Exploring new provider payment models to incentivize performance improvements in Hungary

Overview

Responding to a rise in chronic disease and observed fragmentation across provider groups in Hungary, the Care Coordination Pilot was launched by the national government in 1999 to experiment with provider payment mechanisms to encourage more coordinated care delivery. Under the Pilot, Care Coordinator Organizations, run by health providers from general practices or polyclinics, were established to act as virtual fund holders for capitation-based health care budgets within their local regions. All financial control was retained by the National Health Insurance Fund Administration (NHIFA), meaning Care Coordinator Organizations had no actual budget holding responsibilities; virtual budgets were simply a tool to guide management improvements. Any budget savings were transferred to Care Coordinator Organizations at the end of the year, serving to incentivize efficiency improvements. A careful mix of other incentives was employed to minimize disincentives or gaming which could result in undertreatment of patients. To increase control over spending, Care Coordinator Organizations entered into contracts with other providers in their region and shared financial rewards in exchange for providers' cooperation. These contracts essentially brought providers within Care Coordinator Organizations under a single-management structure with collective goals, encouraging teamwork across traditional care boundaries. Care Coordinator Organizations implemented and self-policed their own organizational protocols and guidelines to improve care provision within their networks. Access to health care utilization data from NHIFA allowed local monitoring of practice patterns, protocol compliance and patient pathways by Care Coordinator Organizations, as well as an evaluation across local strategies. Early reports showed positive results for the Care Coordination Pilot, including improved care efficiency, coordination and quality. While changing political priorities eventually caused termination of the initiative in 2008, early indications of success from the Care Coordination Pilot warrant consideration.

Problem definition

In the early 1990s, life expectancy in Hungary was 69 years, falling below the WHO European Regional average of 74 years (Box 1). A high prevalence of chronic disease, specifically circulatory disease, cancer and conditions of the digestive system, was found to contribute to early mortality.[1] Fragmented interactions between primary, secondary and social care services often led to inappropriate hospital admissions for chronic conditions and, without incentives to manage patients at lower care levels, overprovision of care in higher-level settings occurred.[1] Moreover, cost-containment policies put in place throughout the 1990s had demotivated providers, contributing to variability in care quality and increased medical migration.

Box 1

What problems did the initiative seek to address?

- Life expectancy below the WHO European Regional average.
- High prevalence of chronic disease, particularly circulatory disease and cancer.
- Fragmented coordination across care levels and concentration of services delivery in higher-level settings.
- Harsh cost-containment policies contributing to demotivation of providers.

Health services delivery transformations

Timeline of transformations

The Care Coordination Pilot was first launched in 1999 as an exploratory approach towards improving the coordination and quality of health

Table 1
What were the chronological milestones for the initiative?

Year	Milestone
1992	Primary care financing reforms introduce a capitation-based payment model for general practitioners.
1993	Financing reforms introduce funding for outpatient specialist services on a fee-for-service basis; acute inpatient care financed through diagnosis-related groups.
1999	Care Coordination Pilot begins with nine Care Coordinator Organizations participating in the project.
2005	Care Coordination Pilot covers approximately 2.2 million people across 16 Care Coordinator Organizations.
2006	Newly-elected government introduces plans to privatize the social health insurance system, leading the Care Coordination Pilot to be suspended; plans for privatization eventually abandoned but suspension of Pilot remains in effect.
2008	Care Coordination Pilot terminated due to lack of political support.

services (Table 1). Nine Care Coordinator Organizations were initially established under the Pilot, each responsible for the needs of between 75 000 and 280 000 enrolled patients. The Pilot was gradually expanded throughout the early 2000s, covering approximately a fifth of the Hungarian population (2.2 million registered patients) across 16 regions by 2005. Despite indications of success, a change of government in 2006 shifted political priorities and led to the eventual termination of the Pilot in 2008.

Description of transformations

Selecting services. The Care Coordination Pilot worked to ensure a wide range of health services were provided under the existing social health insurance scheme, placing additional emphasis on services for the early detection, prevention and effective management of chronic disease.

