Paying Patients for Prevention

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What we know

- Do patients/citizens change health-affecting behavior in response to financial incentives at point of use or in insurance pricing? **Answer: often.**
- Do they change behavior enough to make it worth the money? **Answer: We don't know yet.**

Who cares?

- Politicians who so want preventive care/behavioral change to save money.
- Public Health people who want prevention/behavioral change to save lives
- Consumers who want choices

The theory of financial incentives in insurance design

- Payment is less than cost offset: Pay 100%
- Payment is greater than cost offset and health is improved: Reduce cost by amount of cost offset and take what you can get.
- Payment causes minimal cost offsets but improves health: What is health worth?

An example (warts and all) of payment incentives at point of use

- Volpp et all, JAMA, 2/12/2009
- Long term success in getting people to quit smoking is hard. Smokers try and fail, drop out of programs using drugs and nagging.
- Incentives that do get people into program produce only temporary quits.
- So we designed an RCT with 800+ heavy smoking employees of a global mfg firm.

Experiment and results (biochemically verified quit rates)

	6 months	12 months	18 months
Pay	$250 (+100)	$400	
Treatment	21%	15%	9%
Control	12%	5%	4%

(only got information)

Impediments to financial incentives for preventive care/behavioral change (Volpp, Pauly, Bangsberg, HA)

- Weak evidence that anything works
- Far future benefits: turnover and discounting
- Hospitals and docs lose money from success
- Target efficiency versus equity
- Scruples
- Value of health not salient to decisionmakers
- System over-oriented to white coat prevention.

Directions/conclusions

- Imaginative rewards: prizes, money in contributory account, lower health insurance premiums
- Rewards need to be frequent and relevant, carrots not sticks
- Reward the doctor too.
- Eventually need to confront ROI/business case.