



DIALOGUE SUMMARY



USING FINANCIAL INCENTIVES TO ACHIEVE HEALTH-SYSTEM GOALS IN ONTARIO



16 SEPTEMBER 2015

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Using Financial Incentives to Achieve Health-system Goals in Ontario**

16 September 2015

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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Dialogue

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SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed that the problem can be understood in relation to the three themes presented in the evidence brief that informed the dialogue: 1) Ontario continues to set health-system goals that can be a struggle to achieve; 2) historically, Ontario has sometimes used targeted financial incentives to achieve health-system goals, with variable results; and 3) these variable results may be explained by how financial incentives have been designed (and complemented by other policy instruments), monitored and updated. In particular, participants focused on using these components of the problem to understand how they provide potential opportunities for using financial incentives, and indicated that: 1) financial incentives need to be used more prudently to achieve health-system goals; 2) funding and remuneration systems more generally need to be used more prudently, alone and in combination with other policy instruments, to achieve key health-system goals; and 3) new approaches need to be understood in the context of no new money, how money doesn't necessarily accrue to those who make change happen, and what we define as the system we're trying to improve.

Building on the deliberations about the problem, the deliberations about the elements of a potentially comprehensive approach for using financial incentives were focused on how to make better use of incentives. Dialogue participants saw value in each of the elements of a potentially comprehensive approach described in the evidence brief: 1) supporting dynamic efforts to identify the factors that are hindering the achievement of particular health-system goals; 2) using rigorous processes to design and execute financial incentives and other complementary policy instruments to achieve particular health-system goals; and 3) monitoring, evaluating and reviewing the financial incentives and other complementary policy instruments used to achieve particular health-system goals. However, three slightly revised elements that broadly related to each of these domains emerged from the deliberations: 1) engaging citizens, providers and health-system leaders in getting the 'diagnosis' right for any given goal; 2) engaging citizens, providers and health-system leaders in getting the design and mix of financial incentives and other supports (or policy instruments) right for any given diagnosis; and 3) engaging citizens, providers and health-system leaders in monitoring, evaluating and reviewing the financial incentives and other supports.

Participants agreed that repurposing or redesigning payment systems and incentives is needed to make them more functional and to focus on achieving system-level outcomes. Participants identified three key initiatives that are needed to move forward with this type of repurposing: 1) developing program logic models as part of the roll-out of all new programs; 2) providing clear messaging that repurposing the use of financial incentives will be an iterative process and won't be perfect from the outset; and 3) implementing rapid-response approaches to quickly diagnose problems and identify solutions to them. Success will, however, require supportive activities such as building trusting relationships among relevant health-system leaders, ensuring meaningful public engagement and education, and supporting the use of relevant and high-quality research evidence.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed that the problem can be understood in relation to the three themes presented in the evidence brief that informed the dialogue:

- 1) Ontario continues to set health-system goals that can be a struggle to achieve;
- 2) historically, Ontario has sometimes used targeted financial incentives to achieve health-system goals, with variable results; and
- 3) these variable results may be explained by how financial incentives have been designed (and complemented by other policy instruments), monitored and updated.

In particular, participants focused on using these components of the problem to understand how they provide potential opportunities for using financial incentives. Specifically, in reaction to the above themes, participants indicated that:

- 1) financial incentives need to be used more prudently to achieve health-system goals;
- 2) funding and remuneration systems more generally need to be used more prudently, alone and in combination with other policy instruments, to achieve key health-system goals; and
- 3) new approaches need to be understood in the context of no new money, how money doesn't necessarily accrue to those who make change happen, and what we define as the system we're trying to improve.

We describe the key themes that emerged related to these three components of the problem and opportunities emerging from it below.

Financial incentives need to be used more prudently to achieve health-system goals

In emphasizing the need for more prudent use of financial incentives, several participants gave illustrations of the ways in which financial incentives have not been used optimally in Ontario to achieve health-system goals. For example, several participants agreed with the point from one participant who indicated that while the focus of the evidence brief was on achieving health-system goals, the financial incentives that have been used in the province have been almost exclusively used for very targeted sets of activities (e.g., diabetes assessment and management).

