Incentives and Hospital Performance: The Road to Nowhere?

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Hammurabi, King of Babylon, 2,300BC

Babylonian Medical Fee Schedule	
Operations that saved a life	10 shekels of silver (nobleman) 5 shekels of silver (poor man) 2 shekels of silver (slave)
Setting a fracture	Freeman – 5 shekels Son of a noble – 3 shekels Slave – 2 shekels
Loss of a slave's eye	Pay half the slave's value
Kill a slave during a major operation	Provide a new slave
Kill a nobleman during a major operation	Hands cut off

Outline

- Background
- Activity-based funding of hospitals
  - Will it work?
  - How can it be used to reward for quality?
- Conclusions

Background

- National Health Reform
  - Increased emphasis on performance measurement and public reporting of performance
  - Changes to payment systems (ABF and Co-ordinated Care for Diabetes Pilot)

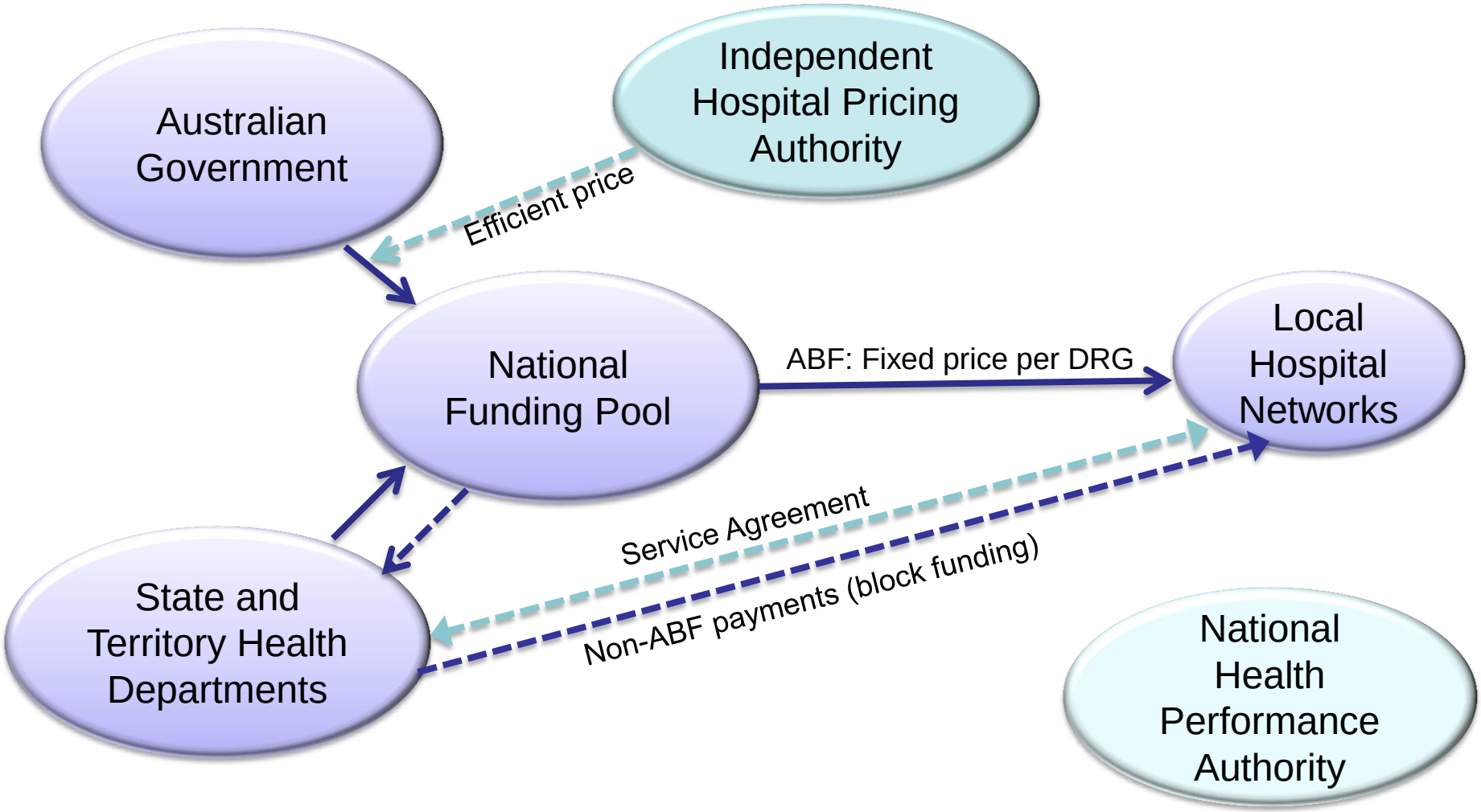
- Need to re-aligning funding arrangements to meet health system objectives

