Health Policy 121 (2017) 407–417

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Implementing hospital pay-for-performance: Lessons learned from the French pilot program

Anne Girault*, Martine Bellanger, Benoît Lalloué, Philippe Loirat, Jean-Claude Moisdon, Etienne Minvielle

Management des Organisations de Santé (EA 7348), Ecole des Hautes Etudes en Santé Publique, 20 avenue George Sand, 93210 Saint-Denis, France

ARTICLE INFO

Article history:
Received 21 October 2015
Received in revised form 12 January 2017
Accepted 20 January 2017

Keywords:
Pay for performance
Qualitative evaluation
Incentive
Implementation

ABSTRACT

Despite a wide implementation of pay-for-performance (P4P) programs, evidence on their impact in hospitals is still limited. Our objective was to assess the implementation of the French P4P pilot program (IFAQ1) across 222 hospitals. The study consisted of a questionnaire among four leaders in each enrolled hospital, combined with a qualitative analysis based on 33 semi-structured interviews conducted with staff in four participating hospitals. For the questionnaire results, descriptive statistics were performed and responses were analyzed by job title. For the interviews, transcripts were analysed using coding techniques. Survey results showed that leaders were mostly positive about the program and reported a good level of awareness, in contrast to the frontline staff, who remained mostly unaware of the program's existence. The main barriers were attributed to lack of clarity in program rules, and to time constraints. Different strategies were then suggested by leaders. The qualitative results added further explanations for low program adoption among hospital staff, so far. Ultimately, although paying for quality is still an intuitive approach; gaps in program awareness within enrolled hospitals may pose an important challenge to P4P efficacy. Implementation evaluations are therefore necessary for policymakers to better understand P4P adoption processes among hospitals.

1. Introduction

Despite a wide implementation of pay-for-performance (P4P) programs in numerous healthcare systems over the past decade [1], systematic reviews conducted by van Herck et al. [2] and Eijkenaar et al. [3] have shown that evidence on the impact of P4P in the hospital setting is still limited [2,3]. Most studies evaluating hospital P4P programs have directed their attention to issues with design features, such as incentive size and structure, or metric choices [4,5]. The aim of these evaluations has been to demonstrate the direct effects of P4P on specific aspects of quality of care [6–9] or its cost-effectiveness [10,11]. In contrast, far less information exists describing how these programs have actually been implemented within hospitals [12–14].

Financial incentives directed at hospitals may elicit different types of responses [15]. Hospitals are very particular organizations in that they rely not only on explicit norms and procedures but also on professional values and implicit

* Corresponding author at: EHESP-Paris, 20 avenue George Sand, 93210 Saint-Denis, France.
E-mail addresses: anne.girault@eleve.ehesp.fr (A. Girault), martine.bellanger@ehesp.fr (M. Bellanger), benoit.lalloue@gustaveroussy.fr (B. Lalloué), loirat.philippe@wanadoo.fr (P. Loirat), jeanclaude.moisdon@free.fr (J.-C. Moisdon), Etienne.MINVIELLE@gustaveroussy.fr (E. Minvielle).

http://dx.doi.org/10.1016/j.healthpol.2017.01.007
0168-8510/

modes of coordination between healthcare professionals [16,17] Therefore, the implementation of P4P programs within hospitals can involve a complex process [12,18].

Some studies have already expressed the importance of better understanding how a few organizational characteristics (e.g. physician leadership, culture, organizational support) may mediate the impact of a financial incentive to improve quality [14,19]. Papers analyzing the implementation of activity-based payment systems have come to similar conclusions [20,21]. Research in related fields has also contributed to understanding the specific challenges hospitals may face when implementing new initiatives internally. In the literature on quality improvement programs, lack of leadership support is often presented as an important barrier [22–25] while effective communication and a facilitating organizational culture have been shown to be key factors for quality improvement [26]. Changing healthcare professionals' routine activities appeared to be more difficult, according to a recent study on the implementation of a quality indicator in France [27].