Designing care. Care Coordinator Organizations established protocols within their local care networks and implemented local strategies designed to improve efficiency and performance.

Organizing providers. Care Coordinator Organizations developed local networks of providers across care levels and increased the role of general practitioners in managing care. All in-network providers collectively became responsible for delivering care for registered populations within the allocated budget for their Care Coordinator Organization. This change strengthened the gatekeeping role of primary care by motivating reductions in unnecessary referrals to specialists in an effort to generate savings across the group. Care Coordinator Organizations also fostered closer collaboration and teamwork among providers within each network. Registered patients retained the right to choose providers freely and could opt to receive care from providers external to the Care Coordinator Organization they were registered with.

Managing services. Responsibility for coordinating the pilot project was overseen by NHIFA. Planning and organization of services was managed directly by Care Coordinator Organizations. Care Coordinator Organizations entered into contracts with local providers in order to influence services delivery for the realization of efficiency improvements.

Improving performance. Care Coordinator Organizations experimented with innovative ways to improve services delivery, using data collected on local practice patterns, protocol compliance and patient pathways to design improvements within their local care networks and evaluate effectiveness of local strategies.

Health system enabling factors

Implementation of the Care Coordination Pilot relied on an amendment to the NHIFA budget passed by the General Assembly. This amendment permitted the devolution of management and organizational responsibilities to Care Coordinator Organizations involved in the Pilot and established the necessary legal framework to enable virtual fundholding and transfer of incentives (Table 3).
The Pilot project made use of both financial and non-financial incentives to encourage improvements in health services delivery. Financing and payment functions continued to be carried out centrally by NHIFA. Newly established Care Coordinator Organizations were assigned virtual budgets – without actual financial or budgetary responsibilities – based on adjusted capitation formulas accounting for the whole spectrum of care from primary to tertiary services. If actual spending of a Care Coordinator Organization was lower than their allocated budget, savings were awarded to them for distribution among in-network providers. Savings could also be reinvested or used to improve working conditions. Additional bonuses were made

Table 2
How was the delivery of health services transformed through the initiative?

Before	After
Selecting services	
Social health insurance covers a wide range of services for patients, but services often overly specialized; lack of preventive, screening or effective disease management services.	Preventive and screening services increased within pilot sites, particularly services for chronic disease.
Designing care	
National guidelines and protocols in place, but adherence described as poor.	Adherence to existing national guidelines and protocols reportedly improved; Care Coordinator Organizations implemented additional local protocols and guidelines.
Organizing providers	
Vertical care structure with high degree of fragmentation across care levels; weak gatekeeping role of primary care; elevated referral rates to specialists.	Care Coordinator Organizations contracted with local providers, essentially developing local care coordination teams to improve teamwork across care levels; gatekeeping role of primary care was strengthened and unnecessary referrals to specialists decreased.
Managing services	
NHIFA paid individual providers directly for services.	NHIFA was responsible for coordinating the Pilot; Care Coordinator Organizations were responsible for managing and organizing services for their local populations.
Improving performance	
All patients assigned a social security number allowing health care utilization data to be tracked; limited use of data to drive performance improvements at the local level.	Care Coordinator Organizations used patient health care utilization data to generate performance improvements.

available for performing preventive services to help overcome the initial rise in costs associated with screening and earlier treatment of disease.

While Care Coordinator Organizations had no responsibilities or penalties for negative budget balances, cost-consciousness of health providers appeared to increase and a culture of efficiency was fostered. All savings were awarded at the end of the year, limiting providers' incentive to undertreat patients as providers needed to generate enough monthly revenue through regular service provision and bonus revenues were not guaranteed. Additionally, patients living in Care Coordination Pilot areas were free to choose where they sought care and could easily access providers outside the Pilot network. However, Care Coordinator Organizations were still held financially responsible for all their registered patients and any costs from patients accessing out-of-network providers were deducted from virtual budgets. This served to incentivize in-network providers to adequately treat patients, as Care Coordinator Organizations had no leverage over out-of-network providers with which to ensure efficient delivery of services.

