ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

Harmonizing incentives for health promotion across providers and patients—what are the issues?

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"New Strategies for Health Promotion—Steering Clear of Ethical Pitfalls"
April 29, 2011

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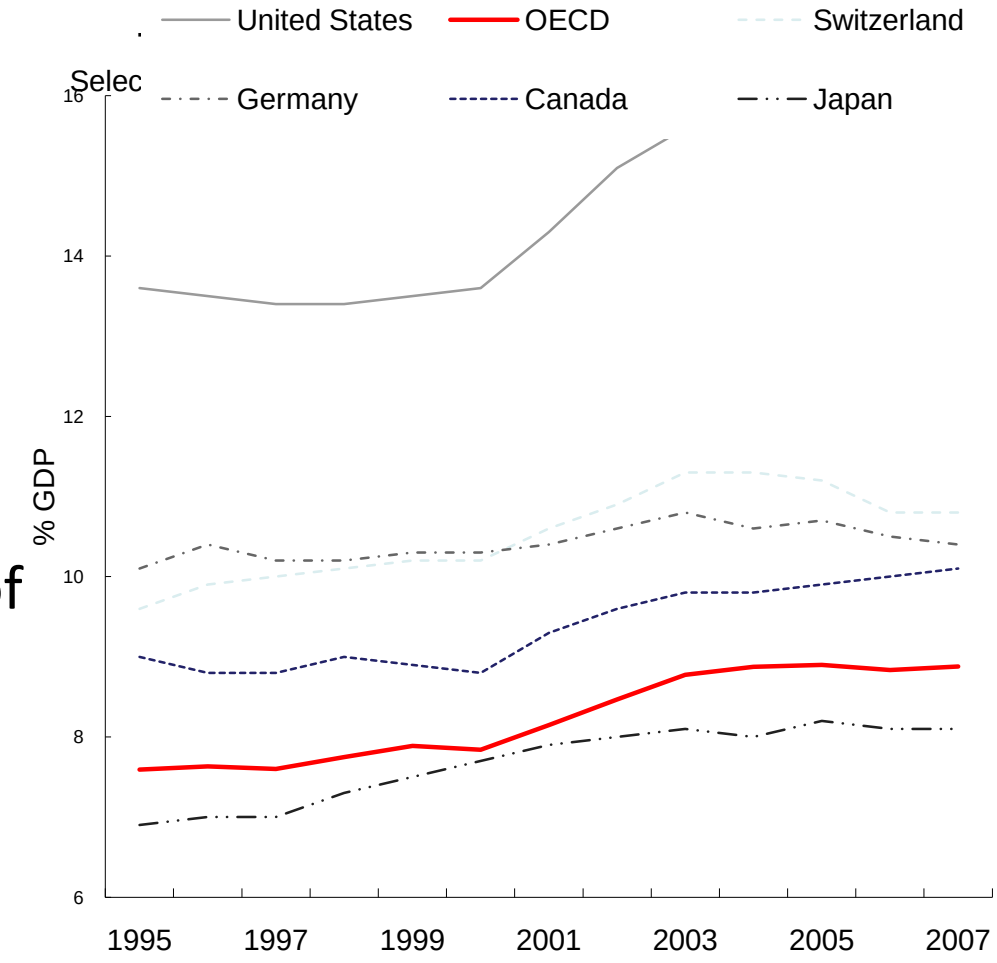
Recent developments in payment models aim to achieve value for money

- Rising burden of chronic diseases and increasing health spending in OECD countries
- Traditional payment models are inadequate
- Many OECD countries are experimenting with new methods of paying health care providers to improve the quality of health care and coverage of priority preventive services (Pay-for-Performance or "P4P")

