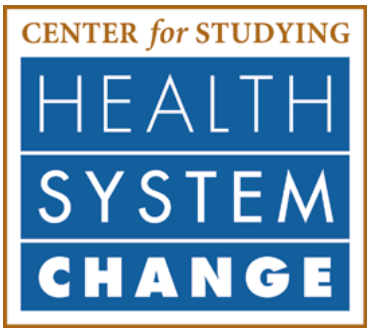
Community Tracking Study

Impact of a Prepaid Incentive on the Community Tracking Study Physician Survey



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COMMUNITY TRACKING STUDY (CTS)

The Center for Studying Health System Change (HSC) documents changes in health care systems over time and tracks the effects of those changes on people. Through surveys and site visits, HSC seeks to describe and analyze how the interactions of providers, insurers, policy makers and others determine the accessibility, cost, and quality of locally delivered health care. The core of these efforts is HSC's Community Tracking Study (CTS), a set of periodic surveys and site visits that allows researchers to analyze information about local markets and the nation as a whole. Because health care delivery is primarily local, both the surveys and site visits are centered around communities in the U.S. In addition, because the focus of the CTS is on change as well as communities, the study is longitudinal.

CTS PHYSICIAN SURVEY

The CTS includes a periodic national survey of physicians. The survey samples are concentrated in 60 communities that were randomly selected to provide a representative profile of change across the U.S. Among these communities, 48 are "large" metropolitan areas (with populations greater than 200,000), from which 12 communities were randomly selected to be studied in depth. Those 12 communities have larger survey samples and also comprise the communities used for the site visits. The survey data can be used to draw conclusions for the nation and for individual communities.

The Physician Survey is a nationally representative telephone survey of non-federal, patient care physicians. Each year of the Physician Survey contains observations from more than 12,000 physicians who spend at least 20 hours a week in direct patient care. The survey is conducted by The Gallup Organization. Physician Survey questions cover a range of topics, including financial incentives, care management, acceptance of new patients, provision of charity care, practice characteristics, income and career satisfaction.

The Physician Survey has been conducted in 1996-97 (Round One), 1998-99 (Round Two) and 2000-01 (Round Three).

ADDITIONAL INFORMATION

For more information on the CTS Physician Survey and related HSC Technical Publications, please visit the HSC web site (www.hschange.org).

This is one in a series of technical documents that have been done as part of the Community Tracking Study being conducted by the Center for Studying Health System Change (HSC), which is funded exclusively by The Robert Wood Johnson Foundation and is affiliated with Mathematica Policy Research, Inc.

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IMPACT OF A PREPAID INCENTIVE ON THE COMMUNITY TRACKING STUDY PHYSICIAN SURVEY

INTRODUCTION

Use of monetary incentives in surveys. Both prepaid and promised monetary incentives have long been used in mail surveys and increasingly in telephone and face-to-face surveys. In a meta analysis on the use of incentives in mail surveys, Church (1993) concluded that prepaid incentives yield higher response rates than promised incentives, that response rates increase with increasing amounts of money (although other research suggests it may do so at a decreasing rate --Crask and Kim, 1988), and that the offer of promised incentives or gifts does not significantly increase response rates.

Singer (1999) analyzed 39 controlled incentive experiments in telephone and face-to-face studies, evaluating the impact of incentive amount, type (gift or money), timing (paid before the interview or promised) and burden. Many of the experiments were pilot studies for larger surveys, conducted to identify the best incentive amount or method of payment. She concluded that incentives were effective in increasing response rates for interviewer-mediated surveys, a finding that was consistent for panel respondents, respondents interviewed for the first time, and those who initially refused. Prepayment increased the response rate in some but not all studies that were reviewed, while gifts were not as effective as monetary incentives in increasing response rates. Singer did not find a relationship between burden and incentive, that is, incentives were effective in low burden as well as high burden surveys. In the few studies that examined data quality (item non-response and length of responses to open ended questions), it appeared that paying incentives did not impair data quality and may have increased participation of groups that would otherwise be underrepresented. The greatest deficiency of reviewed studies is the absence of data on survey costs with and without incentives. Although incentives increase

cost, it is possible that savings on numbers of calls and related supervisory and non-labor costs may be reduced as a result. Most studies also lacked information on differential impact on respondents with different characteristics, long term impacts on respondents' expectations, and impacts on respondents who initially refused.

