Financial incentives, particularly when they are offered as carrots rather than sticks, hold great promise for increasing the provision of clinical preventive services to recommended levels. Positive inducements, unlike negative ones, offer the promise of a reward and build an alliance between the giver and the receiver. A positive incentive helps to create a shared goal; if the induction is successful in motivating a change in behavior, the inducement giver achieves an important goal, while the receiver benefits financially as a result of the changed behavior. This is what we refer to as a "win-win" situation. It is surprising that this approach has not been used more frequently in trying to achieve public health objectives, including increasing appropriate use of preventive care.

There has been little research on the effectiveness of financial incentives on either health plan or physician provision of preventive care. The paper by Kouides, Bennett, Lewis, et al. in this issue of the Journal is a model for the kind of research that is needed to guide policy development on the use of financial incentives to improve provision of preventive care. Their study is the first randomized controlled trial of a financial incentive targeted at individual physicians and physician groups to improve performance in clinical preventive care.

As the authors point out, preventive services, despite their increased coverage as benefits in managed care plans, are still underprovided in the United States. The irony is that when medical care was reimbursed on a fee-for-service basis, few preventive services were ever covered as health insurance benefits. However, with the introduction of capitation payments, preventive services are routinely "covered," but there is no direct financial reward associated with their provision—the health plan, medical group or physician receives the same amount per capita whether or not they provide patients with recommended and covered preventive services.

Rather than return to a fee-for-service reimbursement system for preventive care, the most obvious approach is to offer providers incentives to reach continuously improving performance goals for specific preventive services, such that the higher their level of performance, the greater the reward. This is exactly the model used by Kouides, Bennett, and Lewis in their experiment to increase rates of influenza immunization among Medicare beneficiaries. While their experiment was conducted under a fee-for-service system, where physicians were reimbursed a fixed fee per immunization, if physicians exceeded each of two increasing performance levels, the rate of reimbursement increased accordingly. Particularly given the small size of the incentives ($0.80 per shot for immunization rates above 70% and $1.60 per shot for immunization rates above 85%), the authors were able to demonstrate a statistically significant difference in the rate of improvement from 1990 to 1991 between the experimental and control groups, on top of whatever effect was due to the accompanying community interventions targeted at both groups.

Because there has been so little research on financial incentives, there are still many more questions than answers about how to apply them to increase appropriate use of preventive care. The Pacific Business Group on Health in California requires the health plans with which it negotiates to place 2% of total premium at risk for meeting all performance targets. In the influenza immunization trial, a 10% and 20% increase per shot was offered for exceeding different performance levels. At what level do financial incentives need to be set to achieve their objectives? It would be inefficient to set incentives too high and ineffective to set them too low. But there is so little experience in designing financial incentives to influence provision of preventive care that at the moment we are all simply groping in the dark. Does the level of an incentive need to vary for different types of preventive care? Are positive incentives or the threat of losing income more effective in changing physician behaviors? Are positive inducements more effective for changing some kinds of behavior and less effective in changing others?

A great deal more research, like that presented in this issue of the Journal, is needed to inform policy development on the most efficient and effective use of financial incentives to change the behaviors of physicians, physician groups, and health plans to achieve the Healthy People 2000 goals of access to preventive care for all Americans.
References