

SPOTLIGHTING INTERNATIONAL INNOVATION

Incentivizing Quality Care Through Pay-for-Performance

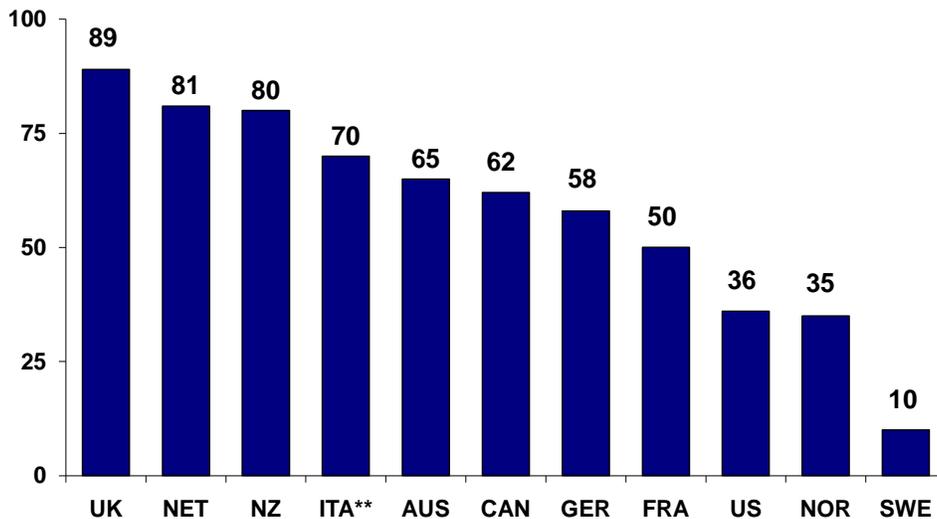
One target of reforms to reduce health care spending and improve quality has been the fee-for-service payment model, long criticized for creating incentives for providers to increase the volume of services, rather than improve the quality and efficiency of care. Alternative payment models have gained momentum [in the U.S.](#) and abroad to align providers' incentives with value rather than volume.

One such alternative is pay-for-performance reimbursement, which rewards providers for meeting designated targets. Rather than replacing traditional payment methods, pay-for-performance approaches can be combined with them to provide incentives to improve. For example, a primary care doctor may receive an extra payment if a certain percentage of his or her patients receive all of their recommended screening tests. Accountable care organizations are another, far more sophisticated, example; in such organizations the target is to provide high-quality care while reducing costs and the reward is a portion of the cost savings.

Many countries have experimented with pay-for-performance models in recent years (Exhibit 1).

Exhibit 1: Primary Care Doctors Can Receive Any Financial Incentives

Percent who can receive any financial incentives for targeted care or meeting goals*



* Can receive financial incentives for any of six: high patient satisfaction ratings, achieve clinical care targets, managing patients with chronic disease/complex needs, enhanced preventive care (includes counseling or group visits), adding nonphysician clinicians to practice and *non-face-to-face* interactions with patients. Italy not asked *non-face-to-face*.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.



These experiences offer examples and lessons for using incentive payments to encourage improvements.

England: The Quality and Outcomes Framework

England's Quality and Outcomes Framework (QOF) remains the largest-scale achievement in pay-for-performance, as a nationwide program spanning a wide array of performance targets. The QOF was the result of contract negotiations completed in 2004 between the government and British general practitioners (GPs) during a time of [significant primary care reform](#). Unlike many pay-for-performance schemes, the QOF was not originally designed to reduce but rather to increase health care spending, considered at the time to be too low in the U.K.

In its current iteration, the QOF offers GPs additional payments for meeting up to 134 target indicators. Performance areas included in the QOF relate to clinical indicators (including for managing chronic conditions such as asthma or diabetes), organizational indicators, patients' care experiences, and providing "extra" services such as child health and antenatal services. Participation in the QOF is voluntary but nearly all GP practices in the country participate. Results are publicly reported and [available online](#). The rewards for meeting the targets are substantial, making up more than a quarter of the average GP's income.

