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Would German physicians opt for pay-for-performance programs? A willingness-to-accept experiment in a large general practitioners' sample

Christian Krauth*, Sebastian Liersch, Sören Jensen, Volker Eric Amelung

Hannover Medical School, Center for Health Economics Research Hannover (CHERH), Carl-Neuberg-St. 1, 30625 Hanover, Germany

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ABSTRACT

Background: Implementing pay-for-performance (P4P) programs is a non-trivial task. As evaluation studies showed, P4P programs often failed to improve performance quality. A crucial element for the successful implementation of P4P is to gain acceptance with health care providers.
Objectives: The aim of our study was to determine, if (and at what bonus rate) German general practitioners (GPs) would participate in a P4P program. We further examined differences between respondents who would participate in a P4P program (participants) versus respondents who would not participate (non-participants).
Methods: A mail survey was conducted among 2493 general practitioners (GPs) in Lower Saxony (with a response rate of 36.2%). The questionnaire addressed attitudes toward P4P and included a willingness to accept experiment concerning P4P implementation.
Results: The participation rate increased from 28% (at a bonus of 2.5%) to 50% (at a bonus of 20%). Participants showed better performance in target achievement and expected higher gains from P4P than non-participants. Major attitude differences were found in assessing feasibility of P4P, incentivizing performance and unintended consequences. The crucial factor for (not) accepting P4P might be the sense of (un)fairness of P4P.
Conclusion: To convince GPs to participate in P4P, better evidence for the effectiveness of P4P is required. To address the concerns of GPs, future endeavors should be directed to tailoring P4P programs. Finally, program implementation must be well communicated and thoroughly discussed with health care providers.
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1. Introduction

Pay for performance (P4P) is a compensation method that relates a part of the remuneration of health care providers to the quality of health care provision [1]. Thus, health care providers receive financial incentives for attaining quality targets [2]. Depending on the aim of a P4P program, different quality and economic targets can be pursued (e.g. clinical effectiveness, structure and process of care, access to health care, patient satisfaction as well as efficiency [3,4]). P4P is based on the premise that physicians respond to financial incentives [5–7].

In 2001 the Institute of Medicine (IOM) postulated to use the power of financial incentives in order to improve the quality of health care [8], as deficiencies in performance quality have been perceived as a major problem of health care systems (e.g. several studies showed that adherence to medical guidelines is limited [9]). Often,

* Corresponding author. Tel.: +49 511 532 4426; fax: +49 511 532 5347.
E-mail address: krauth.christian@mh-hannover.de (C. Krauth).

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the payment system was identified as a potential cause of low health care quality. In the German ambulatory sector, the compensation scheme for physicians is based on fee for service with some limits of reimbursement per patient [10,11]. Thus, the compensation scheme is mainly rewarding the provision of quantities of health care instead of performance quality. Several reforms of the reimbursement system have been conducted in order to restrict orientation on quantities and to prompt quality of health care, though with limited success [11]. Since the IOM-report P4P programs have been implemented in many countries as pilot projects. In the US, the majority of public and private insurers use financial incentives to achieve quality improvements [12,13]. In Europe, the Quality and Outcomes Framework (QOF), which was implemented throughout the UK primary care sector in 2004, is one of the most important P4P initiatives, linking up to 25% of the income of general practitioners (GPs) to the performance in more than 100 clinical and organizational indicators [3,14]. Smaller programs have been implemented in Australia, Canada, Belgium, France, Germany, Israel, the Netherlands, New Zealand and Sweden [15–20].

However, implementing performance-based compensation programs is a non-trivial task. As evaluation studies showed, P4P programs often failed to improve performance quality [9,21]. A crucial element for the successful implementation of a performance-based compensation scheme is to gain acceptance with health care providers [22]. Thus, when designing structural elements of a P4P program (quality indicators and goal-setting, bonus amount, recipients), physicians' preferences toward pay-for-performance should be considered. It should be explored in particular, if additional money (and if so how much) is necessary to gain health care providers' support for pay for performance [9,21]. Just as important is to know about GPs' general attitudes toward quality-based compensation, and in particular, to understand their potential concerns.

Thus, the aim of our study was to determine, if and under which conditions German GPs would participate in a P4P program. In particular, we examined (1) if the participation rate was rising with increasing bonus amount offered (which would be suggested by standard economic theory), (2) how a more or less stringent performance target would affect the bonus amount claimed by the respondents, (3) if there were respondents who would refuse the implementation of a P4P program, and (4) how they differed in their attitudes or socio-demographic profile from respondents who would participate in a P4P program.

2. Material and methods

2.1. Survey data collection

From June to August 2013 all members of the German Association of General Practitioners (GP-Association) in the state of Lower-Saxony were asked to complete a written questionnaire (in a full survey). The GP-Association represents about 49% of all GPs in Lower Saxony [23]. The mail survey (including two reminders) was organized in cooperation with the two regional representations of the GP-Association in Lower-Saxony. All 2493 members of the GP-Association in Lower-Saxony were contacted returning 900 completed questionnaires (which corresponded to a response rate of 36.2%).

2.2. Questionnaire

The questionnaire addressed four topics presented predominantly in closed questions on a five-point Likert scale:

(1) Assessment of the current remuneration scheme in the primary physician sector (not addressed in this article).
(2) Attitudes toward P4P: the questions addressed relevant characteristics of P4P programs, which were identified from systematic reviews of quality-based compensation [2,9,21], and subdivided into six topics: (a) measuring and incentivizing quality of health care, (b) meeting aims of compensation schemes [24], (c) positive and negative effects of implementing P4P (compared to the current remuneration scheme), (d) unintended consequences, (e) publication of target achievement, (f) potential for motivation.
(3) Conduct of a willingness-to-accept (WTA) experiment concerning the implementation of a performance-based bonus scheme.
(4) General practitioners' characteristics: (a) age and sex of the physician, (b) trained GP or internist, (c) practice organization (single practice, shared practice, group practice), (d) practice located in an urban or rural area, (e) years of work experience in general practice, (f) working hours per week and amount of administrative tasks, (g) number of patients per calendar quarter and percentage of private patients.

2.3. Willingness to accept experiment

The WTA experiment was based on the contingent valuation method (CVM) [25–28]. CVM is a survey-based, direct assessment of respondents' preferences using hypothetical scenarios. CVM allows for eliciting preferences before product launch or for valuing non-market commodities. There are different approaches to elicit WTA (open-ended questions, payment card, bidding game, closed-ended questions). Finding the most suitable approach depends on the respective research question [28]. We applied a combined closed-ended/open-ended format experiment.

In the WTA-experiment we confronted the respondents with a hypothetic scenario. In a first stage (closed-ended format) respondents were asked to choose between an annual remuneration of 200,000€ (hypothetic current remuneration) and a novel remuneration system with P4P-component. The P4P-remuneration included (1) a reduction of the fixed compensation by 5% if the GP failed the P4P-goals (i.e. annual remuneration decreased to 190,000€) or (2) an increase of the remuneration by a predefined bonus, if the GP achieved the P4P-goals. Each respondent was offered a unique bonus from the range between 2.5% and 20% at random (which yielded in an annual remuneration between 205,000€ and 240,000€) (Table 1). The goal to achieve was defined as "in at least 80% – (or alternatively 90%) – of your hypertensive patients blood pressure is below 140/90 mmHg (measured in the

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