Unresolved questions

- Doubts about the use of financial incentives to change health care providers' behaviour

  - Quality of the evidence
  - What is the 'right' behaviour?
  - Poorly designed incentive schemes
    - Political
    - Assumes providers are largely motivated by money
    - Potential unintended and undesirable consequences ('gaming', 'multi-tasking')

Activity-based funding



Incentives in activity-based funding

		Effect on LHN budget	Intended behavioural response
LHN ‘A’ actual cost	**$6,000**	Makes a loss	Reduce costs
ABF fixed price per DRG from funding pool	**$4,808**		
LHN ‘B’ actual cost	**$3,000**	Makes a surplus	- Increase volume (FFS) - Re-invest in profitable services

Will ABF improve efficiency?

- What happens now in each State/Territory?
- What % of efficient price will States provide?
- Bailing out deficits and strength of incentives: hard or soft budgets?
- Percentage of hospitals which continue to be ‘block funded’ (eg in rural areas).
- Special pleading (IHPA takes submissions - lobbying)
- Transition issues / stability of prices over time
- How are managers rewarded?
- How will hospital managers persuade clinicians to respond to these incentives?

Sources of waste, harm and inefficiency

- Between 21% and 47% of US health care expenditure is of little or of no value - waste (Berwick, JAMA, 2012)
  - Failures in care delivery (18%)
  - Failures in care co-ordination (4%)
  - Overtreatment (28%)
  - Administrative complexity (19%)
  - Pricing failures (15%)
  - Fraud and abuse (15%)

- Increasing evidence of things that should not be happening in health care.
- ‘Choosing Wisely’ – 9 US specialty societies

- Allergy tests: When you need them and when you don't (American Academy of Asthma, Allergy and Immunology)
- Bone-density tests: When you need them and when you don't (American Academy of Family Physicians)
- Chest X-rays before surgery: When you need them – and when you don't (American College of Radiology)
- Chronic kidney disease: Making hard choices (American Society of Nephrology)
- EKGs and exercise stress tests: When you need them for heart disease -- and when you don't (American Academy of Family Physicians)
- Hard decisions about cancer: 5 tests and treatments to question (American Society of Clinical Oncology)
- How should you treat heartburn and GERD? (American Gastroenterological Association)
- When do you need an imaging test for a headache? (American College of Radiology)
- When do you need antibiotics for sinusitis? (American Academy of Asthma, Allergy and Immunology)
- When do you need antibiotics for sinusitis? (American Academy of Family Physicians)
- When do you need a Pap test? (American Academy of Family Physicians)
- When do you need imaging tests for lower back pain? (American Academy of Family Physicians)

Paying for performance in hospitals

- ‘Evidence check’ for Sax Institute, Nov 2011.

- Not paying for poor quality
  - ‘never’ events (eg wrong site surgery)
  - US Medicare and UK NHS
  - Withhold DRG payments, or complications not included in DRG payment

- Not paying for other adverse events – hospital acquired diagnoses (CMS, US)

  - Evidence – saves money but doesn’t change behaviour

Paying for high (relative) performance

- CMS Premier Hospital Quality Incentive Demonstration
  - bonus payment according to ranking with other hospitals for 33 quality indicators across 5 disease areas
  - Evidence:
    - Well designed evaluations
    - No impact on quality of care
- UK NHS - Advancing Quality Initiative, modelled on CMS scheme
  - Early evidence of small reductions in mortality
- Australia – Clinical Practice Improvement Payment (CPIP) system

Paying for ‘best practice’

- UK NHS –
  - Best practice payments based on evidence-based process of care across a range of disease areas
  - DRG payment replaced with a higher, ‘best practice payment’ and a lower ‘non-best practice payment’
  - Evidence
    - Evidence of small effects on quality of care

Why do some schemes not work?

- Payments made to hospitals and not clinical departments responsible for behaviour change

- Hospitals need to have internal management and accounting systems in place to devolve rewards and penalties to clinicians.
  - This should be part of the policy intervention

Conclusions

- No magic bullets
- Complex interventions that include organisation change, quality improvement activities, investment in IT, as well as incentives.
- ABF and paying for quality
- Careful design – devil is in the detail
- Thoughtful evaluation