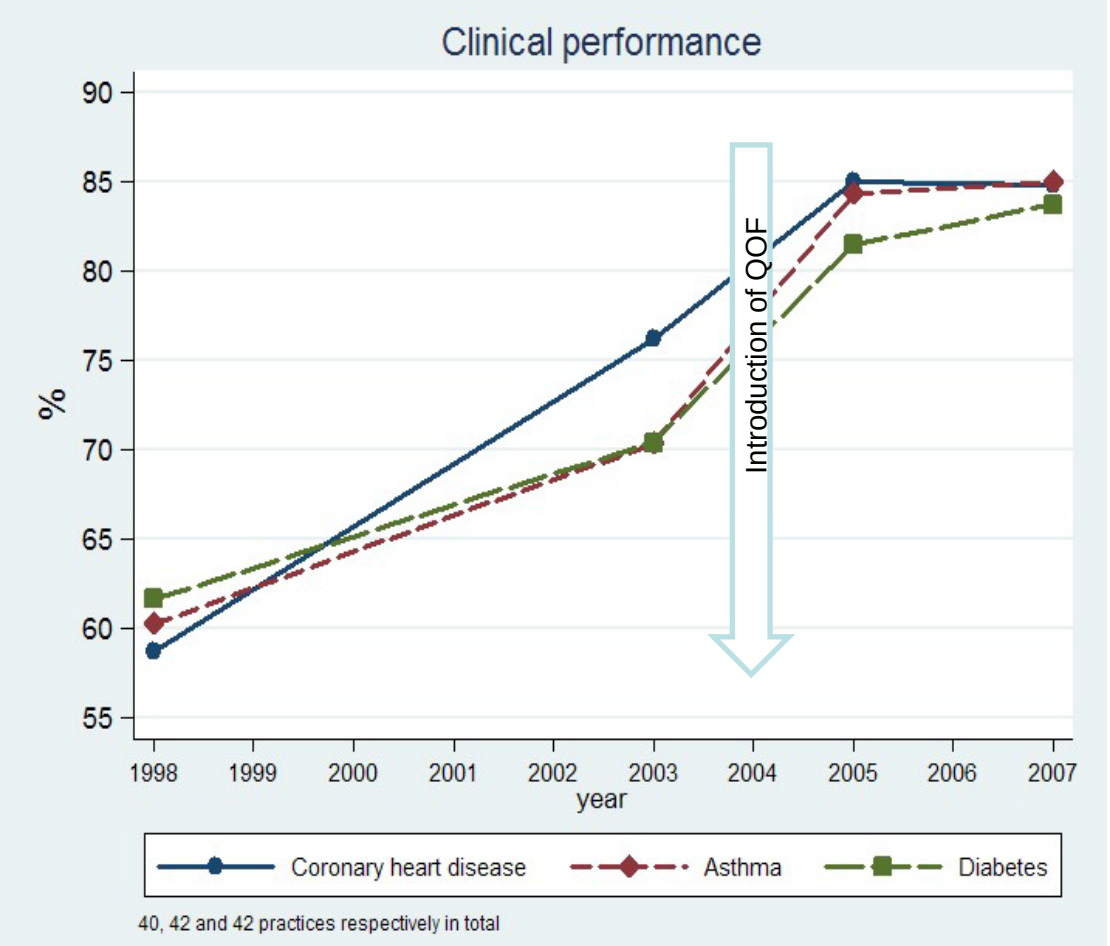


Source: OECD Health Data 2009.

P4P has widespread appeal, but does it work?

- Very few schemes evaluated.
- Evidence of effect on outcomes is weak.
- Performance measures tied to incentives improve, but often marginally.
- Greatest effect when highest payment rates and lowest effort.
- Even less evidence on design and implementation and whether P4P is a cost-effective way to achieve various objectives.

Clinical performance as measured before/after implementation of UK P4P scheme (QOF)