Outcomes

While the initiative was terminated before a full evaluation could be completed, preliminary data analysis and unofficial reviews reported a number of positive outcomes as a result of the Care Coordination Pilot (Box 2).

Box 2
What were the main outcomes of the initiative?

- Health services in pilot sites were seemingly better coordinated, more cost-effective and of higher quality.
- The number of patients with chronic conditions receiving

Table 3
How has the health system supported transformations in health services delivery?

System enablers	Example
Accountability	• An amendment relating to the NHIFA budget permitted virtual fund holding by Care Coordinator Organizations.
Incentives	• Direct financial incentives linked to improved coordination of care were awarded to Care Coordinator Organizations; incentives were shared among local in-network providers and/or reinvested. • Undertreatment of patients was minimized as cost savings were only awarded at the end of the year and amounts were not guaranteed; Care Coordinator Organizations were also held financially responsible for all of registered patients' care.
Information	• NHIFA provided Care Coordinator Organizations with access to patient health care utilization data for monitoring and evaluation purposes.

appropriate care reportedly increased in pilot sites.
- Overall savings were achieved despite higher initial costs of care due to improved preventive and early detection services; Care Coordinator Organizations saved on average 6% of allocated budgets.

Change management

Key actors

Initial steps to establish the Care Coordination Pilot were led by the government who pushed through the necessary legislation to enable change and unite key actors (Box 3). Health providers were assigned a leading role within the initiative and became key decision-makers in the coordination and management of care through the establishment of Care Coordinator Organizations. Care Coordinator Organizations were run by general practitioners or polyclinics, encouraging primary care-led coordination according to patients' needs. NHIFA provided support throughout the initiative, assigning virtual budgets to Care Coordinator Organizations and sharing useful data.

Box 3
Who were the key actors and what were their defining roles?

- **Care Coordinator Organizations**. Acted as virtual fund holders and managed virtual budgets; entered into contracts with local health providers to influence services delivery; implemented local protocols and initiatives designed to improve efficiency.
- **In-network health providers.** Signed contracts with Care Coordinator Organizations; worked as a team with other in-network providers across care levels to deliver care.
- **National Health Insurance Fund Administration (NHIFA)**. Allocated virtual budgets to Care Coordinator Organizations; shared patient database with Care Coordinator Organizations.
- **National government.** Initially backed initiative and developed necessary policies for its implementation; change of government eventually led to disbandment of the initiative.

Initiating change

In the late 1990s, political will to experiment with financing mechanisms pushed the initiative forward in an effort to strengthen primary care and address misalignments in provider remuneration. An amendment relating to the NHIFA budget created the necessary conditions to support the virtual fundholding design of the Care Coordination Pilot.

Implementation

Implementation of the Pilot relied on the existing payment system and administrative capacity of the NHIFA, avoiding the need for costly restructuring or complicated administrative changes. Care Coordinator Organizations formed close partnerships with providers practicing in their catchment area, formalizing these relationships through contracts to ensure cooperation towards achieving common goals across provider groups. Care Coordinator Organizations were responsible for implementing their own network-specific protocols and regular monitoring helped ensure compliance. Furthermore, peer pressure within care networks supported policing of established protocols.

Moving forward

A change in government and political agenda eventually led to the initiative being abandoned. However, early indications of success resulting from this model highlight its potential as a useful strategy and lessons learned from this experiment could be constructively applied in other contexts.

Highlights

- Carefully chosen financial incentives guided performance improvements by rewarding efficiency, incentivizing preventive care and encouraging treatment in lower-level settings.
- Empowering professionals with new responsibilities helped overcome provider dissatisfaction.
- Extensive data collection supported analysis and comparison of local organizational arrangements.

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1 Evetovits, T. (2011). *Exploring new ways to pay healthcare providers and improve performance*. [PowerPoint] from http://www.ehfg.org/fileadmin/ehfg/Website/Archiv/2011/Presentations/W3/w3_3_evetovits.pdf