How to integrate P4P into a blended payment system? Lessons from Estonia

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Estonia in brief

Population 1.3 million

GDP per capita 15 883 EUR (2016)

ALE at birth 77.7 years (2015)

- Male 73 years
- Female 82 years

Health expenditures (2015)

- 6.5% of GDP
- Per person 1006 EUR
- Public expenditure 75.7%

Social health insurance (single payer) since 1992

- Coverage with health insurance 94-96% of population

PHC milestones since 1992

- 1992
  - Family Medicine integrated to the curricula
- 1997
  - PHC reform
  - 5-year transition period starts
- 1998
  - Patient lists
  - New contracts
  - New payment system
- 2003
  - 5-year transition period completed
- 2006
  - Voluntary P4P is introduced
- 2013
  - Organizing PHC centralized to the Health Board
- 2017
  - New health centers model introduced

Fundamentals of PHC

- Family doctors are **private entrepreneurs** owning patient list
- Family medicine practice can be **owned only by family doctors** or **local municipality** (latter is rare)
- **Family doctor's practice cannot provide specialist care** and vice versa
- **All people** should be **registered with a family doctor**, open enrollment
- Health Insurance Fund has **direct contracts to family physicians'** practices
- Family doctor is a **partial fund holder** and **partial gate-keeper**
- **New health center model** (transition starts 2017) widens minimum team – 3 family doctors, 3 family nurses, home nurse, midwife, physiotherapist

PHC in numbers

800 family doctors with **patient list**

456 family medicine **practices**

75% solo practices

Annually **3.2 family doctor visits per capita** (3.2 specialist visits)

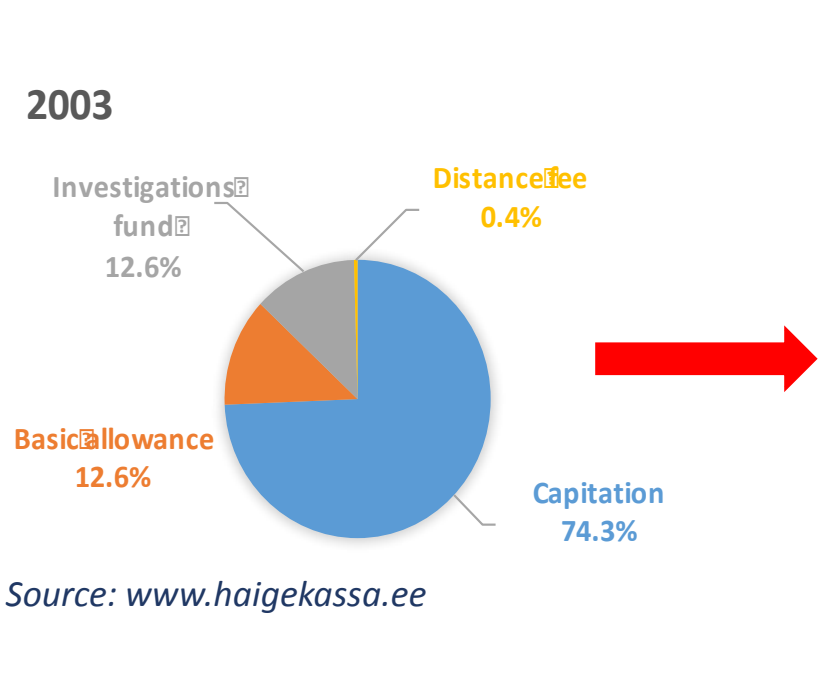
Average size of the patient list **1700**

