



Review

Effects of pay for performance in health care: A systematic review of systematic reviews

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ABSTRACT

Background: A vast amount of literature on effects of pay-for-performance (P4P) in health care has been published. However, the evidence has become fragmented and it has become challenging to grasp the information included in it.

Objectives: To provide a comprehensive overview of effects of P4P in a broad sense by synthesizing findings from published systematic reviews.

Methods: Systematic literature search in five electronic databases for English, Spanish, and German language literature published between January 2000 and June 2011, supplemented by reference tracking and Internet searches. Two authors independently reviewed all titles, assessed articles' eligibility for inclusion, determined a methodological quality score for each included article, and extracted relevant data.

Results: Twenty-two reviews contain evidence on a wide variety of effects. Findings suggest that P4P can potentially be (cost-)effective, but the evidence is not convincing; many studies failed to find an effect and there are still few studies that convincingly disentangled the P4P effect from the effect of other improvement initiatives. Inequalities among socioeconomic groups have been attenuated, but other inequalities have largely persisted. There is some evidence of unintended consequences, including spillover effects on unincorporated care. Several design features appear important in reaching desired effects.

Conclusion: Although data is available on a wide variety of effects, strong conclusions cannot be drawn due to a limited number of studies with strong designs. In addition, relevant evidence on particular effects may have been missed because no review has explicitly focused on these effects. More research is necessary on the relative merits of P4P and other types of incentives, as well as on the long-term impact on patient health and costs.

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1. Introduction

In many countries, healthcare delivery is suboptimal. For example, adherence to professional medical guidelines

is often low [1–3], while costs of care continue to rise. Pay-for-performance (P4P) has become a popular approach to increase efficiency in health care. In addition to the United States where P4P has become widespread, P4P programs are being implemented in many other countries, including in the United Kingdom, Canada, New Zealand, Taiwan, Israel, and Germany [4]. In P4P, care providers receive explicit financial incentives based on their scores on specific performance measures that may pertain to clinical quality, resource use, and patient-reported outcomes.

Along with the dissemination of P4P, the literature on the effects of P4P has expanded rapidly over the past

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15 years. Although this is a desirable development, the evidence has become fragmented. Several systematic reviews have synthesized available evidence, but they all had different foci (e.g., only including experimental studies, only focusing on preventive services, not addressing other potential P4P effects besides impact on incentivized performance, etc.) and hence different conclusions. Consequently, it is challenging to comprehend this evidence and to extract success factors and pitfalls when it comes to implementing P4P.

In this paper, we summarize the existing literature on P4P effects in a broad sense by conducting a systematic review of published systematic reviews. The paper adds to the literature by synthesizing key findings from these reviews. The goal is to provide a structured, comprehensive overview of the evidence on P4P effects and mediating factors. We achieve this by addressing the following six questions: to what extent has P4P been (1) effective and (2) cost-effective? (3) Which unintended consequences of P4P have been observed? To what extent has P4P (4) affected inequalities in the quality of care and (5) been more successful when combined with non-financial incentives? (6) Which specific design features contribute to (un)desired effects? To our knowledge, no prior study has provided such an overview. The results will be of interest for policymakers who intend to implement a P4P-program as well as those who have already done so.

The next section provides a theoretical background on the relevance of these questions. Next, after describing the search strategy and inclusion and exclusion criteria, the results are presented for each question separately. In the discussion, the results are compared with findings from recent studies not included in any of the identified reviews (if available and relevant). We end with discussing the implications of our findings for research and policy.

2. Theoretical background

Effectiveness. Both economic theory and common sense support the notion that payment for health care should be determined, at least in part, based on meaningful indicators of quality or value [6]. Given notable deficiencies in the quality and efficiency of care, that healthcare providers (be they individual physicians, physician groups, or institutions) are responsive to financial incentives and that improving performance requires changes in their behavior, that many current base payment methods (e.g., fee-for-service, capitation) do not explicitly stimulate good performance, and that performance measurements have become more accurate, it seems natural to tie a portion of providers' compensation to their performance. However, although the idea underlying P4P is simple, in practice there are many potential pitfalls, as outlined below.

Cost-effectiveness. P4P can be considered cost-effective when improved quality is achieved with equal or lower costs or when the same quality is achieved with lower costs. Even in case P4P leads to cost increases it may still be viewed as cost-effective, as long as quality improvements are large enough [7]. Yet designing and implementing a successful P4P-program is complex [8]. Engaging providers, reaching consensus about program design,

collecting and validating data, calculating payments, and maintaining and evaluating the program likely involve high transaction costs. This raises the question whether P4P can be cost-effective.

Unintended consequences. In theory, P4P may have several unintended consequences. First, when differences in casemix between providers are not taken into account, providers have an incentive to select healthy/compliant patients and to avoid severely ill/noncompliant patients, especially for outcome and resource use measures. Moreover, even sophisticated risk-adjustment models may fail in preventing selection because providers are likely to have superior information about their patients than included in these models [9]. Other strategies, such as allowing providers to exclude noncompliant patients from performance calculations [10], may be necessary. Second, P4P may cause providers to focus disproportionately on aspects of care that are incentivized and possibly neglect other important aspects that are not [11]. A broad set of measures (including e.g., clinical quality, patient satisfaction, continuity of care) seems therefore important. However, this is often not feasible in practice. Third, P4P may crowd out providers' intrinsic motivation to provide high quality care, especially when the definition of performance is not shared. P4P could then play a trivializing role regarding the non-financial motivation [12], which may have several undesired effects. Finally, to maximize income, providers may manipulate data so that their performance looks better than it is in reality ("gaming").

Inequalities. P4P may narrow, widen, or maintain inequalities regarding access to/receipt of high-quality care [13]. Inequalities may widen if P4P encourages risk selection or results in reduced income for providers serving minority populations [14]. Providers in deprived areas will typically have lower performance and be less likely to receive incentive payments compared to providers in affluent areas, for example because their patients are less likely to adhere to treatment [15]. By adversely affecting the income of providers practicing in deprived areas, P4P may reduce both the number of providers working in such areas and their ability to invest in performance improvement. Widening inequalities can be prevented by rewarding improvement in performance, adequate risk adjustment, inclusion of measures that are more important for minority patients, or directly rewarding reductions in inequalities [14–16].

Non-financial incentives. Non-financial incentives such as public reporting (PR) and timely performance feedback to providers may complement P4P incentives. PR and P4P both reward providers for good performance, but the financial incentive in PR operates indirectly via consumer choice [13]. Performance feedback and reminders make treatment patterns and performance issues salient and can activate providers to adjust their practice style. Feedback may also create a reputational incentive if reports include information on peer performance.

Program design. The design of P4P has important consequences for the incentives that physicians experience and how they respond to them [17]. Seemingly important design elements are the number and type of included performance measures, risk adjustment, the entity targeted

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