Implementation of Pay for Performance Policy in England

To the Editor:

Our recent article\(^1\) and editorial\(^2\) address changes in hypertension awareness, treatment, and control in England. In the editorial,\(^2\) Drs Mohan and Campbell reported that the annual changes in rates of awareness, treatment, and control appear to be slightly lower after implementation of “pay for performance” (PFP) compared with corresponding rates before PFP. However, these estimates did not take into account that, in 2003, a new automated device, the Omron HEM 907, was introduced to measure blood pressure, as a replacement for the Dinamap 8100, which had been used in previous Health Survey for England surveys but had become obsolete.\(^3\) To allow comparisons of 2003 with previous years, a calibration study was carried out to provide suitable regression equations to derive predicted Omron readings from Dinamap readings.\(^4\) In addition, in 2003 and 2006, samples were weighted to allow for nonresponse differences, whereas previous samples were not weighted. So, in comparisons among 1994, 1998, and 2003, we used unweighted predicted Omron readings for 1994 and 1998 and unweighted real OMRON readings for 2003, as previously published.\(^4\) For comparisons between 2003 and 2006 we used weighted Omron readings. Using these data, the rates of change can be reasonably compared (Table). Overall, the annual change in rate of awareness was marginally lower after implementation of PFP compared with before PFP, but the annual change in the rate of control tended to be higher after PFP than before. Interestingly, the annual changes in rates of awareness, treatment, and control after PFP were different between men and women; among women, all 3 of the parameters increased after implementation of PFP compared with before PFP, whereas among men, the opposite was true (Table). It is not possible to necessarily attribute the overall increase in annual change in control rate after 2003 to the PFP policy, and the reasons for the apparent differences between men and women are not clear. However, the greater opportunity to improve control rates among women after 2003 because of more frequent consultations may have contributed to the differences observed between the sexes. PFP is a substantive incentive that can encourage treatment and control of hypertension. However, before the introduction of PFP, trends toward improved awareness, treatment, and control were also noticed. Combinations of tactics, eg, PFP, with others, eg, the development of primary healthcare teams and national patient and healthcare professional education programs, might yield further improvements.\(^5\)

Table. Changes in Annual Rates (%) of Awareness, Treatment, and Control (<140/90 mm Hg) of Hypertension in England Before and After Implementation of PFP Policy

<table>
<thead>
<tr>
<th>Sex</th>
<th>Change per Annum Before PFP, %</th>
<th>Change per Annum After PFP, %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Awareness</td>
<td>Treatment</td>
</tr>
<tr>
<td>Men</td>
<td>2.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Women</td>
<td>1.2</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>1.8</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Disclosures

N.R.C.C. has received honoraria for advising and speaking from most major pharmaceutical companies that produce antihypertensive drugs. S.M. is supported by the Canada-HOPE fellowship. The remaining authors report no conflicts.

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Hypertension. 2009;54:e5; originally published online May 26, 2009;
doi: 10.1161/HYPERTENSIONAHA.109.133215

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World Wide Web at:
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