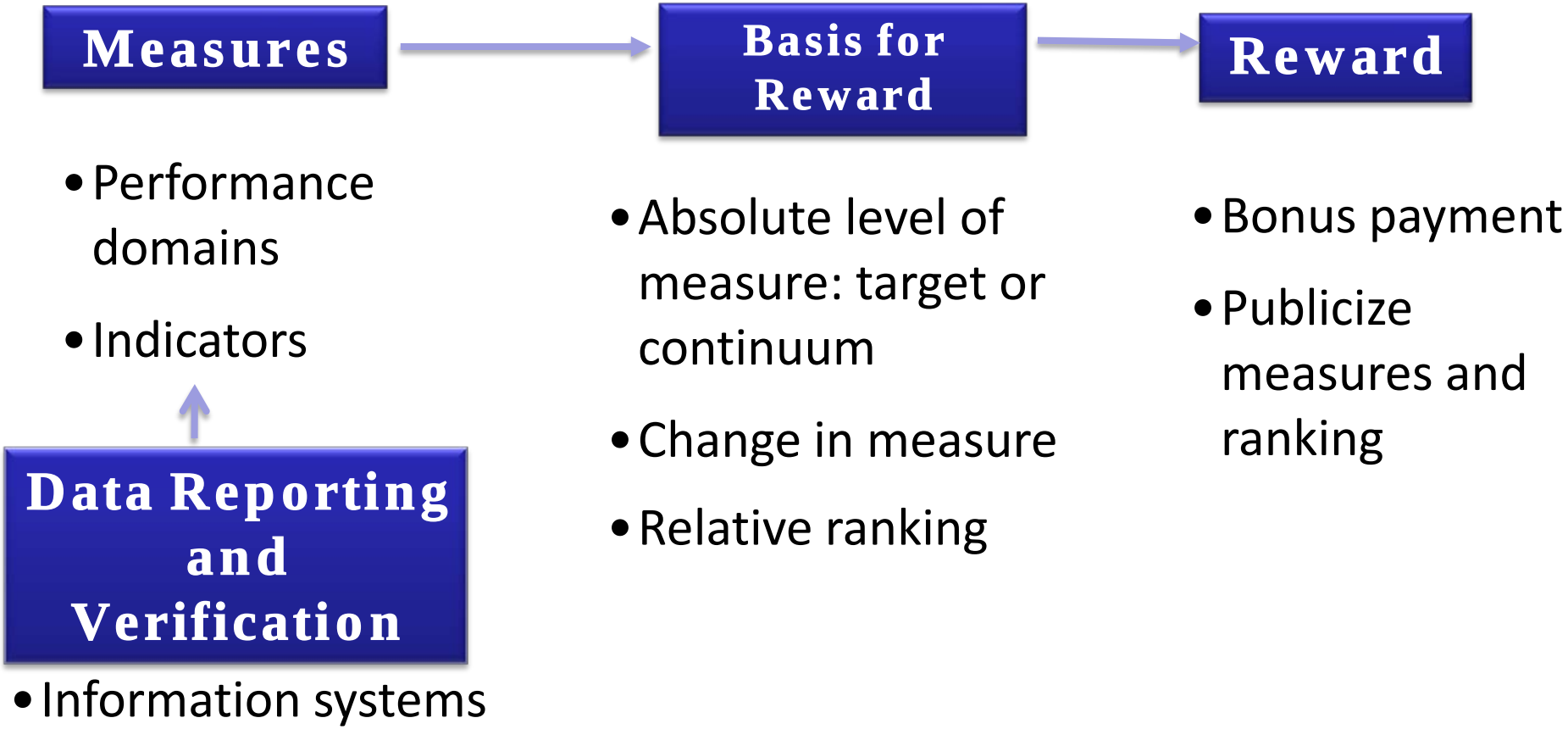
OECD/World Bank study reviewed P4P experience in 6 countries

The objectives were to:

- Better understand the elements design and implementation of P4P schemes
- Assess to what extent schemes meet their objectives
- Identify factors that contribute to or limit success
- Generate lessons for low- and middle-income countries

Schemes from a variety of contexts	
Large national schemes	Australia, New Zealand, U.K.
Pilot schemes feeding into a national initiative	U.S., France
Small local scheme part of national policy agenda	Brazil

A standardized framework was used to describe and assess the schemes



Source: Adopted from Scheffler RM: *Is There a Doctor in the House? Market Signals and Tomorrow's Supply of Doctors*, Stanford University Press, 2008.

Most schemes include incentives for health promotion

	Countries providing incentive	Effect?
Cancer screening (breast, cervical)	Australia Brazil New Zealand U.K.	**Significant** increase in screening rates (BR) **Modest** increase in screening rates (NZ) **Targets met** (UK) **No** improvement (AU; FR)
Asthma	Australia U.K.	**Modest** increase in completion of treatment cycles (AU) **Targets met** (UK)
Diabetes	Australia France New Zealand U.K.	**Modest** increase in screening and preventive testing and management (AU; FR; NZ) **Targets met** (UK)
Hypertension	France New Zealand U.K.	**Modest** improvement (NZ) **Targets met** (UK) **No** improvement (FR)
Vaccination	Brazil France New Zealand U.K.	**Significant** increase (NZ—children) **No** improvement (FR; NZ--adults) **Targets met** (BR; UK)