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Ontario;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three elements of a comprehensive approach (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of a comprehensive approach for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of a comprehensive approach for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
- 10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

In the context of incentives only being used for very targeted sets of activities, several dialogue participants also questioned why financial incentives continue to be used to pay for activities that health professionals are already doing, which was seen as entrenching the status quo rather than incentivizing change within the system. One participant indicated that “the face validity of incentives is limited” in the context of paying for what should be routine parts of a care provider’s job. Similarly, one participant questioned why incentives are being used to pay for processes instead of outcomes, with another participant similarly noting that “many patients would be aghast at the notion of paying for what they would view as already privileged providers doing what they are already well paid for.”

In considering the complexities of changing incentives in order to use them more prudently, participants noted that part of the challenge of changing the way incentives are currently used is that they often turn into an expectation that becomes hard to take away, and eventually they become a disincentive to moving towards the next health-system goal. One participant specifically emphasized that without clarity on target outcomes as well as systems to measure progress towards achieving them, the prudent use of incentives will be difficult due to a lack of evidence about whether and how to change course to achieve goals.

Funding and remuneration systems more generally need to be used more prudently, alone and in combination with other policy instruments, to achieve key health-system goals

Several dialogue participants pointed out that funding and remuneration systems cannot be considered in isolation from other policy instruments that are needed to support efforts to bring about needed health-system changes. Moreover, participants generally agreed with the point made by one of the participants that incentives have been targeted to professionals, which have not driven change fast enough to address the urgent health-system transformations that are needed. Several agreed with another participant who indicated that part of the challenge of considering financial incentives in isolation from other policy instruments is that “all funding creates incentives.” However, while participants generally agreed that the current approach to using financial incentives is not working, most saw significant potential if incentives are used in the context of a more coordinated and comprehensive approach with other policy instruments.

Noting that financial incentives are not working as well as they could, one participant indicated that “too often the policy discussion is to use incentives instead of other policy levers, whereas the discussion should be about how to use incentives along with other policy levers, and to lead with the other levers and make sure the targeted incentives follow and match their design.” Similarly, another participant emphasized that incentives are only one of the many things that are needed to support needed behaviour change, and a limitation on their use has been not considering the additional range of levers needed to support their implementation.

Key examples provided by participants of the lack of an integrated approach to using incentives included:

- having financial incentives entrenched for specific professions instead of using a more nuanced mix of organizational funding and provider remuneration that brings teams of professionals together;
- taking a patient-centred approach where a base support model reinforces the types of activities that are needed in different contexts (as opposed to an approach that incentivizes services delivered to address specific conditions); and
- combining incentives for people to engage in important short-term behaviour (e.g., seeking needed care) with other instruments is needed to sustain change in the long term.

However, some participants indicated that taking such a coordinated policy approach to achieving health-system goals requires a clear delineation between unavoidable payments (i.e., core funding/financial arrangements) and optional targeted incentives, but as noted by others, this is difficult because these are inherently intertwined.

One participant suggested that a related part of the problem that is not often discussed is the lack of monitoring and updating of financial incentives, which requires the use of a broader set of policy instruments and data-collection systems. This participant noted that the lack of evaluation of incentives used in the province (as outlined in the evidence brief) is a significant issue as there is a need to know whether incentives are achieving the targeted outcomes and, if not, to adjust their design and/or use based on the outcomes of monitoring and evaluation. Moreover, it was highlighted by another participant that the lack of monitoring and evaluation also hinders the ability to identify those incentives that have worked well and achieved their objectives, which can then be changed into something else over time to support the achievement of other objectives. However, as indicated by another participant, this requires being able to identify specific targets and outcomes for incentives, which is challenging in some areas.

New approaches need to be understood in the context of no new money and what we define as the system we're trying to improve

While agreeing on the need to address the challenges outlined above, participants also commented on several occasions that changing the way incentives are used will be difficult given that any new incentive will need to be implemented in the context of “no new money” or a “zero sum game.” As one participant noted, “we can’t just ignore the fact that incentives are part of physician compensation packages, so it’s not easy to just say that we’re going to take them away, because it has larger implications for physician remuneration and funding packages.”

