

Editorial

The right incentives for high-quality, affordable care: a new form of regulated competition

In most Western health care systems, producing high-quality care efficiently is not rewarded by higher revenues. 'Pay for performance' schemes have emerged, rewarding improved performance of providers through financial incentives, but these schemes are simply overlaid on systems that are flawed [1,2]. In this editorial, we discuss a system with patients and providers in the leading roles, not imposing impossible burdens on patients, which induces providers to take the lead in providing high-quality care efficiently. The system would not rely on health plans or insurance companies *contracting* care for patients. In this system, patients themselves would 'shop' for their care, being guided by a system of 'smart' copays.

Such a market set-up requires regulation to ensure the desired outcomes: timely, effective, safe, patient-oriented, affordable care. Here, we only discuss the model's outlines.

Four issues are paramount to such a system. First, *equal access to a basic package of health care services* that encompasses all 'necessary' care is essential (e.g. through an obligatory system of health insurance). Through regulation, risk-selection should be mitigated, or an adequate insurance pool to ensure equal access should be created. For systems that see 'solidarity' as a basic value, ensuring equity in this way is fundamental [3].

Second, *competition should be organized around the integrated care for a patient's disease or condition* [4]. This care product (such as 'diabetes care') should ideally include all activities and materials that are part of the handling of this care: tests, hospital stay, physicians' fees, home care, medication, and any complications that might occur as a result of the care received by the patient. This aligns with the Diagnosis Related Group (DRG)-like payment systems many countries have opted for.

Often, a single organization will not be able to offer all components of an integrated care product. Just how professionals and providers work together to put these products on the market, however, should be up to them. They, after all, are the source where the innovation and quality-increase that is possible should come from. A single coordination point (within the providers' organizations involved or a 'health care contractor') for the care product is essential [5].

Third, *prices should be all-inclusive, set by providers and posted publicly*. The provider of 'total hip replacement' is paid a preset amount for each patient treated, regardless of the precise activities undertaken for any individual treatment. Prices include all component costs for providing the integral product (e.g. doctors' work, medication, the prosthesis). Individual providers set their own prices, and chronic care (diabetes, COPD) can be priced in 1-year episodes.

Fourth, *the quality of the product should be measured and posted publicly*. A cheap hip prosthesis, after all, is not necessarily a good hip prosthesis. Providers should publish up-to-date information about the effectiveness, safety, and patient-centeredness of their care products. Indicators will have to be set at a regional or national level to afford proper price/quality (=value) comparisons. Ultimately, the indicators should reasonably comprehensively capture the quality of care delivered for care products while remaining feasible [6].

A healthy health care market: the value index

Encouraging health care 'trade' of integrated care products will reduce the fragmentation typical of most Western health care systems. Being able to compare the value of health providers' products will also stimulate quality improvement efforts [7]. To make *patients* the basic force to stimulate high-value care, however, we still need to solve two problems: (i) patients appear to rarely use quality information in choosing providers [8] and (ii) fully insured patients have no real incentive to consider the prices of their care ('moral hazard' [9]).

The challenge is to incentivize the patient to search for high-value care, so that providers have to provide better care more efficiently than their competitors. This can be done by *linking copayment to value*: (i) no copay for patients choosing a high-value provider and (ii) a copay (calculated as a percentage of the product's costs) for patients who opt for a more expensive and/or lesser quality provider (see Figure 1).

A provider's case-mix-adjusted price for a product is compared with other providers' prices, and its relative position in this comparison determines the localization on the 'price' axis. The quality scores are built up from the case-mix-adjusted subscores on the domains of effectiveness, safety, and patient centeredness, and plotted on the 'quality' axis. Quality measures are relative, so that one's categorization is not only dependent on one's own score but also on the scores of one's competitors. This guarantees constant innovation and improvement.

Setting the quality indicators (developed by panels of professionals, providers, patients, and payers) should ideally be the task of an independent or government agency; filling in the exact copays and weighing the price/quality ratio could be a task for individual insurance companies.