The Community Tracking Study Physician Survey. Since 1997, over 12,000 practicing physicians across the country have been surveyed bi-annually to obtain their perspective on how the health care delivery is changing. Physicians respond to a series of questions about whether they are able to provide needed services for patients, how they are compensated, and what effect various care management strategies have on their practices, as well as questions about their practice arrangements. Interviews are conducted with a sample of physicians in 60 sites (metropolitan statistical areas or groups of counties), supplemented with an independent national sample to improve the precision of national estimates. Primary care physicians are sampled at a higher rate than specialists. To improve estimates of change, a sample of physicians selected for one round of data collection are sampled again for the next round. Physicians completing interviews in one round who are sampled for the next round are known as the panel component.[1]

For the first two rounds of the survey, eligible physicians were offered $25 honoraria for participation and mailed checks after completing the survey. The incentive was designed to demonstrate commitment rather than to compensate physicians for their time. We promised the honoraria to physicians who completed the survey rather than mailing checks prior to the initial call because of uncertainty concerning the benefits and costs of prepayment. Many physicians sampled for the first time have incorrect addresses and approximately 15 percent are not eligible. Incorrect addresses reduce efficiency by increasing the number of checks that have to be re-

[1] See Technical Publications 9 and 32, respectively, for descriptions of the first two rounds of the physician survey; the round 3 technical report is forthcoming.

mailed before calling sampled physicians and ineligible physicians may cash checks before they are called.

We reconsidered this decision for the round 3 panel component because eligibility and participation were likely to be high for this group and we had information from the last survey on current addresses, which reduced financial risk. Our objective in testing prepayment was to increase response rates and reduce cost. Interviewing costs for prepaid physicians would be less than for physicians promised payment if fewer calls were needed to complete interviews. Savings from reduced calls include interviewer labor, supervision, and related non-labor and indirect costs (e.g., telephone calls, computer, overhead). On the other hand, some physicians mailed checks prior to the interviewer's first call may cash them without completing an interview, increasing the cost of prepayment. An experiment provides an opportunity to assess the cost effectiveness of prepaying physicians.

EXPERIMENTAL DESIGN

The sample for the incentive experiment was selected from the round 3 panel component, that is, from physicians who had completed round 2 interviews and were sampled for round 3. The survey contractor selected the experimental sample from panel replicates released early in the survey to ensure equal effort between the treatment and the control groups. Physicians selected for the study were randomly assigned to prepayment (treatment group) or promised payment (control group). The initial intent was to select 2,500 physicians to each group; however, replicates used in the experiment included 6,135 physicians, so the selection algorithm assigned 42 percent (2,571) to prepayment and 58 percent to promised payment. Table 1 shows

TABLE 1

SAMPLE CHARACTERISTICS (PERCENTAGES)

Characteristics	Type of Incentive	
	Prepayment	Promised Payment
Region		
North East	24.0	24.27
Midwest	22.25	20.45
South	30.61	32.21
West	23.10	23.06
Urban/Rural		
Urban	92.03	92.06
Rural	7.94	7.94
Age		
Less than 40	12.41	11.14
40-49	38.78	37.26
More than 50	48.81	51.60
Board certification		
Board certification	76.58	77.36
Not Board-certified	23.42	22.64
Gender		
Male	76.35	75.56
Female	23.65	24.44
Primary Care/Specialist		
Primary Care Physician	60.40	58.70
Specialist	39.60	41.30
Income		
Less than $100,000	20.19	19.78
$100,000-$150,000	34.31	33.50
More or $150,000	45.51	46.72
Total	41.9	58.1

Note: The percentages of the prepaid and promised payment characteristics are not statistically different that the total percentages.

demographic and practice characteristics of the two groups; the two groups did not differ on any of these attributes. Letters explaining the upcoming survey and compensation were mailed to the prepayment and promised payments groups prior to the interviewers' initial call (see Exhibits 1 and 2).

We hypothesized that prepaid physicians would have a higher response rate, require fewer calls to complete interviews, and require fewer days from first to final call than those promised payments. We assessed the cost effectiveness of the procedure by determining the added cost in checks cashed by physicians in the prepaid sample who did not complete interviews and the savings in reduced calls. The amount of the incentive could not be increased for budget reasons and was not varied.

