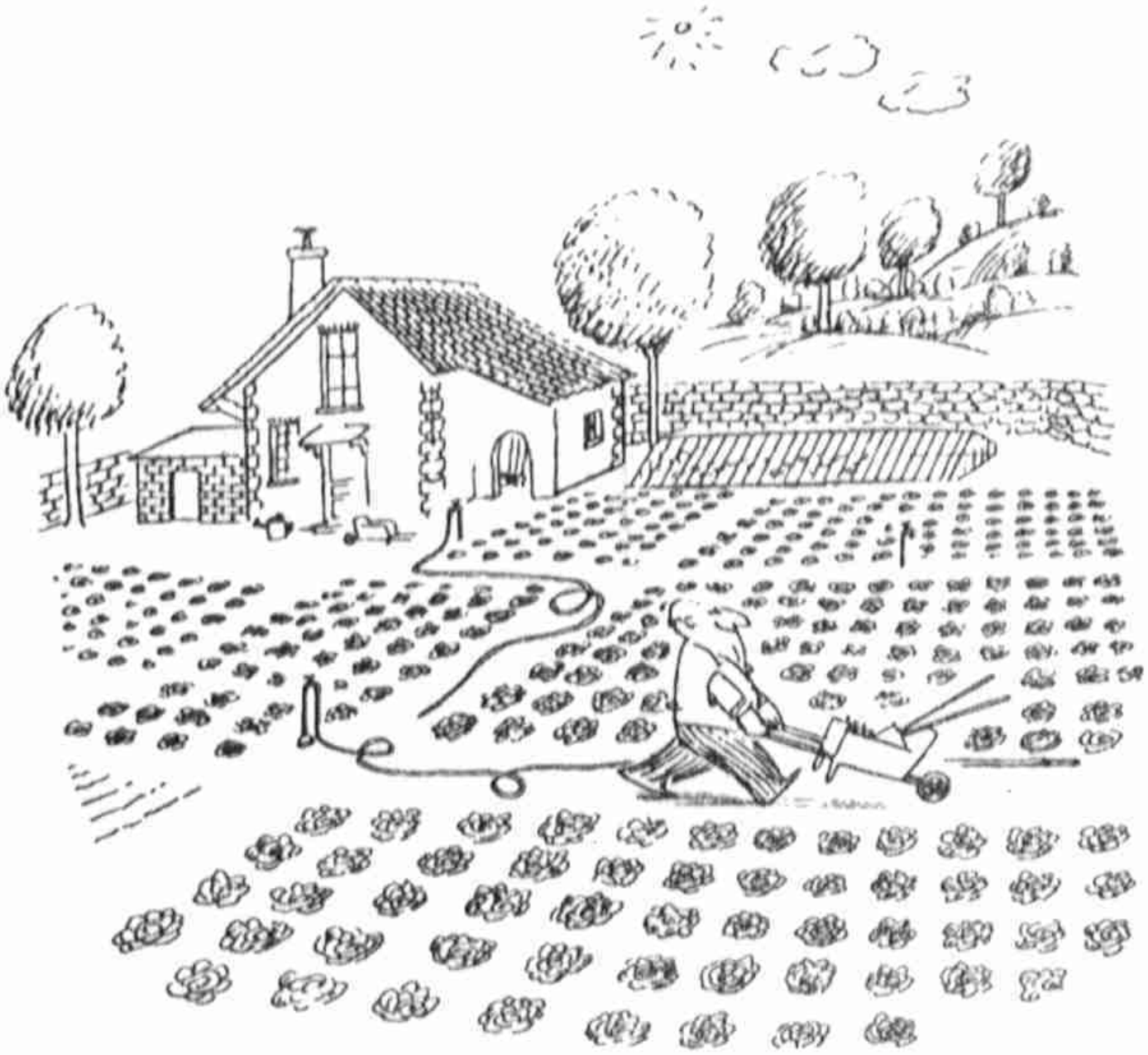
Some focus on the environment and forget the personality

