Incentives Are Not Improving Care, Expert Says

BY JEFF EVANS
Senior Writer

WASHINGTON — The few studies that have examined the effectiveness of incentivized pay-for-performance programs have found a mix of moderate to no improvement in quality measures, which, in some cases, may not be attributable to the programs themselves.

It is important to note that little evidence exists to support the claim that pay-for-performance programs actually improve quality because "people are making this association," said Dr. Mark, director of the Outcomes Research and Assessment Group at the Duke (University) Clinical Research Institute, Durham, N.C.

During the last 20 years, incentivized pay-for-performance programs have shown that "what you measure generally improves what's easiest to measure. But the ease of measurement does not necessarily define the importance of the measurement."

Furthermore, very little, if anything, is known about whether these initiatives are cost effective for the health care system at large, Dr. Mark said, although he noted that that may be an oversimplification of the outcomes of such programs.

A systematic review of 17 studies published during 2005-2005 on pay-for-performance programs found that 1 of 2 studies on system level incentives had a positive result, another found no improvement, and 1 found an unintended consequence. In nine studies of incentive programs aimed at the provider level, seven had partially positive or fully positive results but had "quite small" effect sizes.

Positive or partially-positive results were seen in five of six programs at the physician level (Ann. Intern. Med. 2006;145:265-72).

Nine of the studies were randomized and controlled, but eight had a sample size of fewer than 100 physicians or groups; the other study had fewer than 200 groups. "If these had been clinical trials, they would have been considered to have failed to show a benefit," Dr. Mark said.

Programs in four studies may have created unintended consequences, including "gaming the system" by physicians in order to avoid sicker patients, and an improvement in documentation in immunization studies without any actual change in the number of immunizations given or effect on care. The studies did not include information on the optimal duration of these programs or whether or not their effect persisted after the program was ended. One study found that "the evaluation of the program's cost-effectiveness was ambiguous."

Another study compared patients with acute non-ST-elevation myocardial infarction in 57 hospitals that participated in CMS's Hospital Quality Incentive Demonstration and 113 control hospitals that did not participate in the program to determine if a pay-for-performance strategy produced better quality of care. There was "very little evidence that there was any intervention effect," according to Dr. Mark. Measures that were not incentivized by CMS also did not improve (JAMA 2007;297:2373-80).

In the United Kingdom, family practice physicians participated in a pay-for-performance program in 2004 that focused on 146 quality indicators for 10 chronic diseases as well as measures related to the organization of care and the patient's experience. The National Health Service substantially increased its deficit that year because the approximately £3.2 billion that was allocated for the project was eaten by greater than predicted success in achieving the quality indicators. This led to an average increase in the physicians' pay of about £40,000 that year (N Engl J Med. 2006;355:373-84).

Other investigators noted that in the 1998-2003 period prior to the NHS project all of the quality indicators had already been improved, "so it's not clear how much the program's achievements can actually be attributed to the program itself," Dr. Mark said (N Engl J Med. 2006;355:373-84).

Another study showed that public reporting of measures alone could improve a set of quality indicators on heart failure and acute care. Priority indicators were selected to be the same magnitude as a pay-for-performance program that included public reporting (N Engl. J Med. 2007;356:486-96).

There are more than 100 reward or incentive programs that have started in the private U.S. health care sector under the control of employer groups or managed care organizations, according to Dr. Mark, but congressionally authorized programs by the Centers for Medicare and Medicaid Services have received the most attention.

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