But the incentives for health promotion are not very effective

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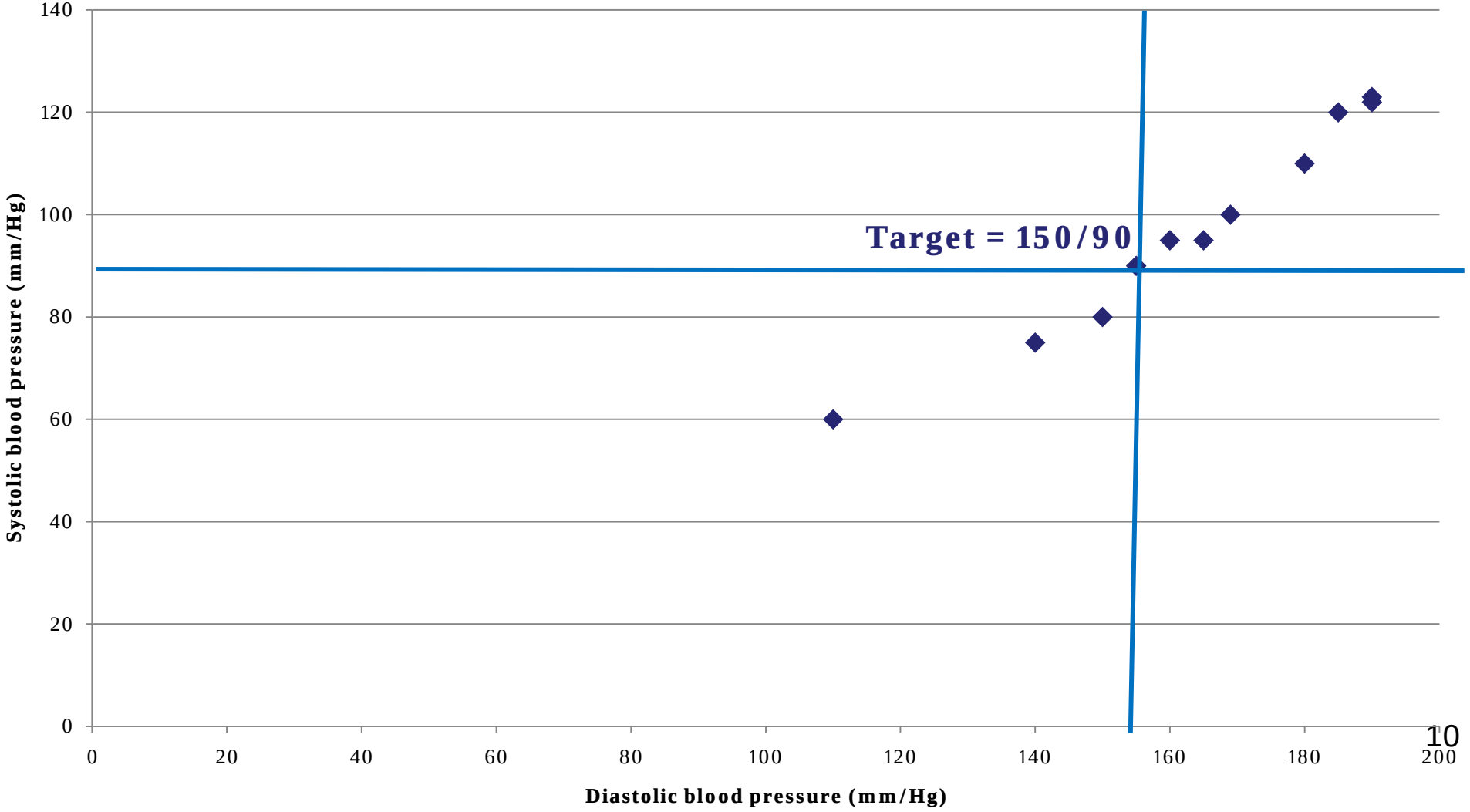

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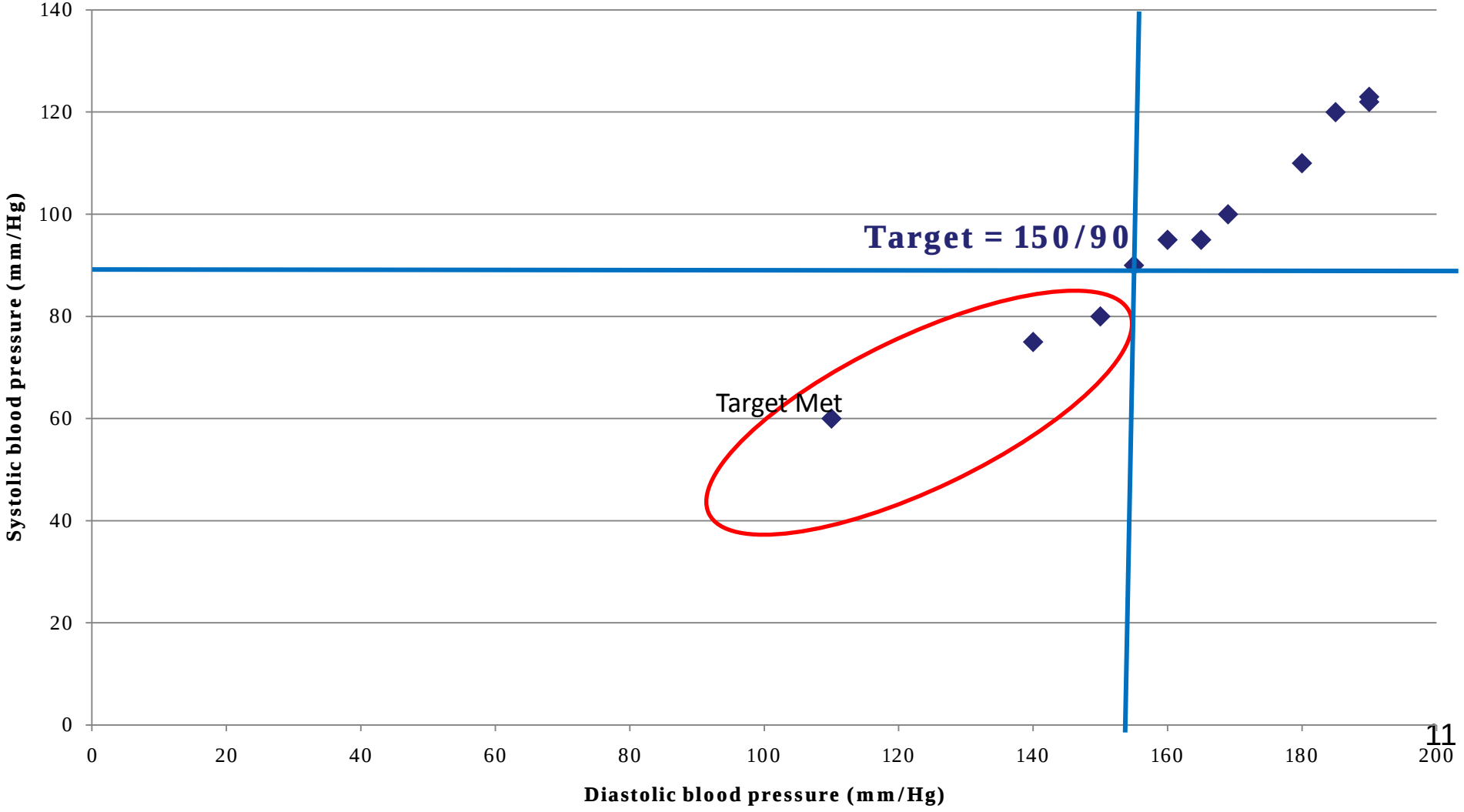