In relation to this challenge, several participants indicated that the problem cannot be diagnosed properly until we have a better understanding where we want to get in the long term (i.e., specifying what needs to be changed in the system). One participant outlined that the incentives currently in place were introduced to strengthen primary care because that was where the focus was at the time, but emphasized that the system has undergone substantial evolution since then and incentives therefore also need to change. However, one participant highlighted that such change requires long-term planning (i.e., for the next 10-15 years) and indicated that “we do not have the courage to say where we want to be in the long term, and everything currently being done is focused on the short term.” In deliberating about the focus of such long-term planning, several participants emphasized the need to shift the use of financial incentives from spending money on specific conditions to broader system-level goals (e.g., incentivizing the uptake of evidence in practice or supporting groups to improve timely access to services) or population-health outcomes (e.g., improving housing or other social determinants of health that will have broader impacts on health outcomes).

DELIBERATION ABOUT APPROACH ELEMENTS

Building on the deliberations about the problem, the deliberations about the elements of a comprehensive approach for using financial incentives were focused on how to make better use of incentives. Dialogue participants saw value in each of the elements of a potentially comprehensive approach described in the evidence brief: 1) supporting dynamic efforts to identify the factors that are hindering the achievement of particular health-system goals; 2) using rigorous processes to design and execute financial incentives and other complementary policy instruments to achieve particular health-system goals; and 3) monitoring, evaluating and reviewing the financial incentives and other complementary policy instruments used to achieve particular health-system goals. The deliberations focused on each of these elements are summarized below, including how they need to be revised, followed by how participants viewed the full array of elements when taken together.

Element 1 - Support dynamic efforts to identify the factors that are hindering the achievement of particular health-system goals

Deliberations related to the first element centred on participants' views about four specific needs they believe to be important for moving forward with such an approach: 1) the need to better understand why people in the system aren't doing what they should be; 2) the need to take a system-level perspective in identifying barriers, challenges and where supports are lacking; 3) the need for courageous leadership and especially for leaders to underpin a conceptual shift towards a system-oriented approach; and 4) the need to take advantage of opportunities to learn from what is currently being done.

With respect to the first need, several participants highlighted that we don't fully understand whether and how existing financial incentives are influencing healthcare providers to make the changes needed to achieve broad health-system goals. One participant suggested that there is a lack of understanding about why certain professionals aren't doing what they should be. Several other participants agreed, but also suggested that this process should focus on determining, more generally, who needs to do what differently to achieve health-system goals. For example, efforts could be pursued to identify what teams and organizations could be doing more (or less) of, both in terms of process (e.g., more collaboration) and outcomes.

The second need identified by participants was to clearly establish the importance of taking a system-level perspective in identifying key barriers and challenges that needed to be addressed. Many participants agreed that the traditional approach has been to focus within sectors on where supports are incomplete and barriers exist – such as primary care or cancer care – without considering the broader context, which has led to incomplete 'diagnoses' of the challenges. To illustrate this point, one participant used the example of existing wage disparities between acute care and other sectors, which is a dimension that would be overlooked without taking a system-level perspective. However, as a third need, most participants agreed that this proposed change constitutes a broad cultural shift, and as such will require courageous leadership, with committed leaders working collaboratively within and across sectors. Finally, a number of participants suggested that what's also needed is to take advantage of the many opportunities to learn from existing financial incentives. Such learning opportunities were identified as critical for informing future efforts to design and implement financial incentives more prudently in order to achieve health-system goals.

Participants generally agreed that addressing each of these needs is essential, and that the result will be a more comprehensive and nuanced set of 'diagnoses' that reflect health-system (rather than sector-specific) barriers and challenges, while providing a solid starting point for the appropriate design and use of financial incentives in the future.

