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Do family physicians need more payment for working better? Financial incentives in primary care

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KEYWORDS
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Abstract
Introduction: Financial incentives are widely used in health services to improve the quality of care or to reach some specific targets. Pay for performance systems were also introduced in the primary health care systems of many European countries.
Objective: Our study aims to describe and compare recent existing primary care indicators and related financing in European countries.
Methods: Literature search was performed and questionnaires were sent to primary care experts of different countries within the European General Practice Research Network.
Results: Ten countries have published primary care quality indicators (QI) associated with financial incentives. The number of QI varies from 1 to 134 and can modify the finances of physicians with up to 25% of their total income.
Conclusions: The implementations of these schemes should be critically evaluated with continuous monitoring at national or regional level; comparison is required between targets and their achievements, health gains and use of resources as well.

PALABRAS CLAVE
EGPRN;
Unión Europea;
Indicadores de calidad de asistencia médica;
Pago de incentivos;
Pago por desempeño;
Atención primaria

¿Son necesarios los incentivos para trabajar mejor? Incentivos económicos en atención primaria

Resumen
Introducción: En muchos países europeos se aplican en atención primaria diferentes programas de pago de incentivos en función de objetivos alcanzados.
Objetivo: El objetivo de nuestro estudio es describir y comparar los indicadores más recientes utilizados en estos programas.

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Métodos: Se realiza una revisión bibliográfica sistemática recogiendo las principales publicaciones sobre el tema. De forma complementaria se remite un cuestionario a diferentes expertos en atención primaria de diferentes países de la red *European General Practice Research Network*'.

Resultados: Diez países tienen publicados sus indicadores de calidad (IDC) asociados a los incentives económicos. El número de indicadores varía entre 1 y 134. En 8 países los IDC y los incentivos están incluidos en el salario mensual del médico, suponiendo entre el 1 y el 25% del mismo.

Conclusiones: Los IDC se basan fundamentalmente en el registro de determinadas variables tanto por el médico como por el equipo directivo, aunque la validez de los mismos puede variar según la fuente de datos utilizada. Los programas se monitorizan de forma continua a nivel nacional o regional, de acuerdo con cada sistema de atención sanitaria y los recursos disponibles.

Introduction

Although medicine is a natural science it is very similar to the arts. Both are focusing on human beings and therefore it is hard to be characterized with numbers only. Measurement usually needs numbers, but how could be the level of physicians' work measured? Why could it be considered as good in scientific or practical point of view? How could it be estimated by the patients or by other health workers? Is it based on the knowledge, experiences, circumstances, available resources or on other methods?

There has been an extreme, unpredictable growth in the biomedical sciences in the previous decades. Medical knowledge is continuously changing, developing and thereafter getting out of date early.

Humans are examined, diagnosed and treated by humans. How could the doctors be motivated for better work, performing more efficient and effective treatments and operations? What are the best factors for motivation? Possible answers could be: satisfied patients, health gain, cost reduction in health care, professional success and/or financial incentives.

The quality of care plays an important role in health services researches worldwide for decades. But it is difficult to define and to measure. Quality has different approaches from qualitative or quantitative techniques.

The quality of care can be improved by continuous training program, using the Evidence Based Medicine (EBM) or the creation and of clinical guidelines and their application in everyday practice. Assessing and evaluation plays a pivotal role in the objective assessment and can improve quality.[1] The most commonly used quantitative measurement tools are the quality indicators (QI).[2] The quality indicators were initially used for assessment of the quality of hospital care. However, a significant proportion of the doctor-patient encounters take place in primary care, so there was a need for the development, identification and application of primary care indicators. The strategies for the introduction of quality indicators are not effective without understanding the factors required verify the history of its development without transmission their use between settings and countries.[3]

''Pay for performance'' was a new strategy regarding contracts between doctors and health systems (initially in Australia, UK and United States). Providers under this arrangement were rewarded for meeting pre-established targets for delivery of healthcare services. Also known as ''P4P'' or ''value-based purchasing,'' this payment model rewards physicians, hospitals, medical groups, and other healthcare providers for meeting certain performance measures for quality and efficiency. The American Medical Association (AMA) has published principles for pay-for performance programs, with emphasis on voluntary participation, data accuracy, positive incentives and fostering the doctor-patient relationship, and detailed guidelines for designing and implementing these programs.[4]

The first United Kingdom (UK) experiment in pay-for-performance (P4P) was the introduction of financial incentives to achieve targets for childhood immunisation and cervical cytology. These incentives were associated with a substantial rise in the achievements in these clinical areas, especially among previously low performing practices. The best known pay-for-performance system, the QOF (Quality and Outcomes Framework) was introduced as part of a new general Medical Service (GMS) contract for primary care in the UK in 2004 (Table 1).[5]

This type of motivation become more and more accepted and recognized by GPs, health authorities and professional bodies. In the past decades different pay for performance programs were introduced in several countries worldwide. Also in many European countries different financial incentive schemes were implemented. [6] The European Community funded *PHAMEU* (Primary Health Care Activity Monitor for Europe) project developed indicators for comparison of primary health care systems in different countries (structure-process-outcome indicators), these measurable international indicators were used to monitor the quality of primary care in 31 European countries.[7] *EUprimecare* project was funded by the European Commission's 7th Framework Programme used research methods to describe specific primary care organisational models in Europe and studied the possible compromise between quality and costs in each model. One of the main objectives of the study was development of specific clinical and non-clinical indicators.[8]