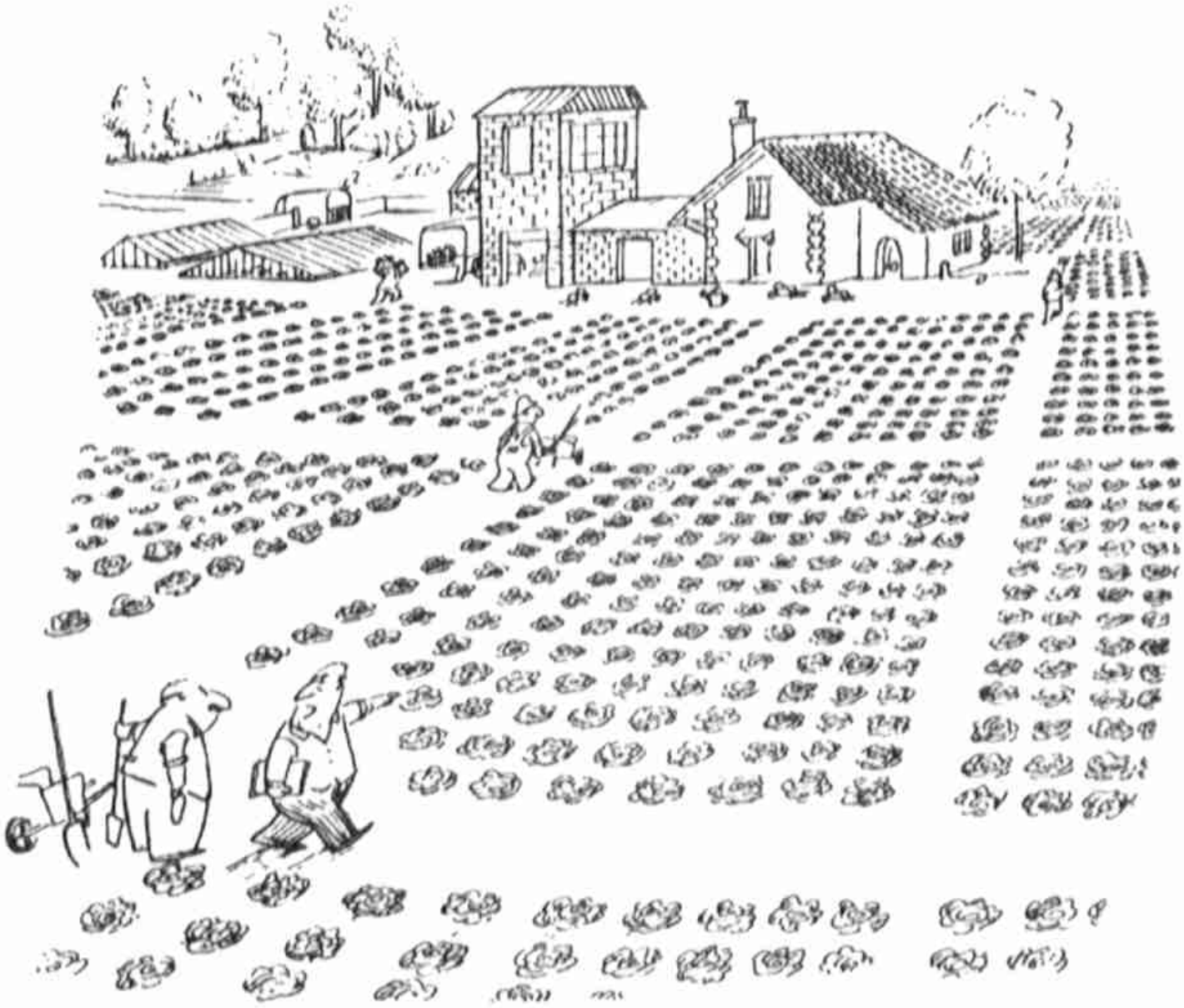
1

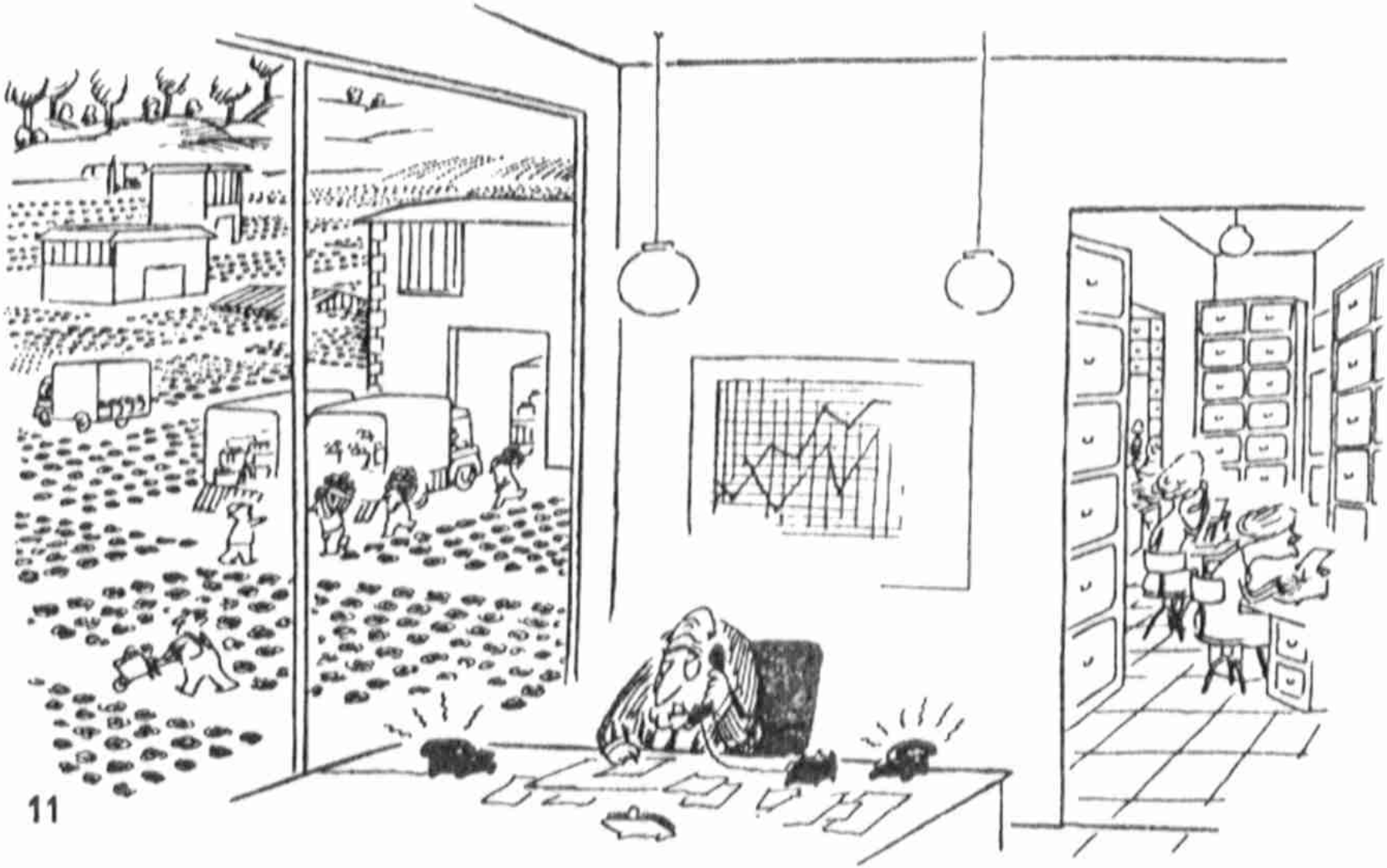
2











Quality of Care (cont.)

However 2:

Especially for people with SPMI it is explicitely not only medical but **also social outcomes** which matter –
e.g. who should pay for „housing“ of people with SPMI? Social system? Health system? Entitlement? ‚Housing‘ is ‚therapeutic‘.

Purpose of this presentation 2

(2) Little is known from studies which could be used by decision makers as a recipe for how to act in the framework of a specific mental health care system. However,
some lessons might be learned from general health care
> a tool for the assessement of financing mechanisms and inbuilt incentives in a specific national/regional health care system is presented

Outline

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2. **FINCENTO – a tool for assessing systems of financing mental health care and their inbuilt incentives**
3. Outlook: Provider payment mechanisms for treatment of people with SPMI

The REFINEMENT Project

EU funded 7th Framework Project - HEALTH-F3-2010-261459

„REsearch on FINancing Systems‘ Effect on the Quality of MENtal Health Care in Europe“

Lead partner: University of Verona
8 European countries with very different health care systems
(Austria, England, Finland, France, Italy,
Norway, Romania, Spain)

REFINEMENT DECISION SUPPORT TOOLKIT

(1) Manual

(2) 4 Tools

- **FINCENTO Financing and INCENtive Tool**
- REMAST Service mapping tool
- REPATO Pathway of care tool
- REQUALIT Quality of Care tool

(3) Glossary

www.refinementproject.eu – download area

The REFINEMENT Project

Research on Financing Systems' Effect on the Quality of Mental Health Care

FINCENTO

Financing & INCENtive TOol

A tool mapping of health and other services for adults with mental health needs and identifying details of related financing systems

