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# Pay-for-Performance Does Not Improve Patient Health, Finds UK Hypertension Study

***As news outlets throughout Europe and the U.S. report on the plummeting health of Western adults and children, there is no shortage of culprits. One villain often bandied about is the "fee for service" system of incentives for physicians. Clearly, if doctors are financially rewarded for simply performing more procedures, costs will soar at the expense of patient health.***

Enter Pay-for-Performance, an emerging movement in which physicians are rewarded not for what they do, but for quality of care and patient outcomes. Under such a system, economic logic dictates that patients should theoretically show marked improvements when doctors' incentives shift from procedure to patient.

This new approach was implemented in the United Kingdom in 2004 in a program termed "Quality and Outcomes Framework." But whether or not such an approach has actually improved patient health remains an open question.

A new study published January 26 in BMJ presents the strongest evidence yet that Pay-for-Performance does not offer any benefit to patients with hypertension, despite the enormous administrative costs required to maintain such a system.

"No matter how we looked at the numbers, the evidence was unmistakable; by no measure did pay-for-performance benefit patients with hypertension," says lead author Brian Serumaga, formerly of Harvard Medical School/Harvard Pilgrim Health Care Institute, but now at University of Nottingham Medical School.

Working closely with researchers at Harvard, Nottingham, and the University of Alberta in Canada, Serumaga and his colleagues focused on how Pay-for-Performance might affect outcomes in patients with hypertension, a condition where other interventions such as patient education have shown to be very effective.

Analyzing data from the UK's Health Improvement Network, a large database of primary care records from 358 UK general practices, the international research team identified 470,725 patients diagnosed with hypertension between January 2000 and August 2007, spanning four years prior, and three years after, Pay-for-Performance was implemented.

The researchers looked at various measures including blood pressures over time, rates of blood pressure monitoring, and hypertension outcomes as well as illnesses.

Analysis showed that even after allowing for a number of variations, there was no identifiable impact on the cumulative incidence of stroke, heart attacks, renal failure, heart failure or mortality in both patients who had started treatment before 2001 and patients whose treatment had started close to the implementation of Pay-for-Performance.

"Governments and private insurers throughout the world are likely wasting many billions on policies that assume that all you have to do is pay doctors to improve quality of medical care," says senior author Stephen Soumerai, professor in the Department of Population Medicine at Harvard Medical School and Harvard Pilgrim Health Care Institute. "Based on our study of almost 500,000 patients over seven years, that assumption is questionable at best."

According to Anthony Avery, also of University of Nottingham Medical School, "Doctor performance is based on many factors besides money that were not addressed in this program: patient behavior, continuing MD training, shared responsibility and teamwork with pharmacists, nurses and other health professionals. These are factors that reach far beyond simple monetary incentives."

"Policymakers sometimes legislate large and expensive policies based on their beliefs without the requisite hard evidence," says Soumerai. "Policy makers in the U.S. and in Canada who are attempting to enact such programs need to think hard about other more effective approaches."

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