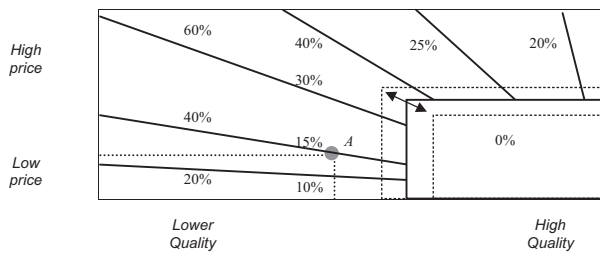


Figure 1 Translating value into copay percentage: the value index. The percentages listed are for illustration purposes only. The size of the ‘0%’ box in the lower-right corner is adjusted so as to cover a fixed percentage—say 20%—of providers. For these providers, no copays are charged, so that there is always a substantial availability of free, high-quality, low-cost providers. Outside of this box, copays rise up linearly to (e.g.) 60% of total product cost, for the most expensive, lowest quality provider; however, the scale can be calibrated to ensure that 50% of providers have copays below 20%. Provider A (of a specific care product) scores low on price and just below average on quality, ending up with a copay for that care product of some 12%. The exact percentages used should be dependent on the variation in prices and quality: when the variation of prices set and/or quality delivered is small, the performance of the ‘worst’ providers is still quite acceptable, and copays should be limited. Vice versa, when ranges are large, large variations in price and/or quality are at stake, and larger copays are warranted. Finally, when supply is scarce, as in rural or deprived areas, ‘0% copay’ providers may be absent. In such instances, the provider should pay the copayment. This would avoid stimulating a patient to make a choice he/she does not have, while retaining the strong incentive on the provider to improve the value of the care provided.

This would be ‘consumer-driven health care’ at its best: a market revolving around the choices of the patient, guided by a system of meaningful copays. Paying a copay for care that is equally good but more expensive is acceptable; why should society pay for luxury or status, for example, that does not translate in outcomes measured? Similarly, although paying a *higher* copay for *lesser* quality may seem counterintuitive at first, lesser quality care will tend to increase the chance of later complications and costs [10]. It is fair to let the patient who opts for such a provider (for whatever reason) share the cost for imposing this burden to the risk pool. The default, *not* opting for any copay, would automatically direct the patient to a high-quality, efficient provider. The system would thus not force choice or financial risks on patients.

Acute conditions such as stroke, acute myocardial infarction, or common trauma care can be included in this system. When the patient is (temporarily) unable to signal otherwise, he would be held harmless or be directed to the closest 0% copay provider. A patient could later always opt to be transferred to a different provider.

This system radically departs from the three-party markets that have dominated care system discussions in the last decades.

Ultimately, health plans, contracting insurance companies, or fund holders, standing between patient and provider, *diminish* the beneficial effects that market incentives may bring by adding unnecessary complexity and administrative costs. In contrast, we have outlined the contours of a much more robust market. Low-value providers will be confronted with a significant loss of market share, creating a strong impulse to search for better and more efficient models of care provision. High-performing providers would finally be rewarded, and the professional drive to innovate the delivery of care would be stimulated.

Everybody wins: insurance companies no longer have to micromanage providers and can return to their core business—devising smart policies and providing insurance. Patients receive high-quality care focused on their needs, while retaining the ability to choose the provider they want. There is no drawback for those unable or unwilling to dive into performance comparison tables: all that one needs to know is that a 0% copay provider is the best guarantee for high-quality care. Professionals and providers are no longer unnecessarily regimented by health plans or other regulations. Governments, finally, can stop trying to control from above a system so complex that it pre-empts any such attempt. By setting a few powerful rules that regulate the health care market and by having these rules implemented by an independent agency, maximally affordable and high-standard care will emerge. The only ones who lose are providers who will not be able to improve the value of the care they deliver.

These few preconditions and rules may be simple conceptually but not easy to realize. Yet these challenges can be overcome. A sufficiently extensive and validated collection of disease- or condition-specific performance indicators is currently the only challenge that has not yet been overcome somewhere, although great progress has been made in many countries. The promise of a system that may deliver care that is timely, equitable, safe, effective, patient-centered, accessible, and affordable should make us focus on meeting these challenges now.

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References

1. Roland M. Linking physicians’ pay to the quality of care – a major experiment in the United Kingdom. *N Engl J Med* 2004; **351**: 1448–1454.
2. Marshall M, Smith P. Rewarding results: using financial incentives to improve quality. *Qual Saf Health Care* 2003; **12**: 397–398.
3. Ham C, Robert G, eds. *Reasonable Rationing: International Experience of Priority Setting in Health Care*. Maidenhead: Open University Press, 2003.
4. Porter ME, Teisberg EO. Redefining Competition in Health Care. *Harv Bus Rev* 2004; **June**: 64–76.

5. Casalino L, Gillies RR, Shortell SM *et al.* External incentives, information technology, and organized processes to improve health care quality for patients with chronic diseases. *JAMA* 2003; **289**: 434–441.
6. Berg M, Meijerink Y, Gras M *et al.* Feasibility first: developing public performance indicators on patient safety and clinical effectiveness for Dutch hospitals. *Health Policy* 2005; **75**: 59–73.
7. Marshall MN, Romano PS, Davies HT. How do we maximize the impact of the public reporting of quality of care? *Int J Qual Health Care* 2004; **16 (suppl. 1)**: i57–i63.
8. Hibbard JH, Stockard J, Tusler M. It isn't just about choice: the potential of a public performance report to affect the public image of hospitals. *Med Care Res Rev* 2005; **62**: 358–371.
9. Dranove D. *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care*. Princeton: Princeton University Press, 2000.
10. Leatherman S, Berwick D, Iles D *et al.* The business case for quality: case studies and an analysis. *Health Aff* 2003; **22**: 17–30.