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## CONFERENCE ABSTRACT

# An overview of payment mechanisms and contractual models to support patient-centred care integration

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The way health services are paid for will, directly or indirectly, influence what care is provided and the way it is delivered. Many countries are in the process of introducing policies and reforms to enhance collaboration across providers and foster integrated care. Interlinked with ambitions to create more patient-centered care are endeavors to change the health care purchasing model from one based largely on inputs and outputs to one based on outcomes, with the aim of optimising resource utilisation and improving care quality. This study gives an overview of current financial arrangements intended to support patient-centered care integration and reviews its evidence base.

Within the broader meaning of integrated care, we focused on care continuity for patients with long-term illness and the vertical and horizontal integration of care across providers. We reviewed systematic and non-systematic reviews and overviews published in English between 2005 and 2015 in the scientific and gray literature.

Financial arrangements to foster care integration span a continuum from direct financial incentives to encourage cooperation, across payment bundling, to population-based capitation; from the alignment of budgets and objectives, and sharing of financial risk and gains across providers, to full integration of funding and management:

Paying physicians for care coordination can be a relatively straightforward first step towards care integration, specifically in settings where primary care physicians are paid by fee-for-service. In Austria, France and Germany, 'pay-for-coordination' schemes were applied as part of disease management programmes for selected chronic diseases in the early 2000s, later also in Denmark and Belgium.

In systems based on fee-for-service or case-mix payments the (further) bundling of payments by episode or disease have been explored. In the US and Sweden, payment bundling has mainly been used for care episodes; for complex operative procedures to include also rehabilitation and readmission. In The Netherlands, a condition-specific bundled payment model, spanning across primary care providers, was introduced in 2007; initially under a pilot scheme for

diabetes and in 2010 expanded to encompass chronic obstructive pulmonary and cardiovascular disease.

The bundled payment model in The Netherlands is seen as a step towards introducing population-based capitation payment, where a fixed amount of funding, defined by age, medical conditions etc., is provided to cover the medical needs of each individual in a defined population, during a certain time period. Capitation payment can facilitate care integration, but can be difficult to manage across non-integrated providers which may have underlying disparate financial objectives. In the US, capitation models were explored in the 1980s and 1990s under the concept of 'managed care'. Many failed, arguably because of a lacking systems perspective with difficulties of balancing the interests of partners. Further, optimal care provision was not incentivised as there were few quality measures in the contracts. However, two US provider groups with long-term operations under capitation are the Veterans Health Administration and Kaiser Permanente.

Contractual models, where financial risks and gains are shared across providers and payer with more or less formal agreements, include shared-savings, gain-sharing and alliance contracts. Accountable Care Organisations in the US, payer-provider alliances gradually introduced following the Affordable Care Act in 2010, often operate under shared-savings contracts. A regulatory change in Germany in 1999 that allowed for integrated care contracts between insurance funds and providers have resulted in a few population-based integrated care programmes, such as *Gesundes Kinzigtal* which applies a shared-savings model. In Canterbury in New Zealand, the health board has since the mid-2000s established alliance contracts with pre-agreed gain and losses dependent on the overall performance of involved service providers, aiming for a 'high trust, low bureaucracy' approach to contracting.

There is to date little rigorous evidence of the health impact of different financial arrangements to support care integration. Disentangling the benefits or side effects of a financial model per se within the complexity of a healthcare restructuring is often difficult. As financial rewards may create strong incentives, consideration and assessment of how they may change behaviour and performance is necessary upon implementation. This is evidently also applicable to current financial models; reforms may be difficult to implement unless existing underlying incentive structures are properly addressed and considered. Operating new payment systems is likely to add transaction cost and one should be realistic about the time and costs it takes to develop capabilities to manage comprehensive payment models, such as population-based payment. What financial arrangement is most appropriate is highly context-dependent and experiences from one setting is often not directly transferable to other settings; integration requires flexibility and adaptation to local contexts, patients and other stakeholders.