REFINEMENT DECISION SUPPORT TOOLKIT

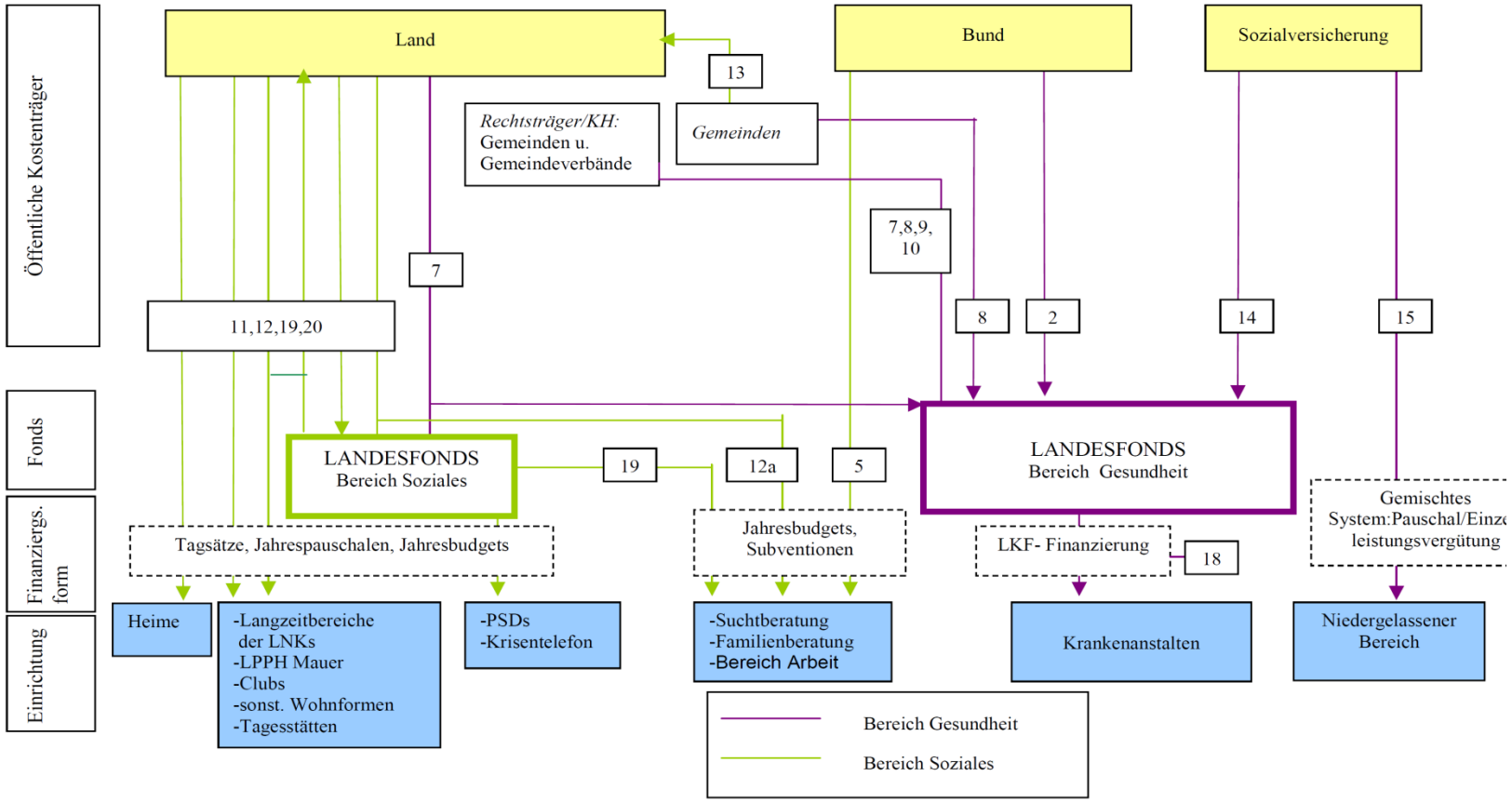
FINCENTO Financing and INCENtive Tool

Purpose: **Assess** in a structured way the health and social care **financing system** as it is relevant for people with mental disorders including the **inbuilt incentives** on a national/regional level

Includes all service types with potential relevance for the care of people with mental health problems, i.e. includes **also services for physical care** (e.g. GPs)

„Boxology“ of a health and social care provider payment system (Mental health care in the Austrian province of Lower Austria)

Abb. 2: Finanzierungsströme der psychiatrischen Versorgung in NÖ – Beteiligung der öffentlichen Kostenträger (s. Legende S. 30)



Structure of FINCENTO

Authors: Heinz Katschnig, David McDaid, Christa Straßmayr and the REFINEMENT Group

- **Introduction – principal agent model etc.**
- **Part A:**
  5 Sections on Regulations, collection and pooling of funds
- Part B:
  6 Sections on organisation, structure, payment mechanisms, regulation, incentives and disincentives for health and non-health system services and subtypes

Table of contents of FINCENTO

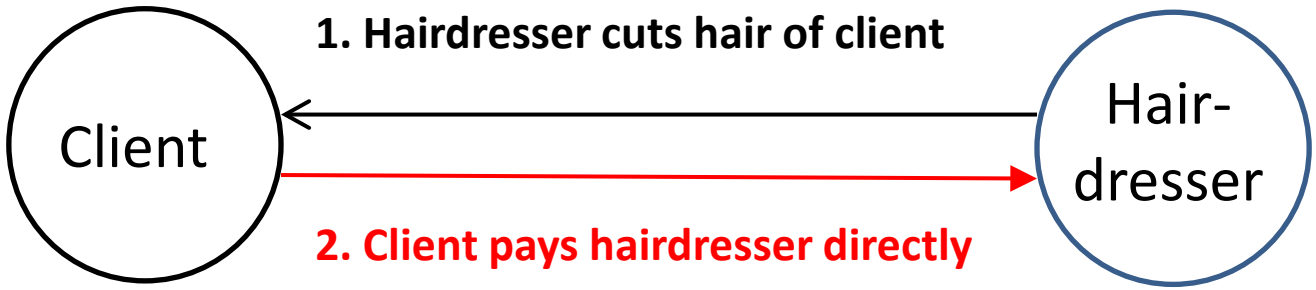
Starting point

"Why do individuals need help in purchasing health services from providers? Is the "middleman" really necessary? ***Can people not just buy health services in the same way they would go to the local market to buy bread, milk, or fruit****—especially since, throughout most of history, that is what most people did? When sick, they contacted local healers directly."*

Schweitzer: Introduction to Langenbrunner et al 2009 (World Bank)