Average family doctor is **56 year old**

Average **monthly revenue >11 000 EUR**

Less than 20% have passed **family medicine residency** program

Payment system evolution



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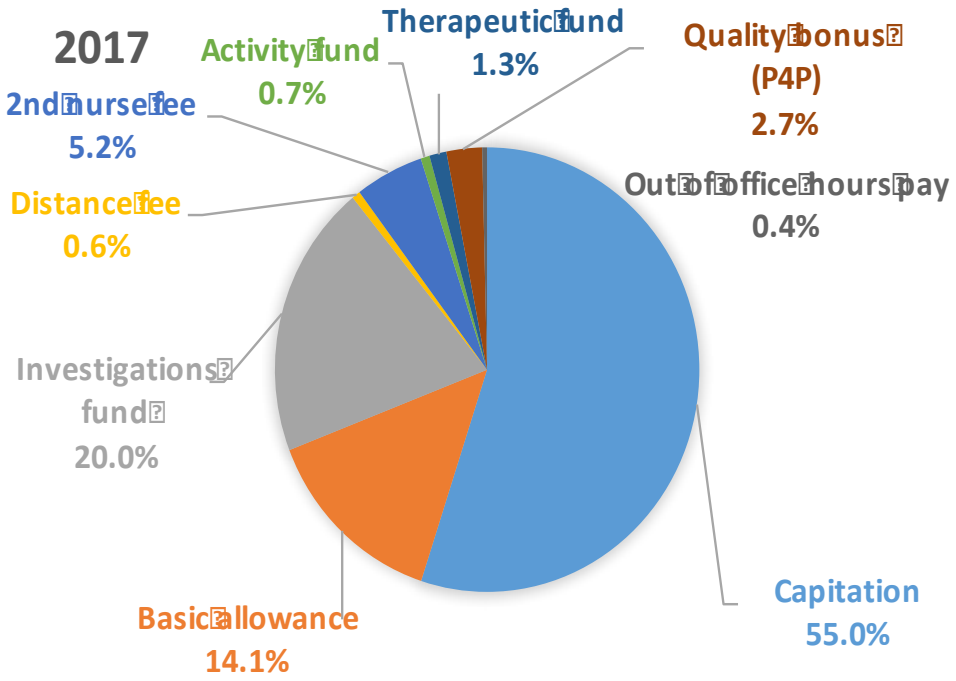
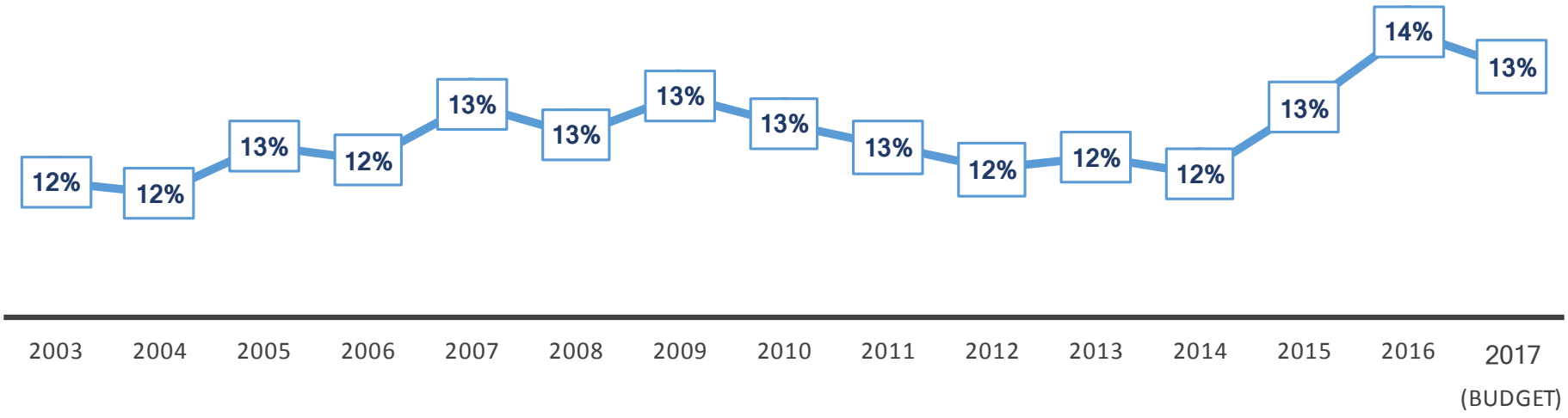


- **All costs** are covered through these different payments
- Over time the role of **capitation** has **decreased**
- **Fee for service** (mostly with cap) part **increases** continuously enabling family doctors to take more role over patient care
- **New incentives**: P4P, out of office hours fee, 2nd nurse fee

PHC % in the health care services budget has remained relatively stable



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Quality bonus system (QBS)

Objectives of QBS:

- More **focus on prevention**
- To reduce **morbidity of vaccine-preventable diseases** and hospitalization from non-communicable diseases
- To improve the **management of non-communicable diseases** at PHC level
- To motivate family doctors **to widen the scope of provided services**

Launched **in 2006** as voluntary system (mandatory since 2015)

Development of the system was **led by family doctors** with health insurance fund's technical support

Was build to the **existing medical claims** system

QBS domains

1st domain "prevention" – 160 points in total

- 0-2 age children's vaccination
- Follow-up of development of child 0-2
- Preschool examination of child

2nd domain "management of non-communicable diseases" – 480 points in total

- Type II diabetes
- Hypertension
- Hypothyreosis
- Myocardial infarction

3rd domain "extra activities" and continuing medical education – threshold set by minimum volume of procedures

