International Research on Financing Quality in Healthcare

Newsletter 4, March 2013

Welcome to InterQuality

Spend not more, but smarter!

Welcome to the fourth issue of the InterQuality project's newsletter!

We are delighted to start the new year with news of first results in InterQuality! The project partners reviewing the literature on project methodology guidelines have produced their final deliverables on 'incentives and payment models' and 'values/benefits'. In this issue, you will find short summaries of the outcomes of these tasks.
Our research in the area of pharmaceutical care is advancing as well. The comparative analysis of pharmaceutical benefit financing models is already finalised. We are also advancing on our work on financing access to medicines and equity of access to healthcare. You will find more detailed information on these in the following pages.
Finally, this newsletter brings you an up-date on our work on communication strategies of healthcare reforms. This comparative study aims to explore how healthcare financing reforms are communicated to the public in different countries and identify good and bad practices related to these communication strategies.
Please also visit our website for updates and do not hesitate to contact us for further information on our activities. In our next newsletter, among other updates, we will share with you the outcomes of our upcoming project meeting on 4-5 March in Odense.

Sincerely,

Prof. Dr Hab. Tomasz Hermanowski
Medical University of Warsaw
Project Leader

In this issue

Project Information

International Research on Financing Quality in Healthcare

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Duration: 36 months

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Consortium

Medical University of Warsaw (MUW) - coordinator

Hannover Medical School (MHH)

University of Southern Denmark (SDU)

University of Catania (UniCT)

Urban Institute Washington (UI)

University of York (UY)

Sopharm Sp.z o.o. (SPH)

Standing Committee of European Doctors (CPME)

European Patients' Forum (EPF)

Activity Report

Work Package 1: The Effect of Provider Payment Systems on Quality, Cost, Efficiency and Access

by Dr Robert Berenson (UI)

In recent years, there has been renewed interest in considering payment reforms to improve the value of health care services health professionals and health care organizations provide to patients. In short hand, many national health systems have adopted the important policy objective of attempting to obtain greater value in quality and positive patient experiences for the substantial financial commitment health systems make paying providers for their services.

To help establish the basis for additional work that will be conducted by the InterQuality consortium of policy research centers, the charge to the Urban Institute based in Washington, DC, was to explore what is known about how best to pay hospitals, physicians and other health professionals, and entities providing "integrated care" within the remit of WP1. The core activity performed was an extensive literature review, going back 25 years, on what high quality studies show about the impact of different payment approaches on quality, costs, and patient access to and experience with care.

To complement the literature review, we also considered the various factors other than the payment incentives themselves that influence the actual behavior of physicians and other providers in providing health care services. For example, physicians are motivated by professional ethics to act in their patients' best interests, whatever the incentives found in different payment approaches. How well physicians adhere to their obligations as professionals varies of course. Nevertheless, we considered the various professional, regulatory, and other influences that interact with the incentives found in various payment approaches, sometimes in a complementary manner and sometimes at cross purposes.

Our analysis also pointed to the context in which payment models are applied as an important influence on how the incentives affect professional and institutional provider behavior. Payment structures that work well in one institutional context often operate differently when transferred elsewhere, mostly because of different organizational cultures. For example, in some circumstances, compensation to physicians by salary supports efficient, patient-oriented practice styles, whereas elsewhere, salaried physicians slacken off and are not attentive to patient needs or organizational objectives.

WP 1 Incentives

WP 2 Value / Benefits

WP 3 Pharmaceutical Care

WP 4 Hospital care

WP 5 Outpatient, Home care

WP 6 Integrated care

WP 7 Dissemination

WP 8 Scientific Coordination

WP 9 Management

A final modulating factor on provider behavior under alternative payment approaches lies within the specific design decisions that any payment approach must have. For example, the relative generosity of the payment can influence to a great extent how providers will respond to the incentives of any payment approach. Thus, a payment approach called capitation, that is, payment ahead of time of a fixed amount per patient served, regardless of the actual use of services, can produce underuse of services if the payment is constrained but more services with a more generous payment amount. It is difficult to disentangle the effects of the basic payment approach from the specific design elements, in this case, the generosity of the payment.

All of these factors make the task of characterizing the behavioral responses of the variety of commonly used and proposed payment models challenging. The confluence of all the various influences described here lead to the conclusion that there is no best payment approach that can apply in all countries and in all situations within any country. Although the results of our

Activity Report-Work Package 1 ctd.

systematic review of the literature permit some tentative conclusions about the effect of different payment models, there is a dearth of literature examining how particular payment implementation designs and health system contexts affect the results. Accordingly, policy-makers should be very careful to distinguish intended from actual results. To help policy makers, we developed a set of attributes of 10 different payment models as well as design options that can assist policy makers in determining whether and how to modify current payment approaches within their respective countries.