Paying for services 1
The „hairdresser“ model

„private – private“ interaction



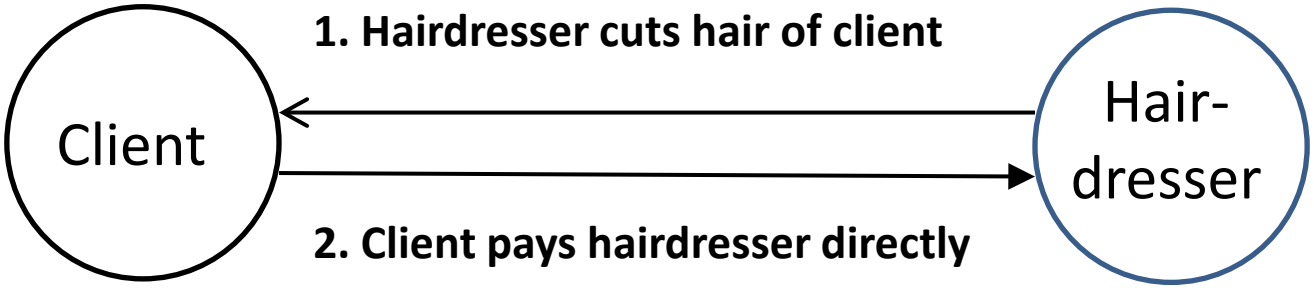
Market mechanism: competing for clients

Client sees immediately the outcome/ quality of the service

Hairdresser sets tariff

Paying for services 1
The „hairdresser“ model

„private – private“ interaction



Client decides which hairdresser to use

Hairdresser might adapt tariff

Client makes new choice

<u>The „invisible hand“ of the market</u>

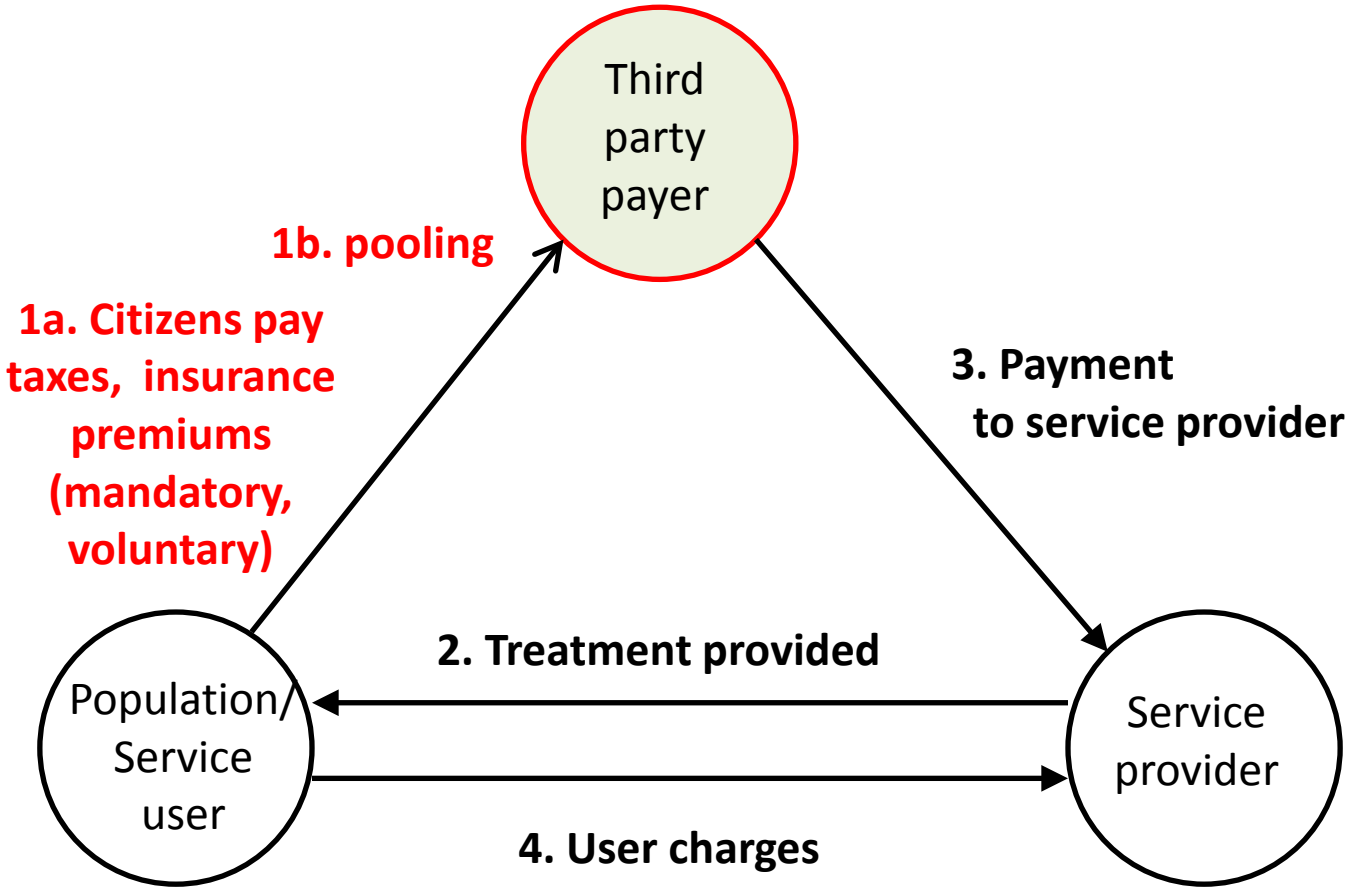
The simple hairdresser market model does not work for health care

because of several reasons, mainly because of the

unpredictability of the occurrence and the costs of health problem events needing a health care service intervention

Bismarck 1883 > first mandatory health insurance for workers established = **third party payer**

Paying for services 2
The „car insurance“ model



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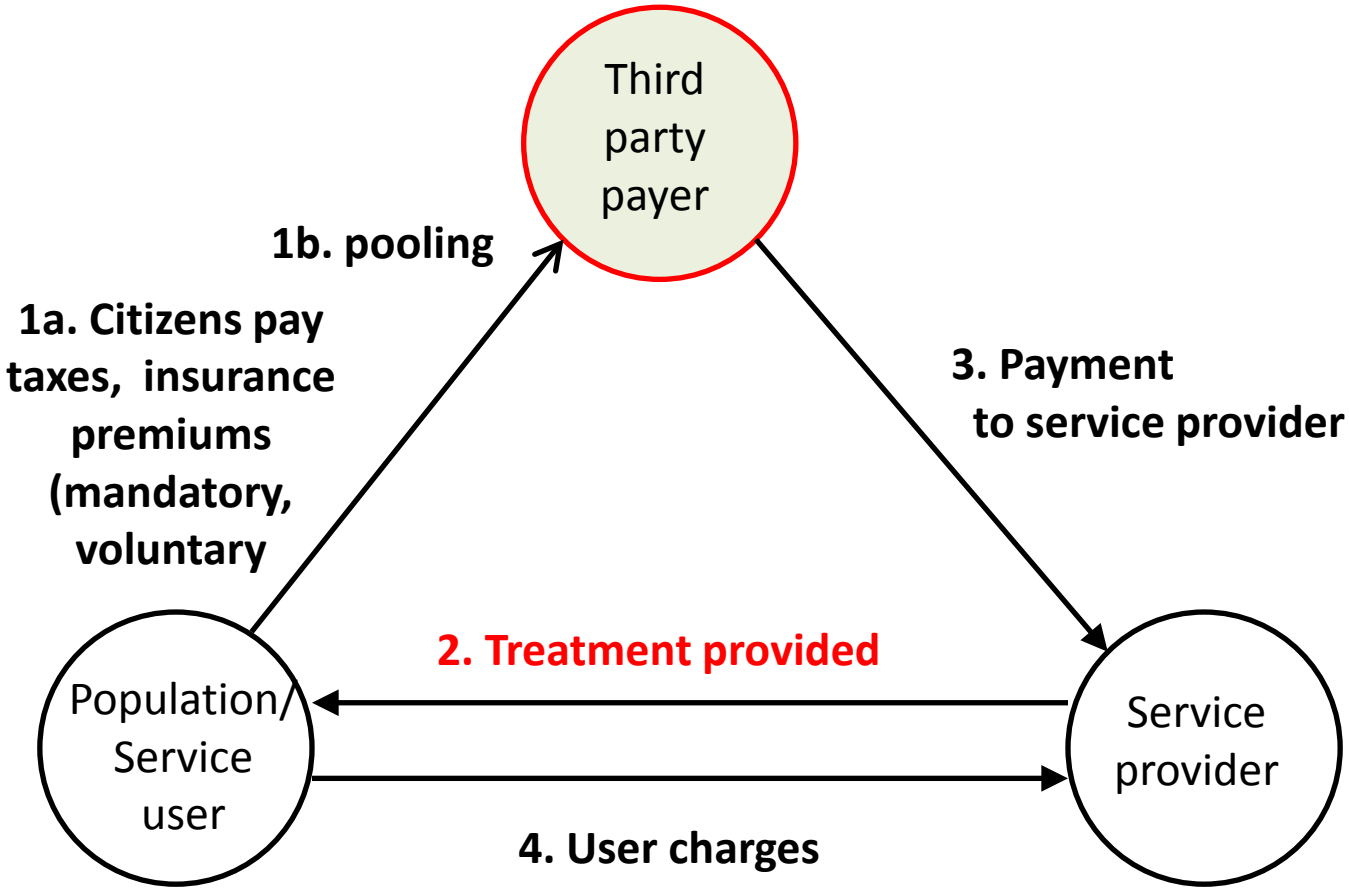