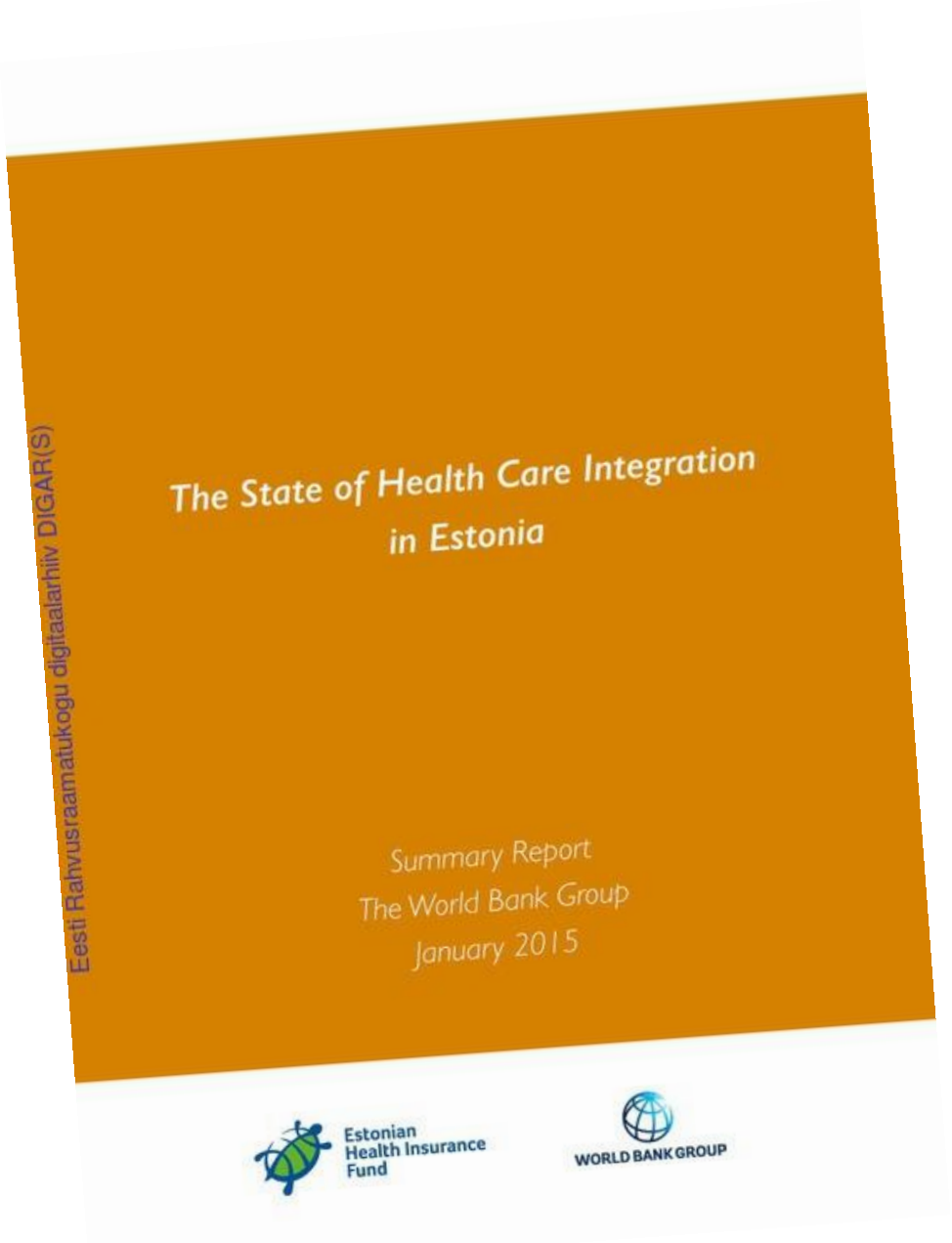
- Pregnant women
- Gynecological examination
- Minor surgery

For **each sub-domain FP „earns" fixed amount of points** if expected coverage target is achieved

Example of QBS: type II diabetes

Type II diabetes	***Expected coverage target for 2017***
Glycohemoglobin test done for patients with type II diabetes once per year	70%
Creatinine test done for patients with type II diabetes once per year	
Total cholesterol test done for patients with type II diabetes once per year	
Fractions of cholesterol measured for patients with type II diabetes once per 3 year	
Nurse counseling for type II diabetes patients	
Prescriptions for metformin	61%

So is there adherence to good clinical practice?