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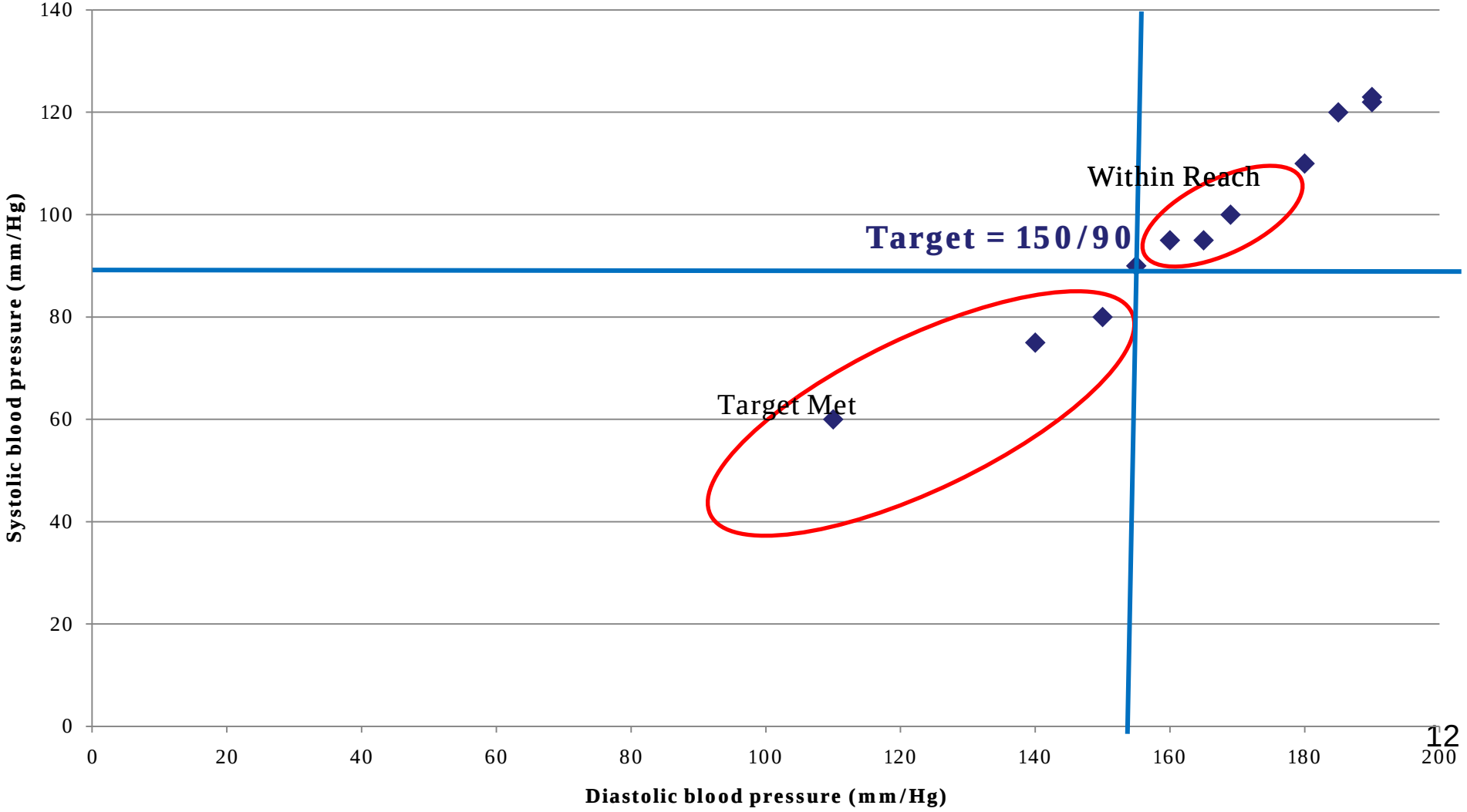