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Activity Report

Work Package 2: Guidelines for further project activities on comparative evaluation of quality, economic and equity issues in healthcare systems

by Dr Joanna Lis (MUW)

In the first phase of the project, a wide review of methodologies of measuring quality in healthcare systems was performed under WP2. There is no consensus on the definition of 'quality of healthcare' nor its aspects that should be measured to assess quality. The definitions are rather general; so research on the quality in healthcare systems should start with establishing the proper measures to be used to enforce and to monitor quality in healthcare systems. Adopting Donabedian's division of quality measures into structure, process and outcome indicators, the latter are of central interest for patients and payers. The validity and stability of such indicators (e.g. survival, recovery, restoration of function) is irrefutable. However a number of considerations limit the use of these outcome indicators. The most commonly used indicators concern hospital care, focusing on hospital mortality and serious surgical complications. Thus, many outcome measures are not relevant to outpatient care and chronic diseases which are not lethal or acute but lead to decrease of quality of life or disability. A fundamental issue is the dependence of outcomes on many other factors besides quality of care. In order to compare outcome measures of alternative healthcare providers, risk adjustment has to be applied.

Another important aspect of quality seems to be efficiency, as it is an economic concept coupling effects and costs in one measure. However, it is important to be aware of certain dualities and difficulties. The construction of an efficiency measure should take into account both the cost-effectiveness of a procedure per se and its effectiveness as measured in health gain both per patient and per society.

According to the principal-agent model used in the framework of the New Institutional Economy, two levels are interconnected:

1. The healthcare provider has to ensure that he/she is being paid, both for the current and future services by adherence to certain institutional standards of the services performed.

WP 1 Incentives

WP 2 Value / Benefits

WP 3 Pharmaceutical Care

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WP 5 Outpatient, Home care

WP 6 Integrated care

WP 7 Dissemination

WP 8 Scientific Coordination

WP 9 Management

Activity Report-Work Package 2 ctd.

2. The healthcare payer, be it an institution, an insurance company or patient, has to ensure that the paid-for-services met a certain standard at least, or else he/she would not seek the services of this particular healthcare provider in the future.
The costs of a procedure or a treatment – another measure influencing efficiency – are crucial factors both for the decision to perform the service as well as whether to pay for it fully or partially. Accounting costs connected to a business transaction – e.g. the rendering of a healthcare service – are easy to estimate. On the other hand, when assessing the real life meaning of cost in healthcare systems it is important to consider opportunity cost – which means the cost of lost opportunity (e.g. the same amount of money may be allocated to end-of-life treatment of a group of oncology patients or as one-year budget of pediatric ward). In addition, there are also costs, which are harder to estimate, called societal costs. This category includes costs of premature death and productivity losses due to absenteeism or presenteeism – costs of underperformance of employees, executives or business owners due to illness or adverse effects of treatment; and it matters not only to them but also to their families.
When balancing above described issues, InterQuality researchers strive to incorporate another quality aspect, commonly overlooked or underestimated: Equity. The conclusion of WHO 2003 report was that "there is a growing consensus that improvement in average levels of health is not a sufficient indicator of health systems performance". The InterQuality project will utilize the concept of 'health equity' focussing attention on the distribution of resources and other processes that drive a particular kind of health inequality – that is, a systematic inequality in health (or in its social determinants) between more and less advantaged social groups, in other words, a health inequality that is unjust or unfair. We believe that this may reveal and document significant disparities among European national healthcare systems.

Discussing InterQuality: conferences & events

On 21-24 October 2012, Prof. Tomasz Hermanowski from the Medical University of Warsaw attended the 29th ISQua International Conference in Geneva. Prof. Hermanowski presented research findings of WP2 to a scientific community of approximately 50 participants. The topic of his presentation was "Proposed law on healthcare quality in Poland and institutional settings of healthcare quality policy in EU member states".

On 3-7 November 2012, Aleksandra Krancberg represented the InterQuality consortium at the 15th ISPOR Annual European Congress, which took place in Berlin with the participation of more than 3500 attendees (doctors, pharmacists, patients, government officials, professionals interested in pharmacoeconomics, etc.). The objectives of the event were to present new methodologies and outcomes related to research in pharmacoeconomics and improve the quality of decision-making through better utilisation of studies on pharmacoeconomics. The abstract presented at the congress was titled "New classification of traditional and innovative pharmaceutical payment methods".

On 8-10 November, 2012 Dr Christian Krauth and Sören Jensen from the Hannover Medical School (MHH) participated in the 2012 European Public Health Conference in Malta, organised by the European Public Health Association. More than 1000 research scientists from all over the world attended in this event. At this event, the WP6 research on pay-for-performance (P4P) programmes was presented. Dr Christian Krauth and Sören Jensen drew attention to the three essential components of successful P4P programmes: "what to incentivise", "whom to incentivise", and "how to incentivise".

