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A behavioral model of clinician responses to incentives to improve quality

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Abstract

The use of pay for performance (P4P) and public reporting of performance (PR) in health care is increasing rapidly worldwide. The rationale for P4P and PR comes from experience in other industries and from theories about incentive use from psychology, economics, and organizational behavior. This paper reviews the major themes from this prior research and considers how they might be applied to health care. The resulting conceptual model addresses the dual nature (combining direct financial and reputational incentives) of the initiatives many policymakers are pursuing. It also includes explicit recognition of the key contextual factors (at the levels of the markets and the provider organization) and provider and patient characteristics that can enhance or mitigate response to incentives. Evaluation of the existing literature (through June 2005) about incentive use in health care in light of the conceptual model highlights important weaknesses in the way that trials have been reported to date and suggests future research topics.
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1. Introduction

There is increasing use of the strategies of pay-for-performance (P4P) and public reporting (PR) of provider performance in healthcare systems around the world. For instance, in the United States (US), recent surveys have shown at least 40 P4P initiatives nationwide sponsored by a variety of health plans and employer coalitions and the Centers for Medicare and Medicaid Services (CMS) that are intended to improve the quality of care provided [1–5]. In addition, there are at least 47 websites publicly reporting about the quality of care provided by physicians or hospitals [6,7]. In fact, almost every provider in the US is subject to P4P, PR, or both [1,6,8]. Similarly, the British National Health Service's new contract with physicians involves extensive use of P4P and there are several PR programs active in the UK [9,10]. Incentives programs also are being used in Australia, Canada, Haiti, Nicaragua, and elsewhere [11–14].

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Some believe that improving quality could be a key strategy to controlling costs and are willing to create incentives for quality to achieve this, while others seek quality for its own sake [10]. Both groups are responding to evidence that quality is poor, with underuse, overuse, and misuse all common events [15,16]. However, despite the growing use of P4P and PR, there is little data on how best to design incentive programs to encourage quality improvement [17].

Although both represent incentive strategies to alter provider performance, PR and P4P are qualitatively different. Both involve the sharing of information with providers, and hence appeal to their professionalism and intrinsic desires to improve. However, by also presenting the data to potential patients and payers, PR generates an economic incentive for improvement—albeit one whose magnitude is hard to calculate—by creating the possibility that a provider may get more (or fewer) patients. The reputational aspects of PR may also create a social incentive, in that providers realize their friends and peers may see the reports and may wish to perform well for this reason. On the other hand, the economic incentives of P4P are much easier to delineate, as they involve direct payments whose magnitude can be estimated based on expected performance, but P4P in itself creates no social or economic reputational incentives.

The rationale for P4P and PR comes from experience in other industries [4,18] and from theories about incentive use from psychology, economics, and organizational behavior [18,19]. However, there are no conceptual models that pull theories from these disciplines together and apply them to health care while also recognizing the dual nature—combining direct financial and public reporting strategies [8]—of the incentive strategies many policymakers are using in health care today.

To address this limitation, we first review the major themes from prior research and consider how they might be applied to health care. We then offer a comprehensive, health-care specific model of how financial and reputational incentives might work (whether together or separately). We next assess the extent to which available research can answer key questions about incentive design. Finally, we return to the model to identify important weaknesses in the way that trials have been designed and reported to date.

2. A conceptual model

The use of incentives in health care occurs in a complex milieu in which many economic and psychological factors influence provider behavior. Furthermore, provider response to incentives is only one determinant of overall system response, with potential mediation of each provider's effort by characteristics of the local health care market, the medical organization (if any) in which he or she practices, and his or her patients. To develop a comprehensive model addressing all these influences, we first consider each topic separately, drawing on the relevant literature (most of which is not specific to health care) from psychology, economics, and organizational behavior. We then propose a model specific to health care that integrates these theoretical considerations.

2.1. Theories about financial incentives and provider behavior

Financial incentive theory has been developed in several disciplines. Psychologists, for instance, have found that characteristics of individual providers—including intrinsic motivation, professionalism, and altruism [20–23]—may influence their response to incentives. These forces may be activated simply by providing performance data in the context of an incentive program and may stimulate improvement independent of any direct response to the incentive. In addition, reinforcement theory suggests that the characteristics of the incentive program itself (using rewards versus punishments, the frequency and type of reinforcement, provider awareness, etc.) are also important [18,24].

Other non-financial characteristics of the incentive may enhance or limit its effect. For example, providers may be more confident that they can control processes of care (what they do to patients) than outcomes, and this may influence their response [25]. Thus, providers might respond more to a payment to deliver dietary counseling than a payment linked to the number of patients who actually lose weight [26].

Economists focus most often on specific financial factors, such as the marginal revenue to be gained relative to the cost of changing behavior. The most commonly used incentives include lump sum bonuses for reaching a specified target, bonuses that increase as performance improves (graduated bonuses), or addi-

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