

14 Dec 2007

The Importance of Incentives in Health Care Systems

A Final Report for the IFPMA

Executive Summary

NERA

Economic Consulting

Executive Summary

Introduction

This report has been prepared by NERA Economic Consulting for the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA). It reviews recent experience in health care reform, placing particular emphasis on the ways in which getting incentives right contributes to successful reform, and how implementing weak or inappropriate incentives jeopardises the benefits of reform. It is not intended to provide a comprehensive survey of recent health care reform. Rather, it illustrates the effects of incentives through a diverse selection of case studies, drawing on the experience of eighteen countries.

Defining successful reform

Our report builds on previous work for the IFPMA which reviewed experience with health care reform and developed criteria against which health care systems' performance could be measured.¹ We use the experience from our case studies to show how incentives contribute to attaining these Global Principles for Better Health Care, which are:

Good performance should be measured against agreed criteria. (Section 1)

- **Fair access:** Access to essential health care services and the contributions of individuals towards the cost of these services should be in line with the views of society about fairness.
- **Efficiency:** The health care system should deliver the maximum improvement in health outcomes given the available resources.
- **Responsiveness to society:** Services delivered and the level of funding should reflect citizens' views, based on high quality information.
- **Innovation:** The health care system should encourage appropriate product, diagnostic, therapeutic, administrative and contracting innovation and its optimal application.

Where do incentives come in to play?

Incentives matter throughout the health care system. The fact that people respond to the incentives which they face is a fundamental element of human behaviour, even if some of those incentives are driven by people's own values rather than set in place by the system. However, where there is a formalised interaction between (groups of) participants in a health care system it is likely that incentives will be particularly strong. Points of interaction are also likely to be those where reforms can most easily alter incentives in a specific

Incentives govern the interaction of health system participants.

¹ NERA (2002) Global Principles for Better Health Care: A Guide for Policymakers, A Report for the International Federation of Pharmaceutical Manufacturers Associations (IFPMA)

(Section 1) direction. Accordingly we split our analysis into a number of stages, in line with the links between different stakeholders in the system.

Health care benefits packages

All systems need to decide who gets what. An explicit transparent approach to this is helpful. (Section 2)

The content of the health care benefits package defines an important component of the interactions between patients and the system. It provides a mechanism which determines which patients receive which services. We study a range of approaches to defining the benefits package in countries including *Chile, Italy, Sweden, England and South Africa*.

Approaches to defining benefits packages, and the degree of rigour and transparency with which they are implemented vary between countries. Decentralisation of the health care system in principle carries with it pressures to be more explicit about what is covered. This transparency is one useful way of forcing policymakers to accept the sometimes difficult position that not everything can be covered, and that a decision making methodology is needed. We believe that transparency of the benefits package acts as an enabling factor for choice of fund.

Participants need incentives to deliver the package in practice. (Section 2)

Financing mechanisms are proving increasingly important in determining the effective content of the benefits package. As prospective cost per case reimbursement spreads, offering fixed payments for cases allocated to a clinical coding system, providers are disincentivised to offer any procedure that is not “on the list”. Even where codes are broadly drawn, procedures that are relatively expensive within a coding group may in practice not be offered.

Making sensible decisions about the health care benefits package – in light of resource constraints – and getting the right incentives to implement it, is an important way in which health systems can deliver **Fair Access**. By acting as an enabler of competition it may also be a building block that allows **Efficiency** to be improved.

Resource and risk allocation mechanisms

Good risk allocation mechanisms can replace incentives to compete on risk selection with incentives to compete on cost and quality. (Section 3)

The allocation of financial resources between insurance funds, or to providers to offer care for a locality, can have crucial effects on incentives. In particular, if the characteristics of the patient population covered are not fairly reflected in the funding allocated, insurance funds have incentives to engage in risk selection – cherry picking “low risk, high funding” individuals, and seeking to deter “high risk, low funding” patients.

Experience in *Colombia, the Netherlands and the Slovak Republic* shows that these concerns are real, and that cream skimming of this nature can destabilise the health system. They also show that risk adjustment mechanisms, that reallocate funding between bodies based on the riskiness of the population covered, can be an effective way of addressing these difficulties, and replacing incentives to cream skim, with incentives to compete on the basis of efficiency and quality.

Basic risk adjustment mechanisms have been increasing in sophistication over

time, providing increasing strong disincentives to compete on the basis of risk selection. The continual review and improvement of risk allocation mechanisms is an example of the successful adoption of **Innovation** in some countries, although the costs of gathering and analysing the data to support more complex systems need to be borne in mind. More broadly, effective risk adjustment mechanisms are a significant way in which **Fair Access** and **Efficiency** can be preserved in a system offering choice of insurer.

Competition and choice of fund

Allowing consumers to choose their insurance fund creates incentives for funds to offer packages that are attractive, and is hence a potentially useful way of holding insurers accountable. Introducing forces of competition offers incentives towards quality and efficiency that are in general well understood, although for them to be fully effective in a health care setting requires patients to be able to make active and well informed choices.

