Strengthening Community Health in Romania

Payment models for preventive services in Europe

International workshop

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Evidence on effective ways to incentivise preventive services

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Objectives

- To provide decision makers in Romania **empirical evidence** on various approaches to contracting and paying for preventive services in primary health care Europe.
- Describe existing payment models for targeted preventive services in primary health care in Europe.
- To search for evidence on the impact of **pay-for-performance** on behaviour of primary care physicians and patient outcomes aiming to provide a comprehensive and objective evaluation of pay-for-performance for decision-makers

Framing the review:
Considerations from the Romanian context

- **The Romanian Health System:** We prioritized studies that were most relevant to Romania, therefore our starting point has been to consider the countries where studies have been published about payment mechanisms.

- **Types of prevention services**
  - *What do we mean by prevention?*
  - In Romania we are mainly considering general practice services and community health services.

What do we mean by prevention?

Health prevention interventions are commonly classified into different levels of prevention:

Primary Prevention—intervening before health effects occur, through measures such as vaccinations, altering risky behaviours (poor eating habits, tobacco use), and banning substances known to be associated with a disease or health condition.	Vaccination, Preventive services (e.g., counselling), Health promotion (e.g. hand washing campaign), Dental or oral health services
Secondary Prevention—screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing.	Screening programmes, Maternal and child health programmes, fluoridated water, statins to prevent cardiovascular and coronary heart disease
Tertiary Prevention— aims to reduce the effects of the disease once established in an individual. Managing disease post diagnosis to slow or stop disease progression through measures such as chemotherapy, rehabilitation, and screening for complications.	Post trauma rehabilitation, Occupational and physical therapy (e.g., physio-therapy, psycological support for PTSD)
Quarternary Prevention— methods to mitigate or avoid results of unnecessary or excessive interventions in the health system	Prevent overmedicalisation, Unecessary testing

Kisling and Das (2021), WHO EMRO (2023)

Romanian Healthcare system

- Common healthcare system typologies
- Categorizations can include how the health system is regulated, financed and delivered

Healthcare system type	Countries
National Health Service	Denmark, Finland, Iceland, Norway, Sweden, Portugal, Spain, United Kingdom ***?Romania?***
National Health Insurance (*some services are contracted out to for-profit providers*)	Australia, Canada, Ireland, New Zealand, Italy
Social Health Insurance *(where societal actors have competence to regulate and finance the health system and most service providers perform for profit)*	Austria, Germany, Luxembourg, Switzerland Slovenia (social-based mixed type)
***Etatist* Social Health Insurance** *(where the state holds the regulatory power but grants privileges for the financing and provision of health services to societal actors)*	Belgium, Estonia, France, Czech Republic, Hungary, Netherlands, Poland, Slovakia, Israel, Japan, Korea
Private Health System	USA

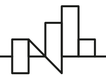
Adapted from Böhm K et al (2013)

“Incentivising behaviour” whose behaviour & how?

- Traditional health payment systems would pay directly to hospitals/ health trusts.
- In this model, health services not incentivized to deliver more or less for the population
- Fee-for-service, capitation models, or pay-for performance indicate a transformation towards funding that ‘follows the individual’
- These incentives can be targeted at the service provider or the individual clinician.
- In this review, we have considered both perspectives

Traditional payment methods

Payment method	Description	Setting	Degree of bundling
Fee-for-service (FFS)	Retrospective activity-based payment: billing of individual services and patient costs	Predominant mode of payment for GPs and outpatient specialist services	unbundled
Payment per case (diagnostic-related groups) (not used for prevention)	Prospective activity-based payment per patient, patient classified into groups based on diagnoses and resource use	Payment for hospital inpatient cases in many countries	
Capitation	Prospective lump-sum payment per enrolled patient covering a range of services	Mode of payment for GPs in a number of countries	
Global budget	Prospective lump-sum payment covering a range of services independent of actual volume provided	Payment for public hospitals in a number of countries	bundled



OECD et al., (2016)

Fee-for-service

(cost reimbursement)

Variable amount

Payment for performance

(results-based or activity-based financing)

Retrospective payment

Prospective payment

Fixed amount

Capitation, Global budget

(block grants)

Implications for various healthcare payment methods

Scoping review method

- Search in PubMed and Epistemonikos (systematic reviews database)
- Results are based on searches of systematic reviews, primary studies, and hand searching.

