International experience with primary health care financing models

Dr Tamás Evetovits
Senior Health Financing Specialist
Head of Office a.i.

Division of Health Systems & Public Health
Barcelona Office
Three pillars for approaching health financing policy

- Where are we starting from?
- Where should we go?
- What kind of vehicle can we afford to get us there? How far and how fast?
Providers’ perspective

• How much should we spend on health care?
  – Typical answer by providers: MORE!

• How would you spend it?
  JUST GIVE US MORE, WE KNOW HOW TO SPEND IT!

• „In God we trust, all others bring data“
Clinical effectiveness & appropriateness

- Proven cost effective interventions are not delivered internationally e.g. control of chronic conditions (hypertension, diabetes, asthma, etc.)
- Inappropriate interventions are delivered, putting patients at risk, offering little or no benefit, and wasting society´s resources

Source: BMJ 2007
Variations in medical practice - everywhere

- US Medicare per capita spending in 2000 was $10,550 per enrollee in Manhattan and $4823 in Portland, Oregon. (Source: Wennberg, 2010)
  - Differences are due to volume effects rather than illness differences, socio-economic status or price of services.


Source: Éva Belicza, 2004
Variation in clinical practice: mostly not justified, but costly

Tonsillectomy rate in different counties of Hungary (age group of 0-14)

Source: MoH/ESKI, Hungary
Primary care sensitive conditions: avoidable hospital admissions

Avoidable admission rates, Hypertension, population aged 15 and over, 2007

1. Includes transfers from other hospital units, which marginally elevates rates. 2. Does not fully exclude day cases.
Moving from passive to strategic purchasing

Know what you pay for!

Measure output, variation and cost-effectiveness

If you pay for inefficiency and bad quality, you will get inefficiency and bad quality!

Reward good performance
“I’ve got a strange feeling we’ve been going round in circles”

Source of slide: Alan Maynard
## Key issues in the European Region

| Structure of service delivery | • Over-investment in secondary & tertiary and under-investment in outpatient / PHC  
|                              | • Payment systems do not facilitate reconfiguration of infrastructure and managing the interface across levels |
| Clinical practice            | • Reflects focus on acute care and less attention to early diagnosis, disease management, and prevention  
|                              | • Continuum of care and patient pathways not observed  
|                              | • Uncontrolled variation and evidence-free practice |
| Patient preferences          | • Patients have become more informed, but focus is still on curative care. Benefits of healthy lifestyle spread slower  
|                              | • Doctors/industry generated myths prevail: generics versus branded medicines; more is better; more expensive is higher quality etc. |
There are many ways to pay primary care doctors: the three worst are…

- **Salary**
  - Monthly payment to health care staff regardless of effort

- **Fee-for-Service**
  - Payment for each service billed according to agreed schedule

- **Capitation**
  - Payment for number of enrolled population regardless of effort
  - Can be adjusted for socio-economic factors & health status
Dominant payment methods at different levels of provision

Primary care: capitation
- Content of service is not well defined
- High rate of referrals to specialists
- Huge variation in clinical practice (incl referrals and prescription patterns)

Outpatient specialist care: fee for service
- Generates more volume
- Operates as entry point to inpatient care

Inpatient care: case-based payment DRGs
- Improves efficiency of inpatient care, but
- No incentives to treat patients at lower levels of care
How to move forward?

- only those patients are treated, who do need care (eliminate unnecessary services)
- those patients, who do need care will be treated appropriately (eliminate under-treatment)
- patients are treated at the lowest appropriate level of care (eliminate unnecessary costs of higher levels of care)

Incentive alignment across the vertical spectrum of care to achieve that:
The main challenge for the future is managing the interface across levels

Choosing the “right” provider payment mix for each level of care is not enough

Frontier is to coordinate care across settings and strengthen chronic disease management

New payment incentives and organizational modalities are being explored
Country examples worldwide

- **USA**
  - new “Value-Based Purchasing” initiatives accompanied by Accountable Care Organizations and Medical Home models

- **Germany**
  - bundled payments to manage chronic conditions

- **Netherlands**
  - GP practices become main purchasers (again)

- **UK**
  - group practices in Primary Health Care Organizations accompanied by incentives for chronic disease management

- **New Zealand**
Multiple instruments

Incentivize doctors to reduce inefficiencies across levels of care
- Less inpatient, more outpatient and primary care

Strengthen care coordination
- Integrated IT system and health records

Pay for good performance
- Especially for prevention and management of chronic diseases

Make use of peer pressure through sharing comparative performance information
- The sense of duty is still at work and inexpensive
Evolution instead of revolution

„The only way to pay doctors is to change the system every three years, because by then they will have found ways to get around it to their own advantage”

Bob Evans
Canadian health economist