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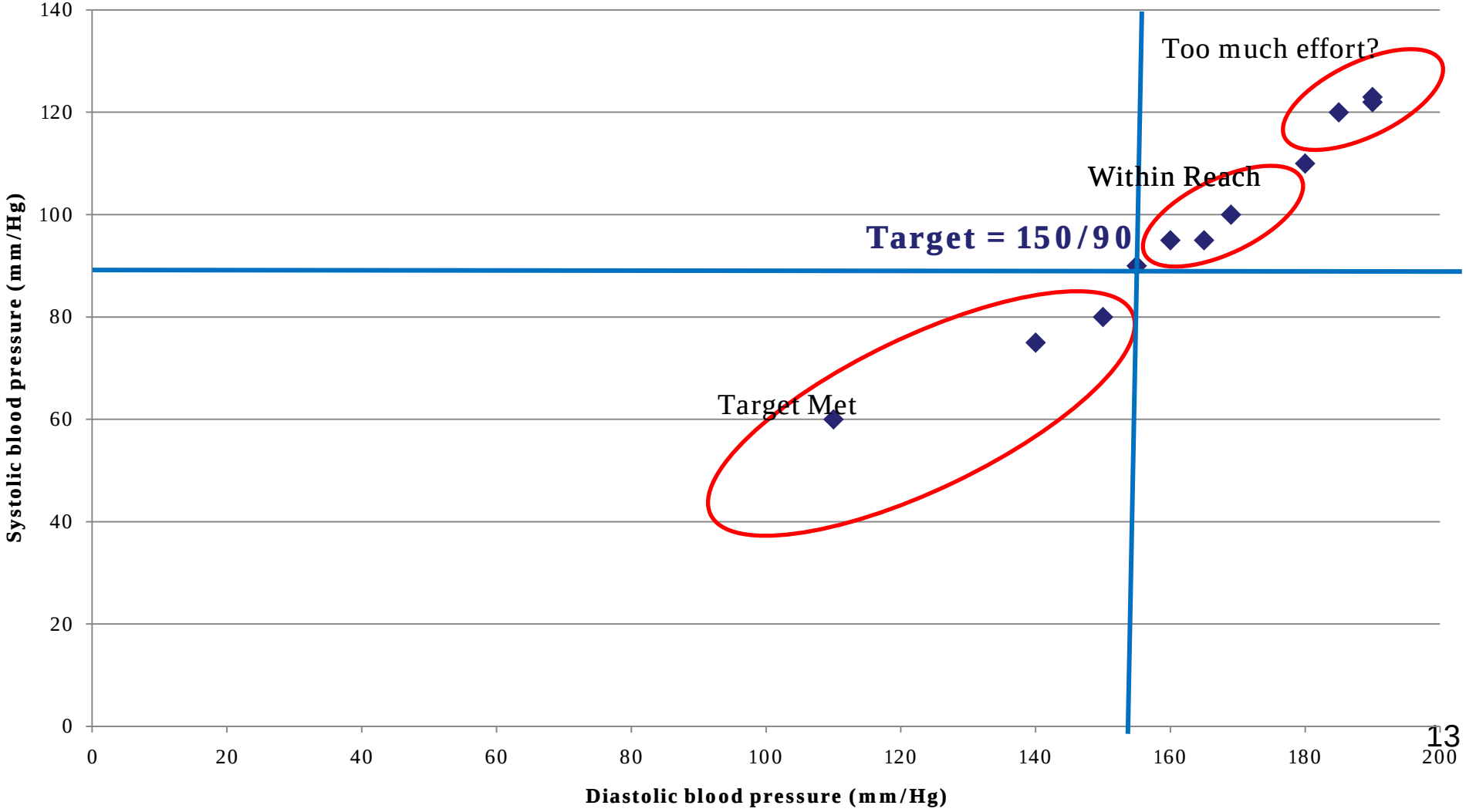

What might limit the impact of provider incentives on health promotion and outcomes?