Element 2 - Use rigorous processes to design and execute financial incentives and other complementary policy instruments to achieve particular health-system goals

In deliberating about the second element, participants focused on how to build on the first (i.e., getting the right diagnoses about barriers and challenges), in order to get the right mix of financial incentives and supports in place. Several key considerations emerged during the deliberations. First, participants broadly acknowledged that there was a need to move away from sector-targeted incentives that largely work in isolation from each other, and towards incentives that align with each other and with system-level goals. This sentiment was directly related to the concepts considered in deliberations about the first element, where a shift towards more appropriately identifying the system-level barriers and challenges was identified as a priority. In discussing the importance of this shift, several participants lamented the existing 'lattice' of sector-specific and individually focused financial incentives in Ontario, which can at times have competing objectives, and often fail to reflect broader system-level goals. One participant used the example of new primary-care models, which incentivize patient enrolment so that care shifts away from walk-in clinics, while

doing nothing to deter emergency-department visits (which is in conflict with existing wait-times targets) as an illustration of why a shift towards system-level design and implementation of financial incentives is essential.

A second major consideration that emerged from the deliberations was that efforts to design and implement financial incentives that address health-system challenges need to be pursued within the context of constrained financial resources. In particular, several participants agreed that it was highly unlikely for there to be new money available in the system to pay for additional incentives. As such, several participants emphasized the need to consider opportunity costs and a redistribution of existing funds in any plan to change how financial incentives are used in the province. Some participants suggested that ensuring accurate diagnoses of the real challenges in the system (element 1) could help underpin decisions to repurpose existing funds and remuneration packages in new, more appropriate ways.

A third major consideration raised by several participants related to the need to engage with the broader range of policy tools that could be alternatives to, or supports for, financial incentives. In particular, some participants highlighted that there are many ways to incentivize individuals (whether patients or healthcare providers), and the full range of incentives - financial and non-financial - should be considered to achieve health-system goals. Several participants agreed that the most important consideration is to ensure that the policy tool(s) used are the most appropriate to address identified challenges.

The fourth consideration identified by dialogue participants for this element was related to ensuring appropriate processes are adopted to identify and design the right mix of financial incentives and other supports. Several participants felt that there was a need to adopt a 'program logic model,' which provides a systematic approach to thinking through what the problems are, what can be done to overcome them (and justification for these choices based on theory), what effects and system impacts should be expected, and what targets or goals should be set. One participant also suggested that this would be essential for establishing robust and appropriate monitoring and evaluation strategies, because it would clearly outline what should be observed and why. Some participants also noted that this particular approach would require an iterative approach that clearly links with the process of diagnosing the problem as proposed in element 1.

A final consideration focused on engagement in the design, and communication of, newly designed incentives and supports. In particular, several participants agreed that the process of designing the right mix of incentives and supports required engaging citizens, healthcare providers and health-system leaders. This was viewed as an important precursor to establishing clear communication channels among all of those likely to be directly affected by the execution of a new set of strategies. Some participants also stressed the importance of considering this engagement in the context of iterations between diagnosing challenges and identifying appropriate strategies, which would require clear avenues for collaboration at all stages of the process.

Element 3 - Monitor, evaluate and review the financial incentives and other complementary policy instruments used to achieve particular health-system goals

Deliberations about the third element were largely a continuation of the major issues addressed in deliberations focused on the first and second elements, and reiterated the need to learn from existing experiences with financial incentives, as well as from any new incentives or supports that are implemented. While the need for a more rigorous approach to periodically monitoring and evaluating the impacts of any strategies was accepted by most participants, some noted the political challenges inherent in doing so. In particular, the chance that the results of monitoring and evaluation could be used to show a past policy decision was unhelpful (or even harmful), or that specific goals or targets were not being achieved, could be politically damaging for policymakers and stakeholders involved in the design and implementation of incentives and supports. Within this context, some participants noted that those involved in the design of a program may not accept the evidence as it emerges from monitoring and evaluation.

