Abstract. Although there has been growing interest in pay-for-performance programs in health, the evidence of their success is weak. Reasons that have been posited for this are that they are misdirected (i.e. individual providers are not directly linked to incentives targeted at a practice level) or that they are too weak, either because of cost considerations or that they have been dominated by strong social or professional norms. In practice, a problem of pay-for-performance programs is that they are based on a transactional view of health care focused on short-term targets (such as vaccination rates, blood pressure control and screening rates). In designing pay-for-performance programs, health care needs to be seen as relational, which means rewarding on the basis of longer-term goals that may be more meaningful to patients, such as control of overall cardiovascular risk, quality of life, continuity of care and prevention of unplanned hospitalisations.

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implemented, are difficult to reverse; once we start to pay individuals to undertake a task, we cannot expect them to undertake that task unpaid in future. A study of financial incentives to improve rates of screening for diabetic retinopathy and cervical cancer in medical facilities run by Kaiser Permanente in California indicated that although such incentives improved screening levels, the removal of such incentives was followed by falls in the levels of screening to levels below (albeit slightly) those observed at the pre-incentive baseline.11

One flow-on effect from incentivising a certain set of tasks is that attention and effort can be drawn away from other tasks. Such incentives can also lead to overuse and duplication. An example is fee-for-service payment, which is not usually put forward as an example of an incentive scheme but is, in one important respect, ‘pay-for-performance’ because it involves providers being paid more the more services they deliver. Such a system in general practice in Australia has often been implicated in overservicing, waste and a lack of coordination in care.12–14

In addition to these explanations as to why they may or may not work, there is the broader question of whether they are targeting the right outcomes. Applications of pay-for-performance have generally been based on payment for short-term targets that are not necessarily meaningful to patients. Typically, incentive programs in health care reward or penalise on the basis of short-term behaviour change, such as targets in relation to incentive programs in health care reward or penalise on the basis of short-term performance have generally been based on payment for short-term targets that are not necessarily meaningful to patients. Typically, incentive programs in health care reward or penalise on the basis of short-term behaviour change, such as targets in relation to vaccination rates, blood pressure control and screening. As such, they involve carrots or sticks doled out separately on a year-by-year basis with no memory built into the system. In this regard they are predicated on the notion of a one-shot doctor or provider–patient relationship where achievements in one interaction count for nothing in how performance is assessed in the next.

However, provider–patient relationships are often long term, involving repeat interactions, and are built on social norms such as trust and reputation. In these instances, a policy maker may be better advised to align the incentives to long-term goals and shift behaviour designed to achieve targets, over say 5 years, such as the control of overall cardiovascular risk, the prevention of unplanned admissions to hospital, continuity of care and quality of life. Viewing interactions between providers and patients within the context of a relationship rather than as a series of isolated transactions will enable the design of incentives that are better aligned with their common goals. However, the achievement of these long-term outcomes may be influenced by a range of external factors, which inevitably complicates the task of attribution. This problem can, to some extent, be addressed through the triangulation with data on secondary indicators of process and activity.

Notwithstanding these measurement issues, there is an important reason for making providers accountable for outcomes that are subject to external factors: it encourages the tailoring of patient care to individuals’ personal circumstances, and the social and physical environments in which they live, rather than on the mechanistic delivery of individual services.

Despite their limited evidence of success, pay-for-performance programs in health care potentially have a role in Australia if incentives target outcomes that are meaningful to patients rather than short-term measures of activity. In designing such programs, decision makers need to recognise the common interest of patients and providers in achieving basic goals, such as long-term health, quality of life and continuity of care, and reward on the basis of these goals. For such measures to be effective, they also need to be designed so that rewards are in some form transmitted to the individual providers responsible for performance. Given that such incentives are costly and can have side effects, decisions to introduce pay-for-performance should also be subject to evaluation alongside other ways to motivate behaviour, such as through the influence of social and professional norms.

Competing interests
The author has no competing interests to declare.

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