- Incentives might not work to motivate better performance for complex tasks.
  - Incentives more effective at increasing "output," e.g. screening
- *Substitution*—providers may shift toward activities with incentives and away from others that have more benefit for health
- *Reduced intrinsic motivation*— shift away from the "heart" in medicine
- "*Cream-skimming*"--incentive to avoid difficult patients
- May miss the real barriers to improvement--not always related to incentives
- Provider incentives ignore the role of patients

And targeted provider incentives pose some ethical issues

- P4P can have a negative effect on equity
  - Incentive to avoid “difficult” or “non-compliant” clients
  - Improving service quality and coverage is costly
- **But** P4P can have a positive effect on equity if explicit measures are taken
  - “exception reporting” in U.K.; higher rewards for reaching vulnerable population in NZ; direct support to small and rural providers in AU
- Not much evidence that P4P is effective, so may be directed away from interventions of known effectiveness
- Providers may “nudge” contact with client toward meeting targets (or worse)

Addressing the supply side and the demand side together……

Can provider incentives be harmonized with patient incentives?

The case of tuberculosis screening, diagnosis and treatment

Characteristics of TB

It is clear what needs to be done

- Nearly 2 million TB deaths occur each year
- TB is curable with appropriate drug therapy
- Standard treatment guidelines using DOTS therapy are widely accepted
- But 40% of patients on average worldwide do not complete treatment

Potential role for incentives/enablers for patients

- TB is largely a disease of the poor, so access barriers are more severe
- Adherence to 6 months of treatment is a challenge
- Incomplete treatment can lead to drug resistance

Incentives in TB control : supply and demand side

Incentives to provider

Bonus payment
Disincentives
Ranking
Public disclosure

- Reward case detection and screening
- Increase case reporting and data collection
- Reward compliance with treatment guidelines
- Enhance follow-up of patients

Incentives to patient

Tokens and enablers
Coupons
Financial incentives upon treatment

- Reduce barriers to diagnosis and treatment ('enablers')
- Enhance case detection and prevention (incentives)
- Reward adherence to treatment (incentives)

Patient incentives and enablers are a subset of CCTs

- **Incentives** are small gifts used to encourage patients to take the appropriate steps needed to complete medical evaluation and treatment.
- **Enablers** are those things that make it possible or easier for the patients to receive treatment by overcoming barriers such as transportation difficulties.

Objectives of CCTs for TB

- The objectives are to achieve treatment completion and cure.
  - To improve both the individual's health and public health
- No direct objectives for poverty reduction and human capital investment.
- **But** a long-term impact on poverty should be a byproduct if the approach is successful.

10 of 33 reporting OECD countries have TB incentive programs

4 supply side
9 demand side

	Case detection		Treatment adherence		Reporting cases	
	S	D	S	D	S	D
Australia				X		
Austria						
Belgium						
Canada		X		X		
Chile						
Czech Republic	X	X		X		
Denmark						
Finland						
France				X		
Germany						
Greece						
Hungary						
Iceland						
Ireland					X	
Israel			X	X	X	
Italy				X		
Japan						
Korea						
Luxembourg						
Mexico						
Netherlands						
New Zealand						
Norway						
Poland						
Portugal						
Slovak Republic						
Slovenia						
Spain						
Sweden						
Switzerland						
Turkey				X		
United-Kingdom				X		
United-States	X	X		X/ X	X	

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Australia				X		
Austria						
Belgium						
Canada		X		X		
Chile						
Czech Republic	X	X		X		
Denmark						
Finland						
France				X		
Germany						
Greece						
Hungary						
Iceland						
Ireland					X	
Israel			X	X	X	
Italy				X		
Japan						
Korea						
Luxembourg						
Mexico						
Netherlands						
New Zealand						
Norway						
Poland						
Portugal						
Slovak Republic						
Slovenia						
Spain						
Sweden						
Switzerland						
Turkey				X		
United-Kingdom				X		
United-States	X	X		X/ X	X	

Diversity of schemes

France:
Cash Envelopes from the *Association against Respiratory Diseases*
Incentive for undocumented workers to register
Bligny Centre (especially for MDR TB) : housing and food

United States:
New York Needle Exchange program: cash envelopes to enhance diagnosis among drug users ($25)
Francis Curry centre and New Jersey Department of Health: housing and vouchers program

Canada:
Assistance program in North Bay: Transportation assistance + meals for the poorest patients who couldn't come to the clinic otherwise.
Needle Exchange program in Vancouver offered $5 incentives for skin test

Czech Republic:
4 municipalities (including *Prague*) provide food vouchers (CZK 100-200) for chest X-Ray as part of screening in the homeless population Same vouchers were provided upon treatment completion in Prague; provider incentive for screening.

