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Evaluation of a policy to strengthen case management and quality of diabetes care in general practice in Denmark

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ABSTRACT

Objectives: To evaluate the utilization of a policy for strengthening general practitioner's case management and quality of care of diabetes patients in Denmark incentivized by a novel payment mode. We also want to elucidate any geographical variation or variation on the basis of practice features such as solo- or group practice, size of practice and age of the GP.
Methods: On the basis registers encompassing reimbursement data from GPs and practice specific information about geographical location (region), type of practice (solo- or group-practice), size of practice (number of patients listed) and age of the GP were are able to determine differences in use of the policy in relation to the practice-specific information.
Results: At the end of the study period (2007–2012) approximately 30% of practices have enrolled extending services to approximately 10% of the diabetes population. There is regional – as well as organizational differences between GPs who have enrolled and the national averages with enrolees being younger, from larger practices and with more patients listed.
Conclusions: Our study documents an organizationally and regionally varied and limited utilization with the overall incentive structure defined in the policy not strong enough to move the majority of GPs to change their way of delivering and financing care for patients with diabetes within a period of more than 5 years.
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1. Introduction

1.1. A new payment policy

Integrated case management and coordination of healthcare services within the primary care sector and across sectors is high on the policy agenda in most western countries [1,2] and general practitioners are key actors in this process [3]. The number of patients living with chronic disease is increasing and this is changing the demands for healthcare [4,5] towards comprehensive and coordinated services [5]. When healthcare services are poorly coordinated, the right services may not be timely delivered [6], risk increases with consequences for quality [7], safety [7] and patient experience [8,9] and the potential for savings or cost-effectiveness diminishes [6,7,10,11]. In 2007, Denmark introduced a new payment policy in the GP-contract aiming to strengthen General Practioners' (GPs) role as case managers for patients with diabetes. [12]. In

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this new policy the GP is paid a capitated budget per patient for covering various elements of disease management and using clinical guidelines.

1.2. Case management, coordinated care and financial incentives

Aligning payment policies with the goals of better coordinated care could be a key factor in the integration of care, but with the exception of pay-for-performance policies [13–17], most payment policies have an objective of cost containment or reflect consideration of issues of access [18]. Non-alignment between integrated care and payment policies could be a barrier to the integration of care [19]. At present, there is limited evidence on the effects and effectiveness of financial incentives and other payment models to promote better case management and integrated care. Most of these incentives have been applied in very specific settings or are at an early stage of implementation, with little or no evaluation available [20].

1.3. Diabetes in Denmark

Diabetes is one of the most widespread chronic diseases in Denmark and internationally [21], and contributes significantly to the overall burden of morbidity and mortality [22]. The cost of treating diabetes and the increased morbidity and mortality constitutes a significant share of health expenditure [23]. It is estimated that there are currently at least 300,000 individuals with known diabetes in Denmark (approximately 4.5% of the Danish population), of which it has been estimated that 80–90% are followed up and treated by their general practitioners [24,25] making general practice a key area of focus in the strive for better and more effective care for this group of patients. A population-oriented and multifactorial approach to the treatment of diabetes and prevention of accompanying diseases has been proven effective in reducing the complications of the disease. This is reflected in the College of General Practice guidelines for treating diabetes [26] and in the description of the new payment policy in the GP contract [27].

1.4. General practice in Denmark

GPs in Denmark work as independent contractors and are financed almost exclusively by taxes via one of the five regions (North, Central, South, Capital and Zealand) who also purchase other primary care services and who own and run the hospitals. GPs' income is from a mixture of capitation, which makes up a third of their income, and fee-for-service (per consultation, examination, home visit, etc.), making up the remaining two-thirds. The approximately 100 different fees and general conditions for working as a GP are defined in a negotiated contract between the Board for Wages and Tariffs of the Regions (consisting of representatives from the interest organizations of the regions and the municipalities and of the Ministry of Finance), and the Organization of General Practitioners in Denmark (PLO). Care is free at the point of service and every resident is listed at a GP of their own choice. GPs are gate-keepers to secondary and tertiary care that mostly takes place in hospitals and at private-practising specialists [28].

The Danish health system, like most Western health systems, is grappling with the dual challenges of strengthening public health initiatives to prevent disease and providing care to a growing number of patients with chronic disease and comorbidity [12,28]. Several initiatives have been implemented to strengthen GPs' position as case managers and coordinators of care [12] and more structured approaches to case management for chronic care is one of the main aims of the new payment policy.

The policy represents a shift in payment for diabetes from the traditional mixed capitation/fee-for-service scheme to a lump sum paid for each patient for managing care. Since the fee for service component is removed the scheme resembles a pure capitation scheme. The theoretical consequences of capitation payment will be discussed further in the following section.

1.5. Economic incentives in general practice

There is evidence to suggest that how and how much you pay physicians is affecting behaviour with consequences for cost, quality, access, referral patterns, patient experiences, etc. The generalizability of these studies, however is unknown [29] and because different clinical, organizational and demographic factors characterizing general practice are also affecting physician behaviour [30], the combined incentive structure might dilute or completely nullify the financial incentives making it difficult to predict the effects.

Capitation payment offers the advantages of budget control for payers and a focus on prevention from providers with positive effects for patients. Under capitation payment, GPs are incentivized to keep costs below the per-capita fee in order to secure profits. Importantly, they may do this by reducing future costs with a focus on prevention [31]. Capitation also carries the potential for less positive effects on physician behaviour for example withholding care, resulting in under-treatment [32] and spillover effects to other sectors as a consequence of changed referral patterns (higher frequency of referrals to specialized care) [33]. Moreover if the capitated fee is not risk-adjusted there is an incentive to, where possible, to select low-risk patients (also known as cream-skimming) [32,34]. In terms of quality, based purely on the direct financial incentive, capitation is likely to produce the lowest level of quality among the three main compensation methods (Fee-for-service, salary and capitation) [35] because the GPs are not paid at the margin for quality improvements and because the direct input costs of quality improvements is imposed on the GP [35].

Capitation can still be an attractive payment option. Combined with proper regulation to avoid cream skimming, control quality and referral patterns, etc., capitation cannot only control cost, but facilitate an improvement in internal efficiency [36] and the transfer of the financial risk from the purchaser to the provider also effectively removes the problems of moral hazard and possibly some supplier induced demand, as GPs bear at least some of the cost

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