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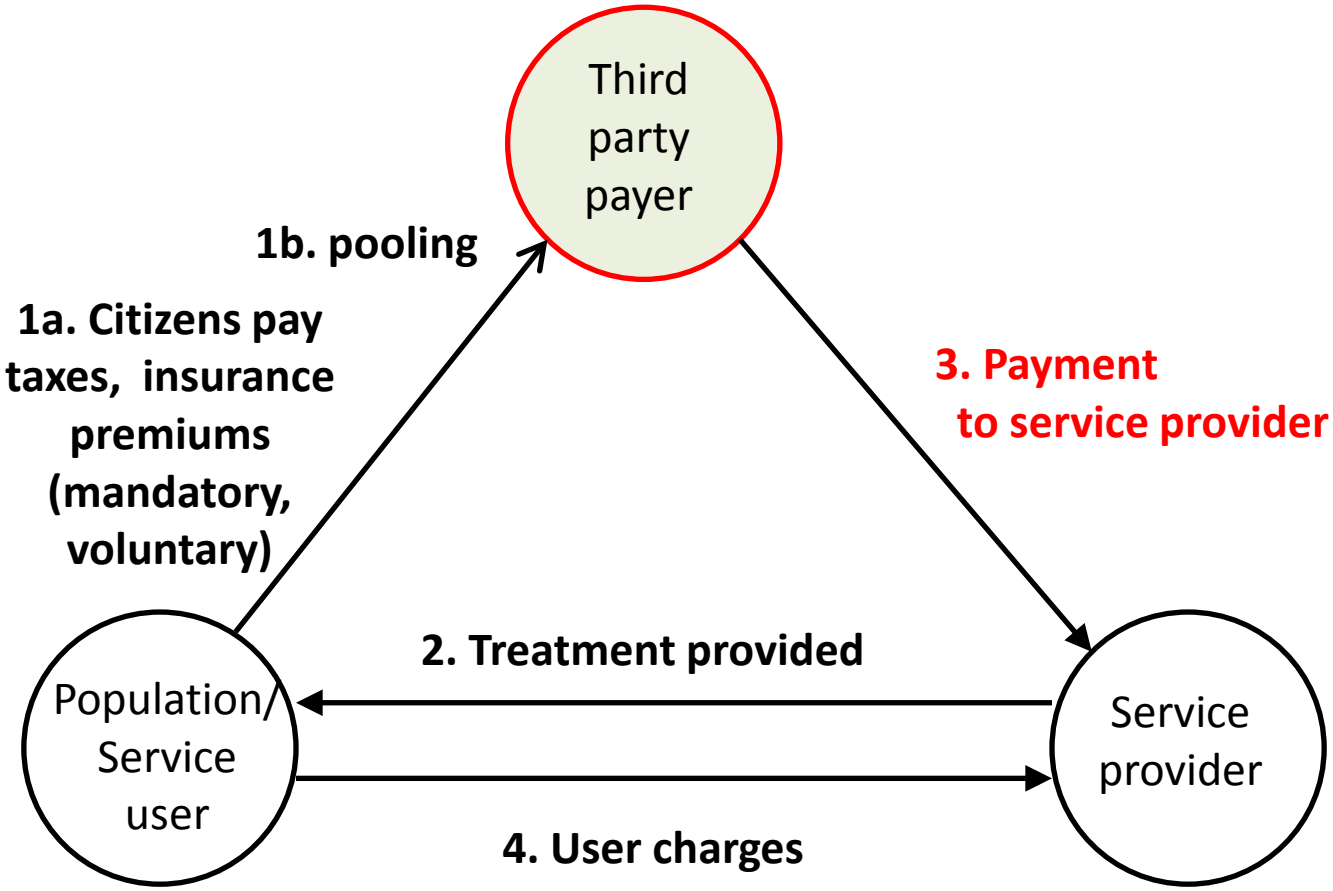

