Financing and incentive alignment

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Health systems respond to NCDs: Experience of the European Region
Parallel workshop 5

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Messages of chapter 12

1. Reasonable levels of public funding
2. More explicit criteria for budget allocation priorities
3. Outcome oriented approach to fund intersectoral actions
4. Incentive alignment across the service delivery interface
Share of health within government budgets in the European Region

General government spending on health as % of total government spending, 2014

Source: WHO, 2017
Diverging trends in countries grouped by income levels

General government spending on health as % of total government spending, 2000-2015

Source: WHO, 2017
Spain - 15%
Great outcomes at reasonable cost - above average fiscal space for health

Sweden – 18%
Generous funding translates into high quality, timely services and excellent health outcomes

Kyrgyzstan – 13%
No room for further expansion of fiscal space for health – need to focus on potential efficiency gains

Latvia – 9%
Room for increasing fiscal space for health - great potential to improve health outcomes and reduce access barriers
Reasonable levels of public funding

1. Increase fiscal space by giving higher priority to health
2. Make a better business case for health and NCD spending and address inefficiencies
3. Engage in fiscal dialogue, understand budgetary processes and public finance rules
4. Apply high taxes on tobacco, alcohol and unhealthy foods for public health impact, but have realistic expectations of earmarking
More funding alone will not do the trick

1. Reasonable levels of public funding
2. More explicit criteria for budget allocation priorities
3. Outcome oriented approach to fund intersectoral actions
4. Incentive alignment across the service delivery interface
Alignment of incentives & service delivery

- Incremental approaches to alignment of incentives
- Larger scale and more complex reforms
Blended payment systems

Pay-for-performance

Pay-for-coordination

Bundled payment for specific conditions

Full capitation to network
Typical care interface

- **PHC**
  - Capitation

- **Specialist**
  - Fee-for-service

- **Hospital**
  - Case-based

- **Undervalues early detection & mgmt**
- **No incentives for task profile expansion**
- **Reinforces episodic orientation**
- **Reinforces traditional levels of care**
- **No incentives for coordination**
Estonia

Pioneer of blended payments in PHC

Share of different payments in PHC budget (2011)

- Basic allowance
- Capitation
- FFS
- Performance payment

Legend:
- Basic allowance
- Distance allowance
- Capitation
- FFS for diagnostics
- P4P
- GP advisory line
Key lesson learnt from Estonia and elsewhere

Without addressing the model of care (single practitioner) and the interface between levels, progress is limited.
Incentives alone will not do the trick to see a breakthrough. Service delivery re-design is equally important – whole system approach. Incremental approaches mitigate weaknesses of base payment mechanisms. Managing the interface between levels of care calls for complex, large scale reforms. Non-financial incentives matter as well.
“You get what you pay for! Don’t be surprised”

Prof. Marc J. Roberts (1943-2014)
“The sense of duty is still at work and inexpensive”

Prof. Alan Maynard (1944-2018)
Is leapfrogging possible? We need to go beyond traditional boundaries of care.

Connect the dots with 4 lines without lifting your pen.