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IN THIS ISSUE

The study, “Does Pay-for-Performance Improve the Quality of Health Care?” appeared in the August 15, 2006, issue of *Annals of Internal Medicine*. The authors, all from Houston Center for Quality of Care and Utilization Studies and Baylor College of Medicine, are: Laura A. Petersen, MD, MPH; LeChauncy D. Woodard, MD, MPH; Tracy Urech, MPH; Christina Daw, MPH; and Supicha Sookanan, MPH.



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HEALTH POLICY research

James A. Baker III Institute for Public Policy-Baylor College of Medicine
Joint Program in Health Policy Research

Do Financial Rewards for Quality Influence Health Care Providers?

“Yes,” says Laura Petersen, MD, MPH, associate professor of medicine at Baylor College of Medicine and staff physician at the Michael E. DeBakey VA Medical Center. “However, effects of such pay-for-performance programs may be smaller than hoped for and may include unintended consequences. Furthermore, despite enthusiasm on the part of policymakers about tying health care payments to performance, there are many unanswered questions about how best to design such programs.”

In 2001, a report from the Institute of Medicine cited health care payment methods as a factor inhibiting quality improvement. Historically, payments to health providers and hospitals have been independent of the quality of services. In some cases, payment arrangements may even discourage quality. For example, when diabetes is effectively controlled, patients suffer fewer complications, such as eye or kidney problems. Fewer complications translate into fewer services, including office visits, which effectively reduces the income of doctors who are paid by traditional fee-for-service arrangements like Medicare. Although doctors wouldn’t intentionally do a poor job in treating diabetes to make more money, it seems logical that payment systems should reward doctors who keep people healthy and deliver excellent care.

By providing financial incentives to providers and hospitals for good-quality health care services, new performance-based payment systems (called pay-for-performance systems) are believed to hold promise in improving quality. But is the promise of these programs supported by evidence of their effectiveness?

To answer this question, Petersen and her colleagues conducted a search of the medical literature. They located 17 articles published between

1980 and 2005 that examined the effects of financial incentives on measures of health care quality. They classified studies into three different methods of distributing funds: to providers, to provider groups, and at the payment system level. Five of six studies that assessed the effects of directly rewarding individual physicians showed that financial incentives improved one or more of the quality measures. Seven out of nine studies provided evidence of effectiveness of financial incentives when rewards were distributed to groups of providers. Two studies that examined the effects of tying reimbursement contracts to performance had inconsistent results.

Although most of the studies suggested that financial incentives can have a positive influence on health care quality, the authors cautioned that many of the studies were small or were not well designed. Perhaps at least partly because of this, the effects of the interventions were modest overall and sometimes may have had more to do with improving documentation in the medical record than with the actual care. Of concern were indications that providers in four studies attempted to manipulate incentive systems for higher payments.

Petersen and colleagues conclude that more rigorous research designs are necessary to determine whether pay-for-performance arrangements result in meaningful quality improvements and are cost-effective. To study those questions, they have a large, randomized controlled trial of pay-for-performance arrangements under way that is funded by the National Institutes of Health and the Veterans Administration.

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