The present study was conducted in the context of the French IFAQ program (named for Financial Incentive for Quality Improvement) that was introduced in November 2012 as the first P4P program piloted for hospitals [28]. The paper specifically aimed to (1) identify hospital leaders' attitudes toward P4P in general, and toward the pilot program, (2) examine information dissemination processes within hospitals, including measurement of staff awareness of the program and corrective actions already put into place, and (3) explore the different quality improvement strategies planned within hospitals. The results of this study were obtained as part of the evaluation of the IFAQ1 program carried out in 2014 within the Coordination for Measuring Performance and Assuring Quality in Hospitals (COMPAQH) research project.

2. Materials & methods

The study design consists of a questionnaire-based study among hospital leaders, combined with a qualitative analysis based on semi-structured interviews with the staff of four hospitals included in the program. The survey characterized attitudes of leaders toward P4P; the qualitative study, conducted in parallel with the survey, helped us interpret the survey results by providing complementary information on hospital staff's perceptions.

2.1. Description of the IFAQ program

The program enrolled acute care hospitals across the country, and was supported by the French Ministry of Health and the National Authority for Health (HAS). IFAQ was modeled after the CMS Hospital Quality Incentive Demonstration (HQID), which predates the Medicare Value-Based Purchasing program (VBP) [29]. The IFAQ program consisted in awarding a financial bonus to hospitals depending on their relative rank, which was calculated based on quality indicator scores, including results from the hospital's accreditation process [30]. No provision was made for financial penalties.

For the first phase of the program, IFAQ1 (2012–2014), participation was voluntary and open to both public and private hospitals (Table A in Supplementary materials). 450 hospitals applied in July 2012, but hospitals that were only conditionally accredited by HAS were subsequently excluded from the sample, thus reducing the number to 426 eligible hospitals. Amongst them, 222 hospitals were randomly selected to participate in IFAQ1, after stratification on hospital type and location (Table B in Supplementary materials). 93 hospitals were awarded bonuses at the end of IFAQ1. The size of the incentive was calculated as a portion of their annual budget, ranging from 0.3% to 0.5%, with minimum and maximum payments of €50,000 and €600,000, respectively. This is similar to other P4P schemes in which the incentive often amounts to approximately 0.1% of annual budgets [31]. The scoring system measured the weighted average of nine quality indicators (QIs), and rewarded both achievement (relative performance) and improvement (performance increase over the period). Contrary to the VBP program, the selection of IFAQ1 indicators relied on process measures only and did not include outcome measures. Selected indicators covered different quality dimensions, such as hospital policy for health care quality and safety, risk management, and internal and external coordination. Such measures were already being reported publicly for other purposes (e.g. accreditation, patient information), which meant that no additional work was required for hospitals [32]. In this respect, IFAQ1 differs from most P4P programs, for which specific quality measures are usually collected, leading to an increased burden for data collection [12].

2.2. Survey

In the survey, we questioned hospital leaders including chief executive officers (CEO), chief medical officers (CMO), chief quality officers (CQO) and chief nursing officers (CNO). A review of the empirical literature was first conducted to define the determinants of P4P adoption and shape the structure of the questionnaire. To ensure validity in the questionnaire design, we developed a draft version and tested it through face validity, using two complementary approaches. First, we gathered a panel of experts (2 physicians, 1 statistician, 2 senior researchers) to evaluate the questionnaire. Second, content validity was checked by sending the questionnaire to a small group of respondents (n = 10) to ensure the questions were relevant and properly answered. Their comments were analyzed and the questionnaires were adjusted accordingly. The questionnaire ultimately consisted of 31 items (Table C in Supplementary materials). Six questions inquired about views on P4P in general (Q14,Q15,Q24,Q25,Q26,Q27) [33]. Seven questions explored respondents' perceptions regarding the design of the P4P pilot program such as metric choices (Q2,Q7), incentive size (Q8,Q9), feasibility of the model (Q5,Q6) and scoring methods (Q4) [5]. In addition, to learn if and how information was disseminated on the program, two questions tested program awareness among hospital staff (Q1,Q3) [34] and six other questions were included to seek information about the initiatives that have been carried out by participating hospitals (Q13,Q16,Q17,Q18,Q19,Q20).