Medical Xpress

Payment incentives to psychiatrists in Ontario do not increase access for new patients

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Incentive payments, introduced to encourage community-based psychiatrists to see new patients after discharge from a psychiatric hospital or following suicide attempts, do not increase access, found new research published in *CMAJ* (*Canadian Medical Association Journal*).

Many jurisdictions have introduced incentive payments to improve delivery of and access to care, and to improve health outcomes for patients. In 2011, Ontario introduced 3 incentive payments for psychiatrists to see new patients within 30 days after discharge from a psychiatric hospital and for 6 months following a suicide attempt. The incentives included a 15% premium for providing care within 30 days after discharge from a psychiatric hospital, a 15% premium for care during the 6 months after a suicide attempt and a $200 annual fee for each patient who receives follow-up care within a month.

"As it stands, the provincial investment in these incentive payments has not produced any discernible value, and psychiatrists are not responding," writes Dr. David Rudoler, Centre for Addiction and Mental Health (CAMH) and the University of Toronto, Toronto, Ontario, with coauthors.

The study included 1921 psychiatrists who were followed over 5 years. The study also captured 304 574 patients aged 16 and older who had been discharged after a psychiatric hospital admission, and 78 375

people who had attempted suicide. After the incentive payments were introduced, the researchers did not find a significant difference in the average number of monthly visits for patients discharged from a psychiatric hospital and for those with previous suicide attempts.

They suggest that the incentive ($30) may not have been high enough to motivate behaviour. For psychiatrists who have reached a certain pay level, such as those in urban areas, there is no behavioural incentive to take on new patients for additional income.

Most research has been on incentives in primary care, rather than mental health services or psychiatric care.

"Although we focused on the situation in Ontario, our findings will be important for policy-makers in all high-income countries where the use of payment incentives to improve health care delivery is an important concern," the authors write. "Our results do not necessarily suggest that financial incentives should be abandoned as a tool to improve the delivery of health care services, but they do indicate that careful thought should be given to the design of such incentives and the context in which they are implemented."

In a related commentary www.cmaj.ca/lookup/doi/10.1503/cmaj.171126, Dr. Ruth Lavergne, Simon Fraser University, writes, "incentives may offer neat and tidy solutions to neat and tidy problems, as suggested by evidence showing that discrete incentives work in the short term. However, the most intractable problems in Canadian health care—which certainly includes managing transitions from hospital to community—are messy. They involve siloed care, poor transfer of information and ambiguous accountability structures."

She suggests that redesigning the payment system within the wider health

system may change behaviour, but individual payments alone will not effect change in physician habits.

The study was conducted by researchers from the Centre for Addiction and Mental Health, the Institute for Clinical Evaluative Sciences and the University of Toronto, Toronto, Ontario.

"Payment incentives for community-based psychiatric care in Ontario, Canada" is published December 11, 2017.

More information: *Canadian Medical Association Journal* (2017). www.cmaj.ca/lookup/doi/10.1503/cmaj.160816

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