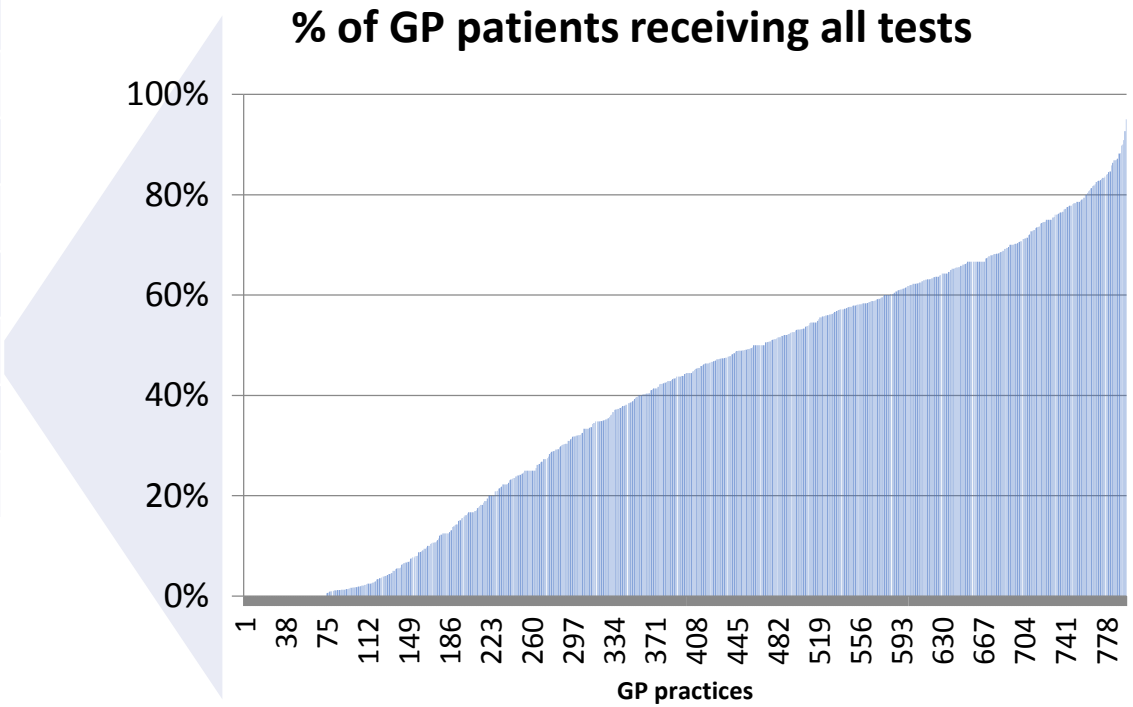
Disease focus:
Non-communicable
System focus:
Primary Health Care

Key question:
Is there adequate adherence to good technical practice (specified by clinical guidelines) in NCD prevention at primary care?

Tracer conditions:
Diabetes mellitus
Hypertension

Less than expected …

Diabetes mellitus Risk prevention	Patient coverage
Tests	
Glycosylated hemoglobin	72.8%
Cholesterol fractions	68.2%
Albuminuria	45.5%
Creatinine	75.0%
All	**41.1%**
None	**20.0%**
Nurse counselling	**65.7%**



… with significant ramifications for system performance …

Hospital type	Total admissions (2013): Respiratory, Endocrine, and Circulatory	% Avoidable (ambulatory sensitive admissions)
Regional	22,903	14.69%
Central	20,612	18.58%
General	18,144	22.33%
Non HNDP	10,138	14.01%
All providers	71,797	17.64%

… which prompted a payment system review and reform recommendations for the QBS and beyond.

QBS components	Policy options
Measuring	▪ Align indicators with clinical guidelines and sector targets ▪ Introduce indicators for enhanced care management ▪ Move from process to outcome indicators (BP, HBA1C)
Counting / Scoring	▪ Improve precision of counting (eliminate specialist activities) ▪ Move from average to an all-or-nothing approach
Paying	▪ Increase as a share of GP revenue (2.7% vs. OECD 5% – 15%) ▪ Structure as withholding rather than bonus payment
Blending	▪ Reduce overlap with FFS
Other	▪ Develop QBS for group practices ▪ Building on QBS, develop comprehensive provider quality monitoring system

QBS lesson highlights

- **Clinical leadership** has been crucial in the QBS development
- **Electronic claims** data has been a key success factor during the implementation but as a result the QBS is still **focused on process** and not outcomes
- Rising awareness of **evidence based medicine**, clinical guidelines and **performance monitoring**
- **QBS** needs to be **part of a broader quality monitoring effort**, the financial bonus seems secondary
- **QBS has limited** (if at all) **role** to create incentives for **care provision at PHC level** – need to rethink all incentives across different levels of care
- What matters more is the **redesign of the service delivery system**, with more prominent role for PHC and integrated with hospital and social care.