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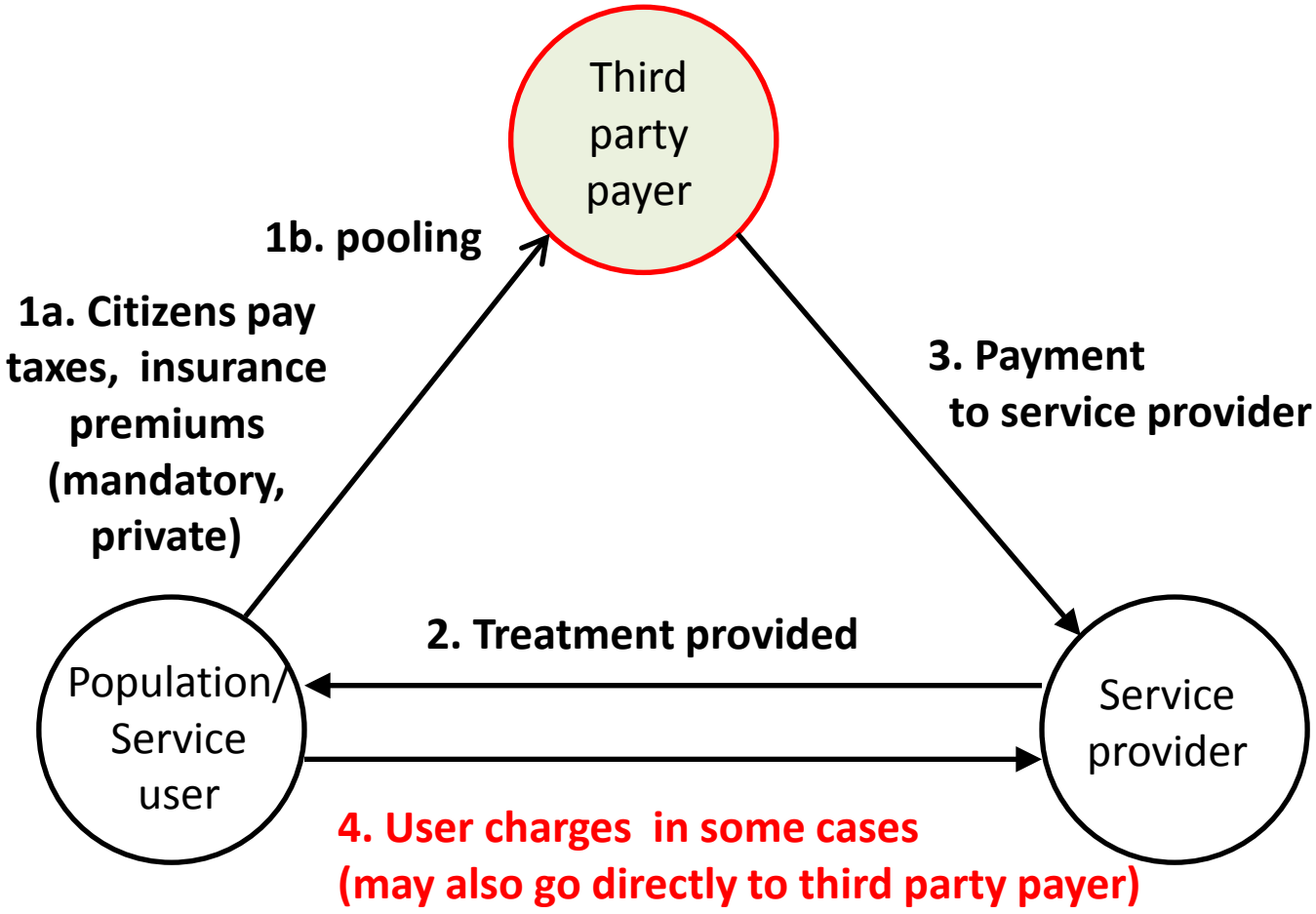
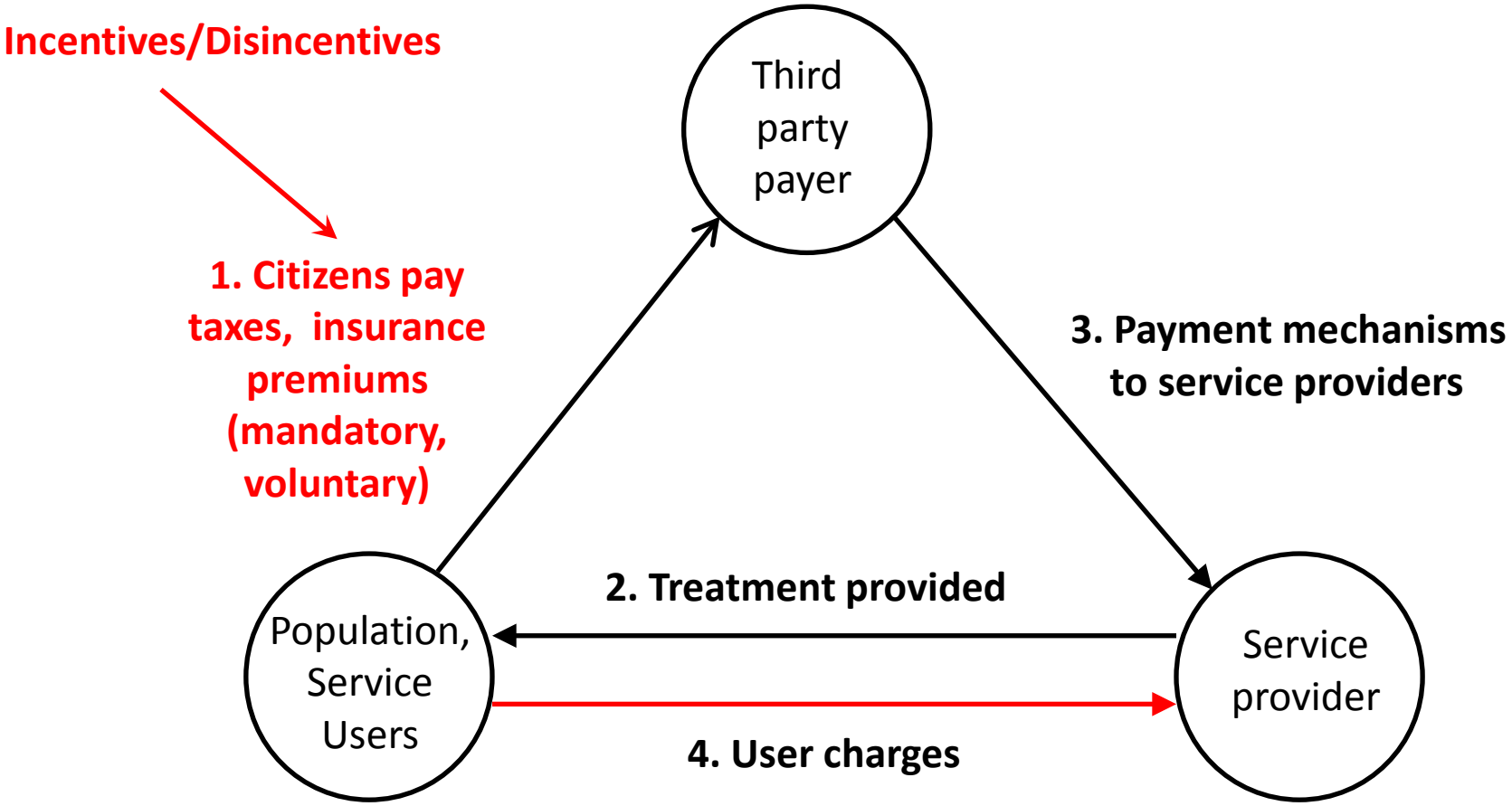


Incentives in Health Care

*"Incentives are the economic signals that direct individuals and organizations toward **self-interested behaviour**. The idea of incentives, therefore, is based on the assumption in microeconomics that individuals and organizations attempt to optimize and take actions that further their own self-interest."*