In its first few years, the QOF appears to have led to improvements in aspects of quality targeted by the program, particularly on process measures. Improvement was especially strong among poorly performing practices, which has [reduced disparities](#). Since then, the improvements have leveled off, possibly a consequence of current targets being set below average performance levels, largely removing the incentive to improve. Evidence is mixed on whether non-incentivized areas of care have suffered or improved under the QOF, and whether the improvements in services have led to improved patient outcomes.

Further Reading

- T. Doran, C. Fullwood, E. Kontopantelis et al., "[Effect of Financial Incentives on Inequalities in the Delivery of Primary Clinical Care in England: Analysis of Clinical Activity Indicators for the Quality and Outcomes Framework](#)," *The Lancet*, Aug. 30, 2008 372(9640):728–36. Epub 2008 Aug 11.
- T. Doran and M. Roland, "[Lessons from Major Initiatives to Improve Primary Care in the United Kingdom](#)," *Health Affairs*, May 2010 29(5):1023–9.
- S. Maisey, N. Steel, R. Marsh et al., "[Effects of Payment for Performance in Primary Care: Qualitative Interview Study](#)," *Journal of Health Services Research and Policy*, July 2008 13(3):133–9.
- R. McDonald and M. Roland, "[Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences](#)," *Annals of Family Medicine*, March/April 2009 7(2):121–7.
- Quality and Outcomes Framework, Online GP practice results database: <http://www.qof.ic.nhs.uk/>.
- B. Serumaga, D. Ross-Degnan, A. J. Avery et al., "[Effect of Pay for Performance on the Management and Outcomes of Hypertension in the United Kingdom: Interrupted Time Series Study](#)," *BMJ*, Jan. 25, 2011 342:d108.

Australia: Practice Incentives Program

Began in 1998, the [Practice Incentives Program](#) (PIP) offers Australian GPs the chance to earn rewards for certain activities and services and for meeting benchmarks. The financial incentives are in addition to other sources of income, with the size of the incentive generally dependent on the number of patients the doctor sees. Enrollment is voluntary.

Activities rewarded under PIP include participating in activities to encourage high-quality drug prescribing; managing diabetes and asthma care; adopting health information technology; hiring nurses and other health professionals such as physiotherapists and dieticians; ensuring patients have after-hours access to care; screening for cervical cancer; and practicing in rural areas or serving indigenous populations. Roughly two-thirds of Australian GP practices participate in the program, with average rewards of over \$19,700 per full-time-equivalent GP practicing in 2009.

Further Reading

- C. Cashinand and Y. L. Chi, "Australia: The Practice Incentives Program (PIP)," The World Bank, March 2011. Available at <http://www.rbfhealth.org/rbfhealth/system/files/Case%20study%20Australia%20Practice%20Incentive%20Program.pdf>.
- Medicare: Practice Incentives Program. Australia Government, Department of Human Services, <http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp>.

Germany: Disease Management Programs

German disease management programs, introduced in 2002, are nationwide, primary care–based programs designed to help patients with diabetes, breast cancer, asthma, chronic obstructive pulmonary disease, or coronary heart disease manage their conditions. For enrolled patients, primary care physicians provide treatment goals, coordinate their care, ensure treatment meets evidence-based guidelines, ensure timely access to care, and, with nurses and other providers, provide education on self-management. As an incentive, they receive an extra \$35 for each patient enrolled. Patients are also given incentives to enroll, including waiving their copayments for care.

Evaluations of the disease management programs find them to have successfully [improved the health and reduced complications for patients](#), as well as [reduced overall costs](#). In October 2009, there were more than 5.5 million patients enrolled, almost 8 percent of the publicly insured population.

Further Reading

- S. Stock, A. Drabik, G. Büscher et al., "[German Diabetes Management Programs Improve Quality of Care and Curb Costs](#)," *Health Affairs*, Dec. 2010 29(12):2197–205.
- S. Kottmair, C. Frye, D. J. Ziegenhagen, "[Germany's Disease Management Program: Improving Outcomes in Congestive Heart Failure](#)," *Health Care Financing Review*, Fall 2005 27(1):79–87.
- D. Squires, [International Profiles of Health Care Systems](#) (New York: The Commonwealth Fund, June 2010).