*Choice of insurer is an effective way of introducing incentives for **Efficiency** and **Responsiveness to Society**. (Section 4)*

Experience in *Australia, Chile, Colombia* and *Germany* suggests that this is in fact the case, and that these incentives do work well in practice. Large numbers of patients have changed insurer. Further, the number of insurance funds has reduced in some countries, with evidence that relatively inefficient funds have been forced out of the market. Administrative costs have also been driven down. Some negative effects have, however, been observed. In particular, it may be that consumers are in a sense too receptive to incentives to switch, denying insurers stability and the ability to manage risk appropriately. Countries have responded by introducing minimum time periods between switches of one to two years.

Choice of fund, appropriately regulated, is hence a useful way effectively incentivising **Efficiency**, and by forcing funds to take into account the preferences of consumers, this also contributes to achieving a system that is **Responsive to Society**.

Competition and choice of provider

Choice can also be introduced into health care systems by allowing patients to choose the provider who will treat them, and we study experience with this in *Denmark* and *England*. The motivation for introducing such choice varies. In some circumstances, it is a straightforward response to differential waiting times between regions – overall maximum waiting times can be reduced if some patients in long-waiting regions choose to travel to locations where there is spare capacity. In other cases, choice is seen as a more fundamental driver of quality and responsiveness, by incentivising providers to compete to attract patients and money.

Choice of provider can work, but only if providers have suitable incentives to react to it. (Section 5)

Experience shows that the success of choice depends heavily on the incentives that go along with its introduction. Unless hospitals are actively rewarded for seeking, or at least accepting, additional referrals a significant impact is unlikely. On the patient side, while some patients seem prepared to make active choices of provider (in particular where good information is available), some are reluctant to go to an out-of-area provider. This could mean that such choice is not valued highly, although it may also reflect concern about travel

costs. Depending on the reasons for implementing choice, policymakers may consider reimbursing these costs.

Choice of provider – backed by appropriate incentives – has the potential to create strong pressures for providers to be **Responsive to Society**.

Contracting

Contracts, being the most visible and practical element of purchasing, are a key tool to influence providers, and hence an ideal opportunity to implement desirable incentives. In this case, providers are held accountable to purchasers, rather than to patients. Since purchasing and provision of health care is separated in most countries there is a rich array of experience, offering the potential for numerous case studies. Our analysis of case studies drawing on *eight countries* suggests a number of themes about the successful incorporation of contractual incentives.

Contractual incentives are a key tool for influencing provider behaviour. (Section 6)

- First, contractual incentives (particularly financial incentives) can be an effective tool for the promotion of both efficiency and quality.
- Second, there are examples of providers responding “too well” to incentives, creating budget pressures for payers. Payers need to ensure that baselines are measured and set realistically and that improvements are worth paying for.
- Third, successful contracting depends largely on the existence of information that allows performance to be measured and monitored, and investments in such information may be needed.
- Fourth, although contracting can provide useful incentives for quality, it may not always be possible to trade incentives for efficiency and quality perfectly, and a role for quality assurance remains. Quality indicators should be correlated with overall performance, and not susceptible to manipulation, or achievement in isolation.

Contractual incentives are a key mechanism for achieving **Efficiency**. They can also help to achieve quality, which is likely to be consistent with **Responsiveness to Society**. In principle, they could be used to incentivise **Innovation** although there is some evidence that in practice they are more likely to stimulate the uptake of new technology where it is cost-reducing than when it is quality-enhancing.

User charges

Although user charging regimes vary internationally, most countries use them to some extent. They may partly be used as a tool to raise revenue but their more fundamental rationale is to incentivise the efficient use of the health care system. At a minimum, user charges can help to signal to patients that health care is not, and should not be treated as, a free resource.

User charges can make some contribution to incentivising

We have considered the experience of *Germany, the Slovak Republic, Singapore, Hungary and others* in the introduction and reform of user charges.

responsible use of the system without unduly restricting access.
(Section 7)

There is some evidence that patients respond to user charges by lowering use, although it is less clear whether such impacts are permanent or a one-off response to the change. User charges also have the potential to reduce efficiency if they deter early diagnosis of conditions, forcing more costly subsequent treatment, although the size of this risk is unknown. Regimes such as Medical Savings Accounts in effect force people to save for health care and hence be in a position to meet copayments, although the existence of a dedicated pot of personal health care financing with little alternative use, may dilute incentives to use these resources cost-efficiently.

Copayments have the potential to make a contribution towards the **Efficient** operation of health care systems; the challenge is to ensure that they do so without contravening **Fair Access**, and there is some evidence that this is possible.

NERA

Economic Consulting

NERA Economic Consulting
15 Stratford Place
London W1C 1BE
United Kingdom
Tel: +44 20 7659 8500
Fax: +44 20 7659 8501
www.nera.com

NERA UK Limited, registered in England and Wales, No 3974527
Registered Office: 15 Stratford Place, London W1C 1BE