Lessons learned

- **QBS in Estonia was not a stand-alone solution but part of a comprehensive strategy to strengthen primary care.** QBS was but one component of a set of systematic, well-sequenced instruments for strengthening various aspects of primary health care, including organizational reforms, new payment mechanisms, integrating evidence into practice, strengthening the health workforce and improving information systems.
- **QBS was designed for integration into a mixed model of provider payment for primary health care with well-aligned and purposefully chosen incentives.** The QBS contributed to weakening the incentive inerrant in capitation payments to under-provide preventative and disease management services and over-refer patients to specialists and hospitals.
- **A centralized data system enabled uncomplicated implementation of the QBS as an integrated part of purchasing health services rather than a stand-alone mechanism.** The existing billing system contained sufficient information about chronic conditions so that physician and nurse activity could be measured against targets without additional data collection.
- **Small resources led to a significant impact leveraging comparative performance information.** Semi-annual performance feedback and publication of overall performance results helped harness intrinsic motivation of family doctors towards professional improvement; normative pressure pushed doctors to meet the standard of their peers.
- **QBS was designed and implemented step by step.** The incremental, multi-year implementation of QBS involved carefully designed steps intended to (i) foster the achievement of realistic targets, (ii) give primary care physicians time to adapt to reforms and (iii) allow changes to the system to be made when areas for improvement were identified.
- **Stakeholder involvement facilitated wider acceptance by physicians.** The involvement of the Society for Family Doctors in designing the QBS ensured wide acceptance of the system by family physicians and helped to present it as a programme to enhance primary care in Estonia and not purely as a financial initiative by the health purchaser.
- **Pay-for-performance has been a powerful means for informing policy-makers and service providers about priorities.** The Estonian Health Insurance Fund used a financial reward to clearly communicate to physicians what is valued by the health system and to drive changes in standard practice accordingly.

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Contact us

This brief is part of our work programme on strengthening the health system response to NCDs. For the full report on Estonia and other information, check out our website at http://www.euro.who.int/en/health-systems-response-to-NCDs.

World Health Organization
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GOOD PRACTICE BRIEF

PAY-FOR-PERFORMANCE IN ESTONIA: A transformative policy instrument to scale up prevention and management of noncommunicable diseases

Summary

In 2006, Estonia introduced the Quality Bonus System (QBS)—a pay-for-performance instrument that provides financial rewards to primary health care physicians when they reach service provision targets in disease prevention and management. Less than a decade since the programme's launch and for a cost of less than 2% of Estonia's primary health care budget, the incentive programme has resulted in significant year-on-year scaling up of disease prevention and management in Estonia.

Estonia—a pioneer in health system reform

To address the growing burden of noncommunicable diseases (NCDs), Estonia focused on earlier detection and more proactive management of chronic conditions. A comprehensive approach to strengthening primary health care and right-sizing the hospital network were at the heart of the reforms. Continuously refined purchasing arrangements by the Estonian Health Insurance Fund created an enabling environment for restructuring service delivery and improving the mix of services with more prevention and proactive management of chronic conditions. The QBS was introduced to facilitate this transformation.

The quality bonus system

The QBS was designed in collaboration with the Society for Family Doctors and was launched in 2006 by the Health Insurance Fund. The objectives were to strengthen primary health care and enhance the role of family physicians in the prevention and management of disease, including a major focus on chronic illness.

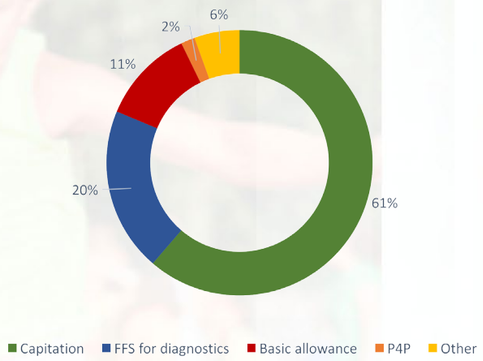
Estonia QBS Key Messages

- The QBS in Estonia was not a stand-alone solution but part of a comprehensive strategy to strengthen primary care.
- The QBS was designed as an integral part of a mixed model of provider payment for primary health care, with well-aligned and purposefully chosen incentives.
- A centralized data system enabled uncomplicated implementation of the QBS as an integrated part of purchasing health services rather than as a stand-alone mechanism.
- Small resources led to a significant impact leveraging comparative performance information.
- QBS was designed and implemented step by step.
- Stakeholder involvement facilitated wide acceptance by physicians.
- Pay-for-performance has been a powerful means for informing policy-makers and service providers about priorities.

The QBS provides additional payment on top of an existing mixed payment mechanism that is dominated by capitation payment, fees-for-service and a basic allowance. Physicians receive lump-sum cash bonuses for achieving coverage targets for specific services.

The QBS is organized into three performance domains, one of which addresses chronic diseases. This domain consists of five indicator sets with a total of 27 indicators. Most indicators are process-oriented and were selected because of their impact on outcomes based on clinical guidelines.

Figure 1. Share of payment mechanisms in PHC budget (2014)



Source of data: EHIF

Physicians are awarded points for reaching coverage targets, which are weighted differently for each domain and indicator. Coverage targets were set in a step-wise fashion to guarantee gradual scaling up of services by all participating physicians: each year's target is equal to the average performance in the previous year plus 10%. Bonus payments are awarded when a predetermined number of points is acquired.