Langenbrunner et al 2009

Paying for services 2
The „car insurance“ model



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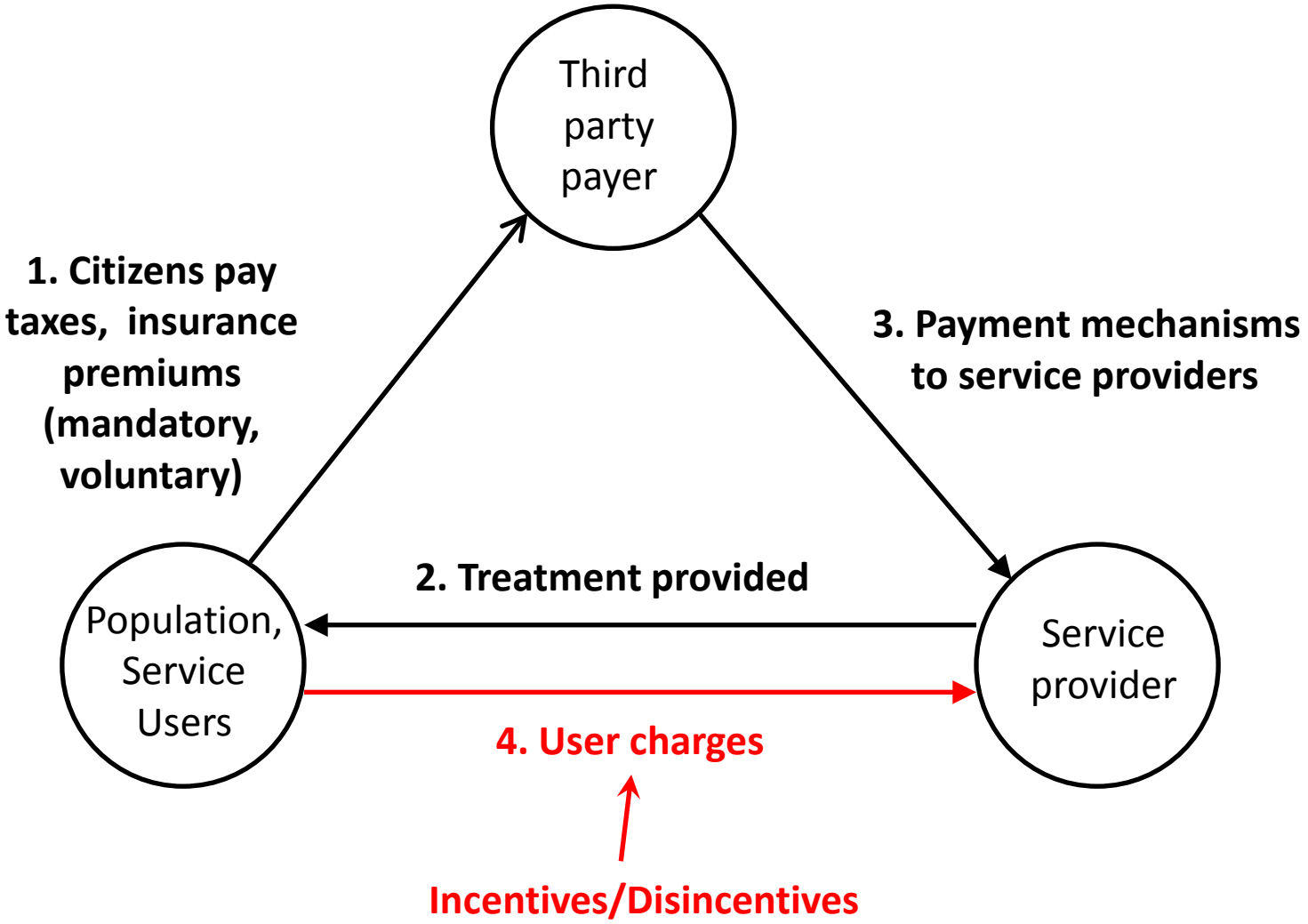

Financial incentives directed towards patients: negative incentives

… in order to avoid overuse of services („moral hazard“) > > user charges

- **Co-Insurance**: Patient pays a predefined proportion of a service bill
- **Co-Payment:** Patient pays a predetermined absolute amount for a specific service (e.g. 5.30 Euro for each pharmacy prescription in Austria)
- **Deductible:** patient pays service costs for a defined time period up to a certain predetermined amount

Financial incentives directed towards patients: positive incentives

Conclusion Offering modest financial incentives to patients with psychotic disorders is an effective method for improving adherence to maintenance treatment with antipsychotics.

Effectiveness of financial incentives to improve adherence to maintenance treatment with antipsychotics: cluster randomised controlled trial

Priebe et al BMJ 2013; 347 doi: http://dx.doi.org/10.1136/bmj.f5847 (Published 07 October 2013) Cite this as: BMJ 2013;347:f5847

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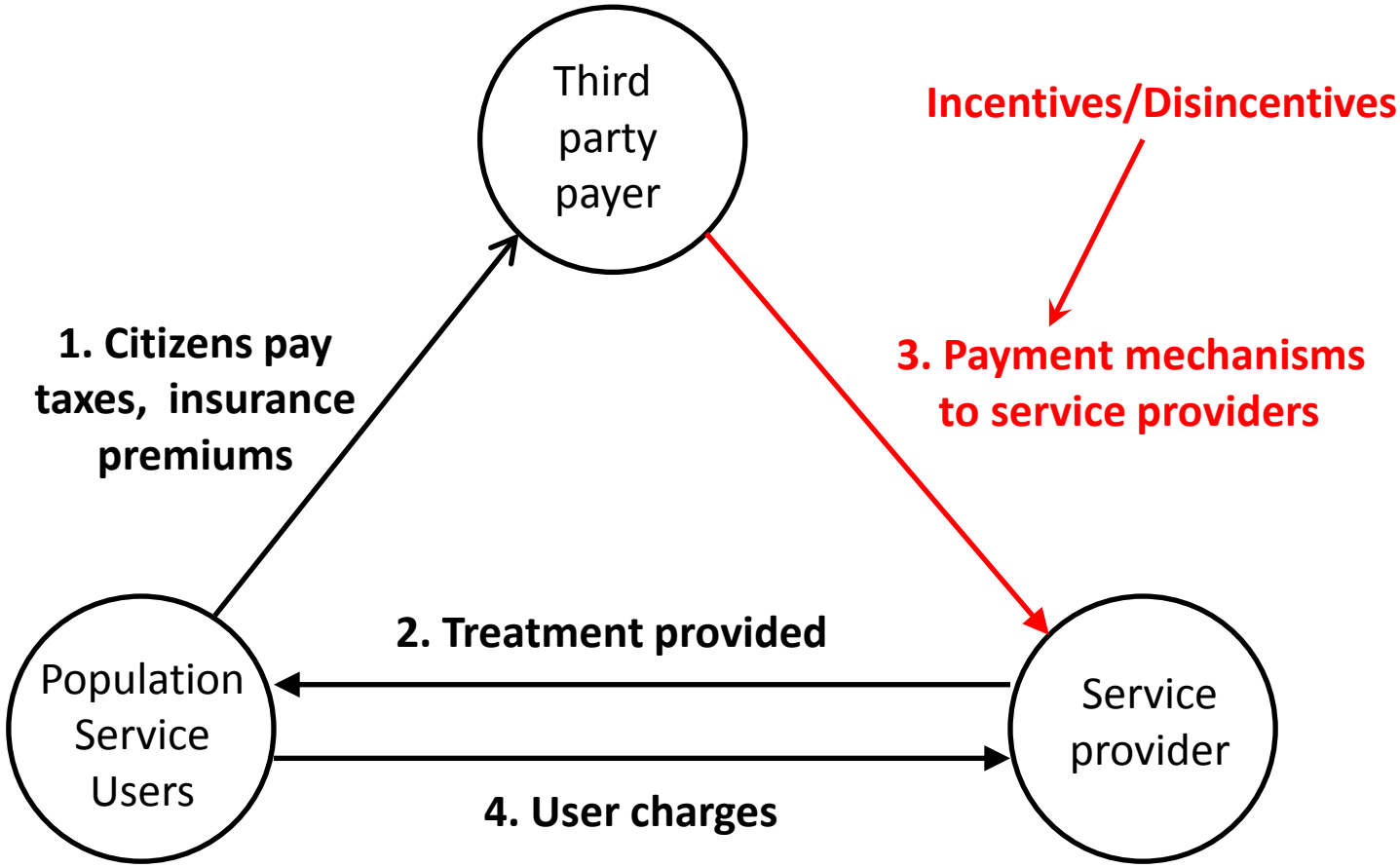

The simple hairdresser market model does not work for health care

Not only because of the unpredictability of the health event and the associated costs, but also because of the

high degree of **"asymmetric information"** in this triangle (Arrow 1963)

i.e., the **provider** knows better than both the payer and the patient and **acts as an agent** for both ("double agent") and both have to trust him/her

it is difficult to control whether he/she makes use of this knowledge for
his/her own interest and
not for the payer's and the patient's interest

Incentives in provider payment mechanisms

"All provider payment systems create economic signals, and individual providers respond to those signals

to maximize the positive and minimize the negative effects on their income and other interests."