Activity Report

Work Package 3: Report on workshops and action points

by Ms Malgorzata Chmielewska MSc. (SPH)

The objective of WP3 is to validate pharmaceutical benefit financing models used in tax or social health insurance systems, as well as private or mixed ones.
In the second half of 2012, the WP3 research team worked on three tasks – (1) a comparative analysis of pharmaceutical benefit financing models, (2) financing access to medicines, and (3) drug distribution financing models respectively. These tasks demanded a very precise specification of the area of exploration to avoid observations and eventual conclusion from becoming too general and superficial and endangering their practical applicability.
After a literature review on these topics, we decided to focus on a limited number of specific issues, which are the most relevant and characteristic ones with regard to our objectives. The choice of the issues for further exploration was based on expert judgment, since we could not find any objective or hard indicators that would allow us to just simply evaluate and rank them. Nevertheless, to assure the judgment process to be optimal and scientific, we decided to apply a combination of two qualitative research methods in the process of defining the final list of topics: the Focus Group Discussion (FGD) and the Delphi Panel Method. As a result of these exercises, we decided to focus on ten topics, to be further evaluated: pricing and reimbursement issues, access and equity, promotion of innovation, distribution, pharmacy benefit manager, eHealth and electronic prescribing (e-prescribing), personalized medicine, transparency, pharmacovigilance, and pharmaceutical care and quality of pharmaceutical services.
The objective of the first task – "comparative analysis of pharmaceutical benefit financing models" – was to identify and describe pharmaceutical benefit financing models in the UK, the US, Poland, Italy, Germany and Denmark. A final report is currently being finished .
The objective of the second task – "financing access to medicines" – is to analyse different aspects of financing access to medicines and their consequences. For this, missing knowledge was identified, a questionnaire for collaborative work was developed, and the statistical analysis on equity of access to healthcare was planned. The detailed methodology of this task is being discussed with interested project partners.
The objective of the third task – "drug distribution financing models" – is to perform a review of drug distribution financing models in the EU and the US. For this task, missing information was also identified and a questionnaire was developed for partners. These were presented and discussed with other project partners during the project meeting in Catania in May 2012.

WP 1 Incentives

WP 2 Value / Benefits

WP 3 Pharmaceutical Care

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WP 5 Outpatient, Home care

WP 6 Integrated care

WP 7 Dissemination

WP 8 Scientific Coordination

WP 9 Management

The next InterQuality General Assembly will take place in Odense on 4 and 5 March 2013.

Activity Report

Work Package 7: Communicating Healthcare Financing Reform by the European Patients' Forum (EPF) and the Standing Committee of European Doctors (CPME)

As in many areas, good communication is an essential ingredient in high quality healthcare. In particular when progress depends on launching a new course of action, deciding between different options or resolving a crisis situation, communication and its set-up takes on a decisive role. Remarkably, this holds true as much for each individual patient-doctor relationship as it does for healthcare on a systemic level. In the broad scope of communication on healthcare policy, which may also include the implementation of public health campaigns for instance, healthcare reforms pose a special challenge. Actors, tools and messages each come together to form a complex web, while the intricate context of pressures and interests in which a reform is set likewise influences expectations, capacities and choices. Communication can thus become a vital tool to determine failure or success.

Realising the potential impact communication can thus have on the content and implementation of a reform, the InterQuality project has dedicated a task to looking into healthcare financing reforms' communication strategies. The objective is to identify good and bad practices in planning, integrating and executing communication strategies and the resulting recommendations in Communication Guidelines.

The task of drafting the Communication Guidelines is being taken forward within WP7 on 'Dissemination'. Starting in 2011, activities first focussed on research into existing reflections on communication campaigns relating to healthcare reforms. While a plethora of guidelines exists on implementing public health campaign communication, far less research has been dedicated to healthcare reform communication.

To better determine the scope of the Communication Guidelines' basis, WP7 agreed on a definition of 'healthcare reform' setting out that

"*By healthcare financing reform we mean implementation of a major innovation in healthcare management and financing, radically changing the way in which healthcare services are produced and consumed, in particular implementation of new financing models, like: integrated healthcare or shared saving schemes, on the supply side [and] high deductible health insurance and Health Savings Accounts, on the demand side.*"

Against the background of this definition, a search for case studies was launched, which focussed on the countries already targeted by InterQuality activities with a view to potentially creating cross-references to other project outputs. Several reforms were chosen for their potential to provide a useful example of a real-life implementation of a communication campaign. It is aimed to collect national level information both from literature and direct contact with selected stakeholders.

To support the examination of these case studies, work has also been invested into identifying decisive elements of communication campaigns as discussed in the literature available. These elements have been processed into a matrix which shall be used as a point of reference to deconstruct the case studies' campaigns. The analysis conducted thus would produce helpful findings to determine good and bad practices.

- WP 1 Incentives
- WP 2 Value / Benefits
- WP 3 Pharmaceutical Care
- WP 4 Hospital care
- WP 5 Outpatient, Home care
- WP 6 Integrated care
- **WP 7 Dissemination**
- WP 8 Scientific Coordination
- WP 9 Management

A progress report shall be shared at the forthcoming InterQuality partners' meeting in March 2013.

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The InterQuality consortium looks forward to welcoming you again soon.