Considering the full array of options

Given the ways in which deliberations about each of the elements unfolded, participants collectively decided that they should be re-framed in a way that better reflects existing challenges, and the approaches needed to address them. Specifically, participants collectively agreed on a revised set of elements to address the core challenges identified:

- 1) engaging citizens, providers and health-system leaders in getting the ‘diagnosis’ right for any given health system goal, which would include efforts to:
 - identify what they want to see more (or less) of from teams, organizations and perhaps from individual health professionals, in terms of process (e.g., more collaboration) and outcomes (e.g., better health system performance),
 - determine who needs to do what differently,
 - collectively identify what barriers are preventing them from doing what they agree needs to be done, and
 - work out what supports are lacking, and which ones are needed to help them do what they agree needs doing, as well as the level (e.g., government, LHIN, organization, team) and sector (e.g., health, community and social services, child and youth services) where the barriers lie or supports are lacking;
- 2) engaging citizens, providers and health-system leaders in getting the design and mix of financial incentives and other supports (or policy instruments) right for any given diagnosis, which would include efforts to:
 - identify potential incentives and other supports (or policy instruments) to achieving an agreed-upon set of goals,
 - clarify how they think the incentives and other supports work for and within particular issues and contexts,
 - consider how, by whom and at what level the incentives and other supports should be communicated/delivered, and
 - specify what targets need to be changed on the way to achieving agreed upon goals; and
- 3) engaging citizens, providers and health-system leaders in monitoring, evaluating and reviewing the financial incentives and other supports, which would include efforts to:
 - monitor the extent of implementation of incentives and other supports,
 - periodically evaluate their impacts, how and why they’re working (or not working) and the views and experiences of those involved, and
 - stop, modify or scale up the incentives and other supports based on what’s been learned, keeping in mind the broader funding and remuneration goals being pursued (e.g., by re-purposing the money while keeping primary care a viable career path).

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Participants identified several important components and considerations for the implementation of the three elements of a comprehensive approach. First, most participants agreed that strong leadership is needed in order to clearly articulate a set of goals that can be achieved through the use of financial incentives (and other policy instruments), and a plan for pursuing them over the long term. However, while it was recognized that leadership is important, the deliberation about the elements made clear that meaningful and sustained engagement of citizens, providers and health-system leaders is essential for implementing them. This means engaging these groups and developing ‘buy-in’ to get the diagnoses right for any given goal, to get the design and mix of financial incentives and other supports (or policy instruments) right for any given diagnosis, and to continually monitor, evaluate and review the financial incentives and other supports. One participant also indicated that a key part of implementing this type of engagement approach will be a well-educated public, and therefore a broad-based public-education initiative may be warranted as part of any implementation strategy. Several participants also highlighted that those involved in implementing the elements need to be

prepared to try multiple times. The participant indicated that this requires robust evaluation designs so that we know what's working (or not) and why, in order to give those making decisions the evidence they need to make adjustments. Lastly, the main barrier cited by participants for reorganizing the use of financial incentives in the province will be the likely 'push back' from providers who rely on the existing set of incentives as part of their income. As a result, implementing the elements will need to pay careful attention to assuage this concern.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Participants identified what they think needs to be done next to improve the use of financial incentives. In terms of what needs to be done next, many participants agreed that repurposing or redesigning payment systems and incentives is needed to make them more functional and to focus on achieving system-level outcomes. Emphasizing this point, one participant indicated that "it's not in our interest to maintain a system with redundant and obsolete incentives." Another participant agreed and indicated that repurposing the use of incentives needs to provide base funding to providers (to help address the barrier cited in the previous section) and then incentivize the formation of teams.

Participants identified three key initiatives as well as several supporting sets of activities that are needed to make the repurposing of financial incentives a reality. The three core initiatives are: 1) develop program logic models as part of the roll-out of all new programs in order to generate the data and evidence needed for iterative evaluation and adjustment; 2) provide clear messaging from the beginning that repurposing the use of financial incentives will be an iterative process and that it won't be perfect from the outset; and 3) implement rapid-response approaches to quickly diagnose problems and identify solutions to them (using data and evidence derived from 1). To be successful, several participants indicated that they or their organizations could contribute to important supportive activities such as building trusting relationships among relevant health-system leaders (e.g., between policymakers and key stakeholder groups), ensuring meaningful public engagement and education, and supporting the use of relevant and high-quality research evidence.



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