RESULTS

Survey participation rates. We computed four rates to evaluate the impact on survey participation:

- *Completion rate* - ratio of completed interviews to the total number of physicians sampled in each group
- *Response rate* - ratio of completed interviews and ineligible physicians to the total number of physicians sampled in each group (assumes eligibility for nonresponding and unlocated physicians is the same as for those who completed interviews)
- *Cooperation rate* - ratio of completed interviews and ineligible physicians to contacted physicians in each group (those who completed interviews, were ineligible, or were located nonrespondents)
- *Eligibility rate* - ratio of completed interviews to the sum of completed plus ineligible interviews

Physicians selected for prepayment were more likely to complete interviews (77.1 percent) than those promised payments (74.9 percent) (see Table 2). However, this did not result in significantly greater response or cooperation rates (although these rates were slightly higher for prepaid physicians), with most of the difference due to a higher eligibility rate for the prepayment group (94.2 percent) compared with the payment group (92.4 percent). Except

TABLE 2

SURVEY OUTCOMES AND OUTCOME RATES BY TYPE OF INCENTIVE (PERCENTAGES)

Survey outcomes	Type of incentive	
	Prepaid	**Promised Payment**
Completed interview	77.1	74.9
Ineligible interview	4.8	6.2
Located but refused interview or did not respond for other reasons	16.3	17.2
Could not be located	1.8	1.7
Outcome rates		
Completion rate[2]	77.1*	74.9
Response rate[3]	81.9	81.1
Cooperation rate[4]	83.4	82.5
Eligibility rate[5]	94.2**	92.4
Sample size	2,571	3,564

*Chi-square significant at p=.0456

**Chi-square significant at p=.0129

[2] *Completion rate*—ratio of completed interviews to the total number of physicians sampled in each group

[3] *Response rate*- ratio of completed interviews and ineligible physicians to the total number of physicians sampled in each group

[4] *Cooperation rate*- ratio of completed interviews and ineligible physicians to contacted physicians in each group (those who completed interviews, were ineligible, or were located nonrespondents)

[5] *Eligibility rate* –ratio of completed interviews to the sum of completed plus ineligible interviews

for a small number of physicians in each group who died, retired, or were otherwise unable to complete the interview, eligibility was determined by three screening questions: [6]

- Are you currently a full-time employee of a federal agency such as the U.S. Public Health Service, Veterans Administration or a military service? IF YES TERMINATE
- Are you currently a resident or fellow? IF YES TERMINATE
- During a typical week, do you provide direct patient care for at least twenty hours a week? [**(If necessary, say:)** Direct patient care includes seeing patients and performing surgery.] [**(If necessary, say:)** Include time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. Exclude time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day.]

Although the survey contractor file did not distinguish among these three reasons for ineligibility, it was unlikely that very many physicians who were providing patient care and eligible for the survey in 1998-1999 had become federal employees or residents by the time they were called again in 2000-2001. Consequently, we assumed that most of the ineligible physicians in the experiment were no longer providing patient care for at least 20 hours per week.

What could have caused a greater fraction of prepaid physicians to say they typically provide patient care 20 hours per week than those who were promised payment after completing the interview? One possibility is that the incentive affected the behavior of physicians providing patient care for approximately 20 hours per week. When asked the screening questions at the beginning of the interview, these physicians could just as easily say they were eligible as ineligible, but receipt of a $25 check prior to the interviewer's call

[6] Of the 123 prepaid ineligible physicians, 83.7 percent were categorized based on responses to the three screening questions in the interview, with the remainder classified based on information obtained outside of the interview (e.g., deceased, retired, out of the country). Among the 221 ineligible physicians promised payment, 85.5 percent were classified based on the three screening questions.

may have induced more physicians to say they were eligible than a promise of payment after completion of the interview.

We tested the possibility if a behavioral impact by comparing hours spent in patient care during the physician's last week of practice between eligible prepaid and postpaid physicians completing the interview (see Table 3). While the mean and median hours spent in all medical activities and in patient care (a subset of all medical activities) are virtually identical for the two groups, prepaid physicians were more likely to practice 20 to 30 hours per week during their last week of practice. This suggests that the higher eligibility rate for prepaid physicians may have resulted from an increase in the proportion of physicians providing patient care slightly more than 20 hours per week compared with those who were promised payment after completing the interview.