Studies identified

- Found 24 systematic reviews that included more than 575 studies, we also included evidence from normative guidance i.e., reports from OECD, WHO and World Bank; and 8 primary studies.
- P4P in primary care is the stellar topic, this is partially because it is an intervention that has been studied widely

Fee-for-service (FFS): cost reimbursement

Positive incentives:
+ increased activity means increase in income
+ refunding of actual costs
+ incentives are to increase marginal costs and then increase marginal income
+ transparency
+ less risk selection issues

Negative incentives:
- risk for over production
- associated with higher costs
- no incentive for providers to deliver a service that is not included in the fee schedule
- alone it does not support care coordination or integration

Financial risks sit with the payer/purchaser

Pay for performance (P4P): results-based or activity-based financing

Positive incentives:
+ increased activity / better results increase income
+ large financial incentives
+ disease management

Negative incentives:
- does not guarantee full coverage of actual costs
- not recommended for long-term behaviour change
- potentially contributes to inequity, patient dissatisfaction
- contributes to medical cost

Financial risk is shared between the payer and the provider

Capitation: global budget, block grants

Positive incentives:
+ cost control (if population is stable in case of capitation)

+ low transaction costs

+ For capitation it can promote efficient use of resources and is seen as a promising model to improve care coordination

Negative incentives:

- increased activity does not increase income

- possible skimping of care

- possible risk selection by providers

- no guarantee for full coverage of actual costs

- For global budget not directly related to the demographic profile of the population served

Financial risks sit with the provider

Implications for various healthcare payment methods

Fee-for-service (cost reimbursement)

+ increased activity means increase in income
+ refunding of actual costs
+ incentives are to increase marginal costs and then increase marginal income
+ transparency
+ less risk selection issues
- risk for over production
- associated with higher costs
- no incentive for providers to deliver a service that is not included in the fee schedule
- alone it does not support care coordination or integration

• ***financial risks sit with the payer/purchaser***

Retrospective payment

Variable amount

Payment per case (pay for performance , results-based or activity-based financing)

+ increased activity /better results increase income
+ large financial incentives
+ disease management
- does not guarantee full coverage of actual costs
- not recommended for long-term behaviour change
- Potentially contributes to inequity, patient dissatisfaction
- Contributes to medical cost

• ***financial risk is shared between the payer and the provider***

Prospective payment

Fixed amount

Capitation, global budget (block grants)

+ cost control (if population is stable in case of capitation)
+ low transaction cost
+ *For capitation* it can promote efficient use of resources and is seen as a promising model to improve care coordination
- increased activity does not increase income
- possible skimping of care
- possible risk selection by providers
- no guarantee for full coverage of actual costs
- *For global budget* not directly related to the demographic profile of the population served

• ***financial risks sit with the provider***

So, what does the evidence say about the different payment methods?

Key findings about capitation

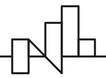
- It is associated with less volume of activity.
- However, preventive activities are inherently incentivized under capitation schemes (Brocklehurst et al, 2013)

Key findings about FFS

- In outpatient settings, it increases the quantity provided.
- For oral health, it induces more clinical activity

Key findings about P4P in primary care settings (1/2)

- The vast literature on P4P in primary care is **not conclusive** whether incentivize quality of care (Ammi and Fortier, 2017)(Houle et al, 2012)(Scott et al, 2011).
- It seems to be more functional in **participation-based schemes** rather than target-based, which reinforces its use for screening programmes (Ammi and Fortier, 2017).
- **Large financial incentives** are more effective in improving performance (Gadsden et al, 2021).
- Effects on providers' behaviour change are **not for long-term** (Chauhan et al, 2017).
- Quality of care (mortality, hospital admissions) improved the **first year at expense of** non-incentivized conditions (Gillam et al, 2012).
- It had a positive effect on **disease management** (Lin et al, 2016).
- As a side-effect, P4P improved **data recording** (Gillam et al, 2012).
- Potential drawbacks are **inequity, patients' dissatisfaction** (with continuity of care) and increasing medical costs (Lin et al, 2016).

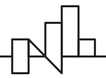


Key findings about P4P in primary care settings (2/2)

- In outpatient settings, it increased quantity and slightly improve the quality of service for targeted conditions (Jia et al, 2021).
- Applied to immunizations, it improved the vaccination rate (Benabbas et al, 2019)
- Applied to cancer screening programmes, it showed partial or no effects, except for colorectal cancer (Mauro et al, 2019)

Conclusion

- This review **described** and provided **empirical evidence** on types of payment models (retrospective vs prospective, and variable vs fixed) for contracting and paying for preventive services in primary health care Europe.
- Regarding the evidence on the impact of **pay-for-performance** on behaviour of primary care physicians and patient outcomes
  - The evidence is not conclusive
  - It may help quality of care in some cases (e.g., disease management), but is also associated with increased costs
  - Blended payment models that include capitation and P4P/add on payments are widely promoted by most health services



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Thank you