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Review:

Strategy to Support Improvement of Healthcare Quality.

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Abstract: One of the latest market-based solutions to the rising costs and quality gaps in health care is pay for performance. Pay for performance is the use of financial incentives to promote the delivery of designated standards of care. It is an emerging movement in health insurance (initially in Britain and United States). Providers under this arrangement are rewarded for meeting pre-established targets for delivery of healthcare services. This is a fundamental change from fee for service payment. 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. Disincentives, such as eliminating payments for negative consequences of care (medical errors) or increased costs, have also been proposed. In the developed nations, the rapidly aging population and rising health care costs have recently brought P4P to the forefront of health policy discussions. Pilot studies underway in several large healthcare systems have shown modest improvements in specific outcomes and increased efficiency, but no cost savings due to added administrative requirements. Statements by professional medical societies generally support incentive programs to increase the quality of health care, but express concern with the validity of quality indicators, patient and physician autonomy and privacy, and increased administrative burdens. This article serves as an introduction to pay for performance. We discuss the goals and structure of pay for performance plans and their limitations and potential consequences in the health care area.
Key Words: Pay for performance; Quality; Health care; Payment models; Quality indicators

Introduction:
In recent years, pay-for-performance (P4P) strategies have attracted considerable interest in the United States, the United Kingdom, Australia, Canada and other Western countries. Their key attribute is a defined change in reimbursement to a clinical provider (individual clinician, clinician group or hospital) in direct response to a change in one or more performance measures, as a result of one or more practice innovations. Currently, across the US, over 170 P4P programs (or quality incentive payment systems) are in various stages of implementation in hospitals and group clinics, in both public and private sectors, covering 50 million beneficiaries. In 2004, the UK National Health Service (NHS) launched the General Medical Services Contract – Quality and Outcomes Framework, which gives family practitioners up to a 25% increase in income if various quality indicators are met. In Australia, Medicare's Practice Incentives Program targets quality in general practice and, in Queensland, a P4P program targeting public hospitals is being piloted from July 2007.

P4P is popular because of the propositions that traditional approaches to optimising care, including education and certification, do not appear to guarantee minimum standards and current quality improvement efforts are slow at reforming systems of care and few financial incentives exist for clinicians and managers to modify the status quo and reward high performance.

However, despite its rising popularity, how effective is P4P, and what are the key determinants of its success? Are its benefits sustainable over the longer term? Are there unintended adverse effects?[1]

Studies and Trends:
Pay for performance systems link compensation to measures of work quality or goals. Current methods of healthcare payment may actually reward less-safe care, since some insurance companies will not pay for new practices to reduce errors, while physicians and hospitals can bill for additional

services that are needed when patients are injured by mistakes. However, early studies showed little gain in quality for the money spent as well as evidence suggesting unintended consequences, like the avoidance of high-risk patients, when payment was linked to outcome improvements.[2]

The 2006 Institute of Medicine report *Preventing Medication Errors* recommended "incentives...so that profitability of hospitals, clinics, pharmacies, insurance companies, and manufacturers are aligned with patient safety goals;...(to) strengthen the business case for quality and safety." A second Institute of Medicine report *Rewarding Provider Performance: Aligning Incentives in Medicare* (September 2006) stated "The existing systems do not reflect the relative value of health care services in important aspects of quality, such as clinical quality, patient-centeredness, and efficiency...nor recognize or reward care coordination...(in) prevention and the treatment of chronic conditions." The report recommends pay for performance programs as an "immediate opportunity" to align incentives for performance improvement. However, significant limitations exist in current clinical information systems in use by hospitals and health care providers, which are often not designed to collect data valid for quality assessment.[3]

Implementation

In the United Kingdom, the National Health Service (NHS) began a major pay for performance initiative in 2004, known as the Quality and Outcomes Framework (QOF). General practitioners agreed to increases in existing income according to performance with respect to 146 quality indicators covering clinical care for 10 chronic diseases, organization of care, and patient experience. Unlike proposed quality incentive programs in the United States, funding for primary care was increased 20% over previous levels. This allowed practices to invest in extra staff and technology; 90% of general practitioners use electronic prescribing, and up to 50% use electronic health records for the majority of clinical care. The first data show that substantially increasing physicians' pay based on their success in meeting quality performance measures is effective. The 8,000 family practitioners included in the study earned an average of $40,000 more by collecting nearly 97% of the points available.[4]

In the 1990s in California health care plans and physician groups developed a set of quality performance measures and public "report cards", emerging in 2001 as the California Pay for Performance Program, now the largest pay-for-performance program in USA. Financial incentives based on utilization management were changed to those based on quality measures. Provider participation is voluntary and physician organizations are accountable though public scorecards and provided financial incentives by participating health plans based on their performance.