Example of treatment adherence incentives and case management in New Jersey

Identified obstacles to completion of treatment:

- homeless: lack of stable environment
- substance abuse
- linguistic misunderstanding of the infection (especially for migrant workers)
- loss of income due to absence at work
- lack of access to public facilities on a regular basis
- family constraints
- side effects of treatment
- personal perception on the disease/stigma
- work-related migration

Example of treatment adherence incentives and case management in New Jersey

New Jersey Department of Health manages and funds the incentive program. It offers the following incentives :

- $5 Mc Donald's coupons
- $10 Grocery Stores gift cards
- $10 Wal-Mart gift cards
-$10 Target gift-cards

- American Lung Association funds a housing program -- $140,000 (yearly)
- Treatment adherence is monitored through weekly reports on individuals' performance, completed by nurses.
- Non-adherence leads to the withdrawal of incentive.

Example of treatment adherence incentives and case management in New Jersey

Results:

99% treatment completion of TB patients, 96% in the housing program (the most contagious and complex cases).

(Treatment completion in France estimated around 75-80% for a 6-month course of treatment)

Lessons learned:

- Case management + incentives – Incentives alone not enough
- The schemes is very cost-effective, as treatment default can lead to development of resistant strains (costly treatments)
- "TB is still a social disease (high correlation with socio-economic status), and incentives and enablers can simply help patients to face the indirect costs incurred by the disease"

There are some potential ethical problems

- CCT (incentives and enablers) for TB are almost exclusively aimed at the poor.
  - *Do the I/E adequately compensate the cost of treatment completion?*
- CCT for TB typically end when treatment ends

Lessons from TB incentives

- It is important to understand the underlying obstacles to case detection, appropriate treatment, and compliance

Do the diagnostics, then apply the evidence.

- Incentives and enablers should be **coordinated on the supply and demand side** so the provider and patient have shared expectations and goals

- Incentives and enablers can be effective when **the steps are clear** (well accepted treatment guidelines) and the **outcome is achievable and measurable** (cure). Not always the case with other public health challenges!

Some final thoughts

- Improving health promotion, care, and outcomes is complex
  - **incentives are only one part (and maybe a small part) of the big picture**
- It is necessary to do the diagnostics first
  - **what are the real barriers to increasing coverage, quality, adherence, behavior change and outcomes?**
- Incentives on the supply side alone do not appear to change much for health promotion or outcomes
  - **the client/patient needs to be engaged and involved**
- Financial resources and incentives can be used to bring the provider and client into closer coordination with shared goals

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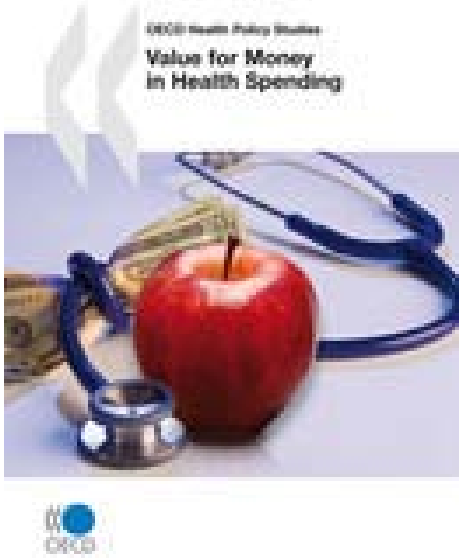

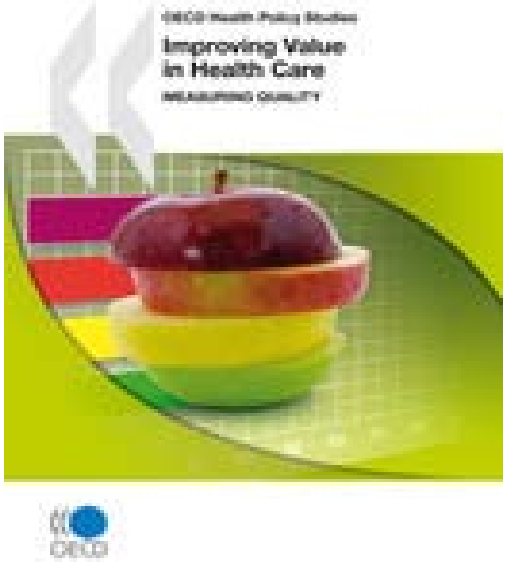

Thank you