including the Hospital Quality Alliance, the Joint Commission, the National Quality Forum, and the Agency for Healthcare Research and Quality. The data are housed at the Center for Medicare and Medicaid Services, which publicly releases performance data on the measures on a website called *Hospital Compare* (*www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html*). These data are reported voluntarily and are available for a very high proportion of the nation's hospitals. Analyses demonstrate substantial regional variation in quality and important differences among hospitals. Analyses by the Joint Commission for similar indicators reveal that performance on measures by hospitals has improved over time and that, as might be hoped, lower performers have improved more than higher performers.

Public Reporting Overall, public reporting of quality data is becoming increasingly common. There are now commercial websites that have quality-related data for most regions of the United States, and these data can be accessed for a fee. Similarly, national data for hospitals are available. The evidence to date indicates that patients have not made much use of such data but that the data have had an important effect on provider and organization behavior. Instead, patients have relied on provider reputation to make choices, partly because little information was available until very recently and the information that was available was not necessarily presented in ways that were easy for patients to access. Many authorities think that, as more information about quality becomes available, it will become increasingly central to patients' choices about where to access care.

Pay-for-Performance Currently, providers in the United States get paid exactly the same amount for a specific service, regardless of the quality of care delivered. The pay-for-performance theory suggests that, if providers are paid more for higher-quality care, they will invest in strategies that enable them to deliver that care. The current key issues in the pay-for-performance debate relate to (1) how effective it is, (2) what levels of incentives are needed, and (3) what perverse consequences are produced. The evidence on effectiveness is fairly limited, although a number of studies are ongoing. With respect to incentive levels, most quality-based performance incentives have accounted for merely 1–2% of total payment in the United States to date. In the United Kingdom, however, 40% of general practitioners' salaries have been placed at risk according to performance across a wide array of parameters; this approach has been associated with substantial improvements in reported quality performance, although it is still unclear to what extent this change represents better performance versus better reporting. The potential for perverse consequences exists with any incentive scheme. One problem is that, if incentives are tied to outcomes, there may be a tendency to transfer the sickest patients to other providers and systems. Another concern is that providers will pay too much attention to quality measures with incentives and ignore the rest of the quality picture. The validity of these concerns remains to be determined. Nonetheless, it appears likely that, under health care reform, the use of various pay-for-performance schemes is likely to increase.

CONCLUSIONS

The safety and quality of care in the United States could be improved substantially. A number of available interventions have been shown to improve the safety of care and should be used more widely; others are undergoing evaluation or soon will be. Quality also could be dramatically better, and the science of quality improvement continues to mature. Implementation of pay-for-performance should make it much easier for organizations to justify investments in improving safety and quality parameters, including health information technology. However, many improvements will also require changing the structure of care—e.g., moving to a more team-oriented approach and ensuring that patients are more involved in their own care. Health care reform is likely to result in increased use of pay-for-performance. Measures of safety are still relatively immature and could be made much more robust; it would be particularly useful if organizations had measures they could use in routine operations to assess safety at a reasonable cost. Although the quality measures available are more robust than those for safety, they still cover a relatively small proportion of the entire domain of quality, and more measures need to be developed. The public and payers are demanding better information about safety and quality as well as better performance in these areas. The clear implication is that these domains will have to be addressed directly by providers.