The Corporate Agreement with General Medicine: improvement of appropriateness indicators to achieve per-capita cost and to unlock incentive attainment

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Background and objectives. The Health Authorities have always included the per-capita expenditures for contracted pharmaceuticals within the Corporate Agreement with General Medicine, encouraging general practitioners (GPs) to achieve the target, in proportion to the number of assisted patients. Since per-capita observance is no guarantee of appropriateness, in order to comply with the expenditure ceiling, but at the same time to improve prescriptive appropriateness, the Corporate Agreement with General Medicine was redefined, to introduce some new specific appropriateness indicators on prescriptive pathways.
Methods. The Agreement is a consensus between Health Authorities and General Medicine stating that GPs who adhere are entitled to receive incentives based on goal achievement. Through available administrative flows, the therapeutic areas associated with the highest expenditures and inappropriateness, namely proton pump inhibitors (PPIs), ACE-inhibitors, sartans, respiratory drugs, vitamin D, were identified for designing the indicators, targeted on three levers of appropriateness, namely patients elected to treatment, therapeutic option selected, and duration of treatment. Evaluating prescription appropriateness to treatment recommendations (based on the three identified levers), these indicators provide a direction change and a tool for expenditure efficiency. For each indicator, the actual value was measured, the target value defined, and based on the achievable margin of improvement on pharmaceutical expenses, the set of indicators to be included in the Agreement was prepared. For each appropriateness indicator, this analysis defined the threshold value necessary for the release of per-capita incentives and the ranges for incentive delivery based on appropriateness.
Results. The identified appropriateness indicators, (the actual values) and target values are the following: (1) % patients with higher-cost active ingredients, for the same therapeutic indications (PPIs, ACEi, sartans, cholecalciferol) (64%)≤30%; (2) % patients with PPIs (AIFA note 48) with duration of therapy longer than 8 continuous weeks (62%) ≤30%; (3) % patients with cholecalciferol (AIFA note 96), without 25(OH)D determination (55%)≤30%; (4) % patients with triple inhaler therapy for chronic obstructive pulmonary disease (COPD), consisting of inhaled corticosteroids (ICs), a long-acting β2-agonist (LABA), and a long-acting muscarinic antagonist (LAMA), non-adherent to treatment, who are not coming from the therapy recommended by AIFA note 99 (92%)<40%. The threshold values for unlocking the per-capita and ranges for appropriateness incentives are as follows: 1-3: ≤50%; 51-100%: no-incentive; 4-50%: 0.10€; 31-40%: 0.20€; ≤30: 0.30€; 4: ≤60%; 61-100%: no-incentive; 51-60%: 0.10€; 41-50: 0.20€; ≤40: 0.30€. The per-capita indicator: target value=regional ceiling; incentive=0.60€ payable upon achievement of the threshold values of the four appropriateness indicators.
Conclusions. With the new Corporate Agreement, appropriateness becomes a prerequisite for the evaluation of the target on the per-capita conventioned healthcare provisions.
Appropriateness indicators, by measuring the reduction of deviation between clinical practice and treatment recommendations, are determinants of improved patient outcome and clinical management. The incentive for GPs, based on a system in which the enabling

condition to obtain the incentive on the per-capita is related to the achievement of appropriateness targets. This performance-management system is oriented towards the fulfilment of both economic-financial commitments and medical care objectives.