The Centers for Medicare and Medicaid Services (CMS) has several demonstration projects underway offering compensation for improvements:

- Payments for better care coordination between home, hospital and offices for patients with chronic illnesses. In April 2005, CMS launched its first value-based purchasing pilot or "demonstration" project- the three-year Medicare Physician Group Practice (PGP) Demonstration. The project involves ten large, multi-specialty physician practices caring for more than 200,000 Medicare fee-for-service beneficiaries. Participating practices will phase in quality standards for preventive care and the management of common chronic illnesses such as diabetes. Practices meeting these standards will be eligible for rewards from savings due to resulting improvements in patient management. The *First Evaluation Report to Congress* in 2006 showed that the model rewarded high quality, efficient provision of health care, but the lack of up-front payment for the investment in new systems of case management "have made for an uncertain future with respect for any payments under the demonstration."
- A set of 10 hospital quality measures which, if reported to CMS, will increase the payments that hospitals receive for each discharge. By the third year of the demonstration, those hospitals that do not meet a threshold on quality will be subject to reductions in payment. Preliminary data from the second year of the study indicates that pay for performance was associated with a roughly 2.5% to 4.0% improvement in compliance with quality measures, compared with the control hospitals. Dr. Arnold Epstein of the Harvard School of Public Health commented in an accompanying editorial that pay-for-performance "is fundamentally a social experiment likely to have only modest incremental value."
- Rewards to physicians for improving health outcomes by the use of health information technology in the care of chronically ill Medicare patients.[5]

Negative incentives

As a disincentive, CMS has proposed eliminating payments for negative consequences of care that results in injury, illness or death. This rule, effective October 2008, would reduce payments for medical complications such as "never events" as defined by the National Quality Forum, including hospital infections. Other private health payers are considering similar actions; the Leapfrog Group is exploring how to provide support to its members who are interested in ensuring that their employees do not get billed for such an event, and who do not wish to reimburse for these events themselves. Physician groups involved in the management of complications, such as the Infectious Diseases Society of America, have voiced objections to these proposals, observing that "some patients develop infections despite application of all evidence-based practices known to avoid infection", and that a punitive response may discourage further study and slow the dramatic improvements that have already been made.

Deselection, ethical issues

Present pay-for-performance systems measure good performance based on specified clinical measurements, such as glycohemoglobin for diabetic patients. Healthcare providers who are monitored by such limited criteria have a powerful incentive to dismiss or refuse to accept patients whose outcome measures fall below the quality standard and therefore worsen the provider's assessment. Healthcare providers who are monitored by such limited criteria have a powerful incentive to deselect (dismiss or refuse to accept) patients whose outcome measures fall below the quality standard and therefore worsen the provider's assessment.[6] Patients with low health literacy, inadequate financial resources to afford expensive medications or treatments, and ethnic groups traditionally subject to healthcare inequities may also be deselected by providers seeking improved performance measures.

Principles for Pay for Performance Programs

Physician pay-for-performance programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in healthcare system. Fair and ethical P4P programs are patient-centered and link evidence-based performance measures to financial

incentives. Such P4P programs are in alignment with the following five principles:

1. Ensure quality of care – Fair and ethical P4P programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect P4P program rewards.

2. Foster the patient/physician relationship – Fair and ethical P4P programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation – Fair and ethical P4P programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting – Fair and ethical P4P programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical P4P programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.[7]

Conclusion

In the Czech Republic are attempts to implement e.g. rating schemes by governments (Czech Ministry of Health) that meet quite a resistance from the health care providers and confusion in public and patients. This could easily lead to high demand for trivial health problems to be treated at the centers of excellence or publishing unadjusted (therefore unfair) mortality data from the hospitals. If payers wish to implement any of the scenarios, they must pay particular attention to the consequences of their actions and choose appropriate scheme for the appropriate provider.

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