Langenbrunner et al 2009

Incentives in provider payment mechanisms

"Provider payment systems can be designed to create economic signals that lead providers to self-interested behaviour that is

also in the interest of the purchaser, the patients, and ideally in the interest of the health care system as a whole."

Langenbrunner et al 2009

In reality this coincidence does not exist - health care provider payment systems and mechanisms have 1

…… *grown historically*

in different countries in different ways and have often been reformed and have usually **not been planned systematically** in order to optimize coordination, continuity and quality of care. Describing health care financing systems is a complicated task (see e.g. the OECD HIT reports).

In reality this coincidence does not exist - health care provider payment systems and mechanisms have 2

……. *different third party payers for different health care sectors* within one and the same health care system (e.g. England: primary care vs. specialist outpatient care; Austria: specialist outpatient vs. inpatient care) which contribute to **fragmentation, lack of coordination, lack of continuity of care,**

It is difficult to compare provider payment systems and to get insights from comparisons

… within one and the same type of payment method
many variations exist in different places. For instance: activity based funding (ABF) for hospitals is different from place to place – an example is the DRG system with many variations across the globe, even if called the same, e.g.„Australian“ DRG system, it is often adapted regionally – we cannot say in general „ABF leads to this and that effect“.

… within one and the same service sector (e.g. psychiatric outpatient care) different types of providers have different payment mechanisms leading to **cream skimming - cost shifting - referral to other providers, equity issues**
(Austria: four types of ambulatory psychiatric care)

Payment mechanisms for service providers in the light of information asymmetry – assumed behavioural consequences

PAYMENT METHOD	WHAT SERVICE PROVIDERS WOULD DO IF THEY DIDN'T BEHAVE IN LINE WITH PROFESSIONAL PRINCIPLES
Salary Line Budget: Pay independent of workload & quality	As little as possible for as few people as possible („underprovision“)
Capitation: Pay according to the number of people on a dotor's list	As little as possible for as many people as possible („underprovision“)
Fee for service: Pay for individual items of care	As much as possible, whether or not it helped the patient („overprovision“) – „referral networks“ (overprovision)

Adapted from Roland, 2012 (quoting B.Sibbald)

Payment mechanisms for service providers in the light of information asymmetry – assumed behavioural consequences

PAYMENT METHOD	WHAT SERVICE PROVIDERS WOULD DO IF THEY DIDN'T BEHAVE IN LINE WITH PROFESSIONAL PRINCiPLES
Pay for performance: pay for meeting quality targets	A limited range of commendable tasks, but nothing else („underprovision“)
Pay per treated case : e.g. Inpatient ABF/DRG	Increase number of cases (regardless of whether needed or not) („overprovision“); taking resources from needier cases and reduce LOS (underprovision)
Daily rate	Increase length of stay , reduce admissions

Adapted from Roland, 2012 (quoting B.Sibbald)

What is the evidence?

- Controlled trials: the internal good validity of the evidence of studying a single financing mechanism **lacks transferability to the real world**, also often different financing mechanisms are combined

- Observational studies on different effects of different financing mechanisms/incentives **cannot control for all other factors**

- Context of the whole health care system can change results – **very difficult to generalize**

Petersen S (2010). Hospital reimbursement and readmissions. Norway 2002, 2005 and 2008. BMC Health Services Research 10, A14.

Analysing the effect of the introduction in 1997 of an ABF/DRG system in Norwegian acute hospitals:

Effects of the activity-based payment system in surgery
- too early discharge of patients,
- more readmissions,

and a need for increased reimbursement from the state.
Thus, more and more financial resources are transferred to the hospital sector. And more and more of these resources are used to treat the same patient more than once.

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Table of contents of FINCENTO (cont.)

Part B: Organisation, structure, payment mechanisms, regulation, incentives and disincentives for health and non-health system services and subtypes

- **Section 6. Physician-Led Primary Care**
- **Section 7. Specialist mental health outpatient care**
- **Section 8. Inpatient Mental Health Care**
- **Section 9. Selected Additional Services for Housing, Employment and Vocational Rehabilitation**
- **Section 10. Prescription Medication**
- **Section 11. Incentives for coordination of care and integrated care**

Each section has up to 10 assessment categories with explanations

Example: FINCENTO Template to map services to support independent housing

1. Types and subtypes of housing support
2. Frequency of these
3. Volume of services provided
4. Legal status / ownership
5. Who pays? Who is the contractor of the service?
6. Payment mechanisms used to pay the provider
7. User contibutions to housing costs
8. Support for user payments
9. Restrictions / incentives on number of supported housing services in a geographical catchment area
10. Types of service user

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Provider payment for treatment of SMI

In: Hewlett E, V Moran: Making Mental Health Count: The social and economic costs of neglecting mental health care,OECD 2014

1. **Primary care incentives** can promote co-ordinated care and improve health outcomes

   England: QoF program for depression /physical comorbidity
   Attention: *Set incentives right to avoid the danger that non-incentivized actions are neglected. Primary care services are most relevant for physical comorbidity.*

   Australia: Mental Health Nurse Incentive Program (MHNIP): relieve workload pressure for GPs and psychiatrists so theY can devote more time to complex cases

Provider payment for treatment of SMI.
In: Hewlett E, V Moran: Making Mental Health Count: THE SOCIAL AND ECONOMIC COSTS OF NEGLECTING MENTAL HEALTH CARE, OECD 2014

2 The **weakness of the DRG classification system** for mental health care gives rise to undesirable incentives *(cream skimming, adverse selection, DRG creep, not for SPMI)*

3 **Per diem systems should take account of length of stay** to avoid overutilization *(reduce per diem after certain time)*

4 Payment systems need to be developed that are **independent of care settings** *(England: Diagnosis independent „Care Pathways and Packages“ approach > 21 Care Clusters)*

5 **Personal budgets** offer enhanced choice, autonomy and individualized care but can contribute to unsustainable expenditure growth *(England, Netherlands)*

Conclusions

When planning and organizing services for patiens with SPMI, assess systematically provider payment mechanisms and incentives in all health and social sectors which are relevant for treating persons with mental disorders.

Pay special attention to

- Dysfunctional incentives in inpatient ABF/DRG systems
- Cream skimming – referral to other services – cost shifting
- Comorbidity with physical disorders
- Fragmentation of care, Continuity of care, Integrated and coordinated care
- Consider new payment mechanisms
  (e.g. personal budgets, care setting independent mechanisms)

Thank you for your attention!