An electronic billing system was in place before the QBS was introduced, which allows the Health Insurance Fund to follow all physician activities and monitor their progress. The system contains detailed patient information, including a list of chronic disease sufferers and a record of all services delivered by family doctors in Estonia. Family physicians receive personal electronic feedback on their performance twice a year, giving them an opportunity to analyse their performance and compare it with that of other doctors. The results of the QBS and a list of participating physicians are published on the Health Insurance Fund website each year for participating physicians and the public.

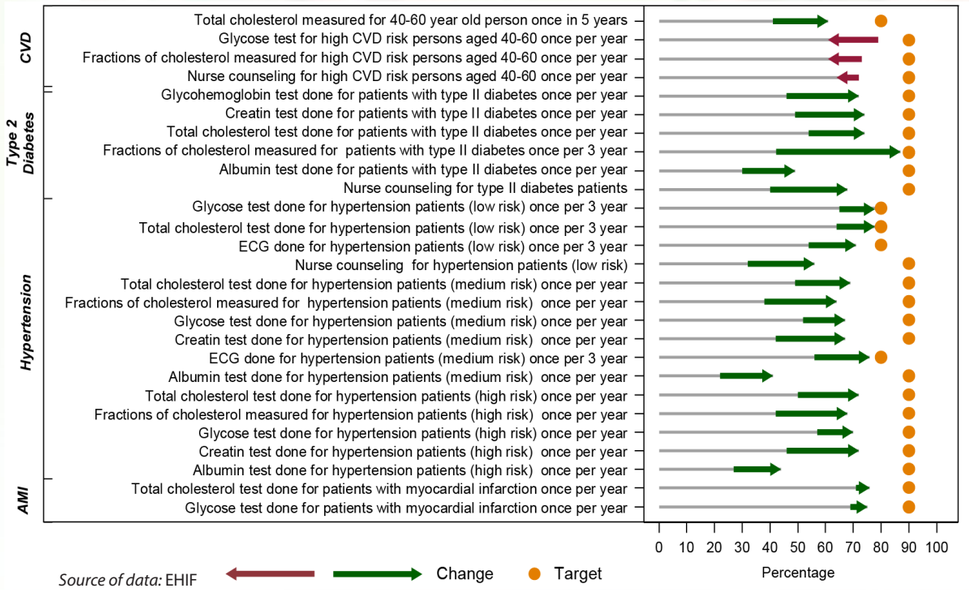
Design of the QBS

- The chronic disease domain is one of 3 disease domains included in the QBS and contains five sets of indicators: (i) prevention of cardiovascular disease, (ii) management of type II diabetes, (iii) management of hypertension, (iv) secondary prevention after myocardial infarction and (v) hypothyreosis.
- Bonuses are paid directly to physicians who then decide how to distribute them among nurses, administrators and other staff members.
- Physicians were initially invited in 2006 to enrol voluntarily in the QBS. By 2011, 90% of physicians had enrolled. The mechanism became mandatory in 2015.
- Special patients and anomalous patient–physician encounters are excluded from reporting to avoid unfair penalties for outcomes beyond physicians' control.
- Bonus payments are paid annually rather than monthly to lower transaction costs.
- The proportion of physicians who qualified for a bonus increased from 4% in 2006 to more than 50% by the end of 2013.

Impact on service coverage

In the 9 years since the QBS was first established it has strengthened chronic disease prevention and management in Estonia and has played an important role in the continued development of a strong primary health care system. Between 2007 and 2013, 24 of the 27 QBS indicators for chronic disease prevention and management improved (Lai et al., 2015). The increases range from 5% to 45% (Habicht, 2014), with an average improvement across all indicators of 18.5 percentage points. Service coverage for most indicators jumped from about 50% of target population covered to about 70% (Lai et al, 2015). Additionally, there is some evidence that patients of physicians participating in the QBS require hospitalization for chronic conditions less frequently than those of physicians not participating in QBS (Habicht, 2014).

Figure 2. Progress towards chronic disease prevention and management targets



Source of data: EHIF

Policy implications for Estonia

These achievements are impressive. They are likely to be the result of a comprehensive approach to strengthening primary health care in Estonia, which included organizational reforms, new payment mechanisms, integrating evidence into practice, strengthening the health workforce and improving information systems.

Further improvement in chronic disease prevention and management and a consequent reduction in avoidable hospitalizations for cardiovascular disease and diabetes are nevertheless possible (World Bank, 2015). Improvement may require further fine-tuning of both service delivery and payment mechanisms. In the single-practitioner model of primary care, it might be costly to further scale up health promotion, prevention, patient activation and proactive disease management for chronic conditions. Ways to share resources (staff, information, activities) among practitioners may be a sensible and necessary next step.

In terms of payment mechanisms, the interface between primary care on the one hand and specialist and hospital care on the other must be considered. The predominant incentive in the Estonian system is upward movement of patients, as primary care is paid mainly by capitation, while specialist and hospital care are paid by capped fees-for-service and case-based payments, respectively. Experimenting with capitation and/or bundled payments across higher levels of care might be a promising way forward.