Aligning financial flows to care pathways: a success factor for efficient care integration?

Frida Kasteng, SINTEF Health Services Research, Trondheim, Norway

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Context and Methods

Context: The way health services are paid will influence what services are provided and how they are delivered.

Objective: Bring together findings on financial arrangements to support care integration.

Methods: We searched the scientific and grey literature. Inclusion criteria: reviews/overviews published in English between 2005 and 2015.

Limitations: Focus on integrated care for patients with chronic diseases and the vertical and horizontal integration of care across sectors.
Theoretical framework: Taxonomy provider payments and contracts

- Per activity payment
- Per case payment
- Per episode payment
- Per condition payment
- Per patient payment
- Per capita payment

Activity/population-based payments

Unbundled
- Payer financial risk-bearer
- Potential service overuse

Less

Conducive to care integration

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- Potential service underuse

More
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- 'Shared savings'
- 'Value-based payments'
- 'Value-based population health'

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Contractual mechanisms
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  - Lead contractor
  - Alliance contract
- Integrated provider
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- **Governance paradigm**
  - New Public Management
  - Traditional Public Management
  - Networked Governance
  - ‘Public goods’
  - ‘Public choice’
  - ‘Public value’

Promoting learning | Developing guidance | Sharing ideas
Findings: Models with focus on financial incentives (provider gains only)

- **Pay-for-coordination (P4C)** in disease management programmes (e.g. Austria, Belgium, Germany, France, since 2000s)

- **Pay-for-performance (P4P)** to promote patient follow-up in primary care (e.g. Australia, England, Estonia, France, New Zealand, 2000s)

- **Shared savings** (e.g. USA 2010s, Accountable Care Organisations to date few with shared risk contracts)
Findings: Models with focus on shared accountability (provider gains + risk)

- **Condition-based bundled payments** (e.g. the Netherlands 2010s)

- **Shared savings/reinvestment payments & risks** (e.g. Germany (Gesundes Kinzigtal), England (North West London Integrated Care Pilot), USA (Pioneer ACOs) 2010s)

- **Alliance networks** (e.g. New Zealand (Canterbury), 2010s)

- **Integrated providers/budgets** (e.g. Sweden (Norrtälje), Spain (Alzira), England (Care Trusts (discontinued))) 2000s, USA (Kaiser Permanente, Veterans Health Administration) last century)
Findings: Literature evidence review

Systematic reviews
- 38 schemes integrating funds for health and social care (Mason 2015)
- 6 P4P schemes in disease management (de Bruin 2011)

Non-systematic reviews
- Secondary data analysis of 8 primary care and 4 hospital P4P schemes (Cashin 2014)
- Review, stakeholder interviews 6 P4C, P4P, bundled payment schemes (Tsiachristas 2013)

Pilot evaluations of national programmes
- 10 care groups with bundled payments for diabetes care The Netherlands (Struijs 2012)
- 16 Integrated care pilots England (RAND 2012)
- Impact evaluation 32 Pioneer ACOs USA (Nyweide 2015)
Discussion

- **Evidence** on the health impact of payment schemes to support care integration is limited. Challenging to evaluate complex interventions and disentangle effects of payment reforms as part of health services redesign.

- Monetary rewards are powerful incentives: **financial arrangements** need to be aligned with health policy goals, or may be counter-productive to integration efforts and efficiency.

- **Balancing the accountability, risk and power** across providers and payer(s) important for the sustainability of financial arrangement for integrated care, as well as balancing detailed contracting versus trust relationships.
Discussion

A one-size-fits-all approach to integration may be counter-productive. **Integration requires flexibility.** However, a challenge with diversification and locally-based solutions may be to assure equity in care quality across populations or geographic regions.

What do you see as the way forward in terms of financial arrangements to support integrated care in your country - in the short and long term?