It also is possible that other factors may have confounded the experimental design. The difference in eligibility rate between the treatment and control groups may have been due to practice or demographic characteristics that interacted with experimental status. This could be tested with a regression model including factors related to eligibility and a dummy variable representing experimental status. While we will examine this possibility in additional analysis, the key issues here are that prepayment did not significantly increase the response rate and may have affected the composition of the survey sample by increasing the eligibility rate, a potentially serious problem for a longitudinal survey. [7]

[7] We also examined differences in participation rates separately for primary care physicians and specialists, respectively; the results were similar for both groups but the differences were not statistically significant for the smaller sample sizes.

TABLE 3

HOURS WORKED IN ALL MEDICAL ACTIVITIES AND IN PATIENT CARE DURING THE PHYSICIANS' LAST WEEK OF PRACTICE PRIOR TO THE INTERVIEW BY TYPE OF INCENTIVE

Hours worked during last week of practice prior to interview	Type of Incentive	
	Prepayment	**Promised Payment**
All medical activities		
Mean	53.1	53.0
Median	50.0	50.0
Patient care activities (subset of all medical activities)		
Mean	45.5	45.8
Median	45.0	45.0
Distribution (percentage)		
Less than 20 hours	1.7	1.7
20 to less than 30 hours	9.9*	8.3
30 to less than 40 hours	19.0	20.2
40 and more hours	69.3	69.7
Missing	0.2	0.2
Sample size (completed interviews)	1,983	2,670

* P-value of the chi-square test =0.057

Number of callbacks and time required to resolve sample. Prepayment is expected to reduce the number of callbacks to complete an interview, thereby reducing cost. Receipt of payment prior to the initial call also is expected to increase receptiveness to the interview, resulting in more interviews completed during early calls and reducing the length of the field period. Both of these hypotheses were supported by the results of this experiment.

Prepaid physicians required somewhat fewer calls and less time in the field than those promised payment (Table 4). The median number of calls for prepaid physicians who completed interviews was five compared with six for those who were post paid. Similarly, the median number of days required to complete an interview was 41 days for prepaid physicians compared with 61 day for those who were promised payment. The mean number of calls and days between first and last call also were greater for physicians completing interviews who were promised payment compared to those who were prepaid.

The main impact of prepayment was during the first several calls (Table 5); as the number of calls is increased, the impact of prepayment on the response rate declines. The difference is approximately four percentage points at 10 calls, narrows to slightly more than one percentage point at 15 calls, and changes very little thereafter. The change in the response rate is shown graphically in Figure 1.

Cost effectiveness. Prepayment clearly reduced the level of effort to complete interviews with physicians in the panel. The mean saving of .55 call per sampled physician translates into a cost savings of $2.85 per sampled physician.[8]

[8] To estimate the cost saving, we first computed the variable cost per interviewer hour of labor (interviewer labor, supervision, telephone and computing costs and related indirect costs divided by total interviewer hours). Labor time per call was computed by subtracting time

TABLE 4

NUMBER OF CALLS AND NUMBER OF DAYS BETWEEN FIRST AND LAST CALL BY TYPE OF INCENTIVE

	Mean		Median	
	Prepaid	**Promised**	**Prepaid**	**Promised**
Number of calls				
Completed interviews	7.44	7.94	5*	6
Ineligible interviews	4.26	4.49	3	2
Refusals and other nonresponses	16.64	17.38	17.5	19
Unlocated	2.04	1.98	1	0
Total sample	8.70	9.25	6**	7
Number of days between first and last call				
Completed interviews	83.76	96.37	41***	62
Ineligible interviews	55.75	60.47	8	5
Refusals and other nonresponses	295.13	307.62	349	363
Unlocated	41.2	41.17	0	0
Total sample	116.2	129.63	57***	91

* P-value of Wilcoxon Mann-Whitney test <.01

**P-value of Wilcoxon Mann-Whitney test <.001

*** P-value of Wilcoxon Mann-Whitney test < 0.0001

(continued)

conducting completed and ineligible interviews from total interviewer labor and dividing by the number of calls. Excluding time spent conducting interviews, the cost per call ($5.18) is the product of the cost per hour of interviewer labor and labor time per call.

TABLE 5

CHANGE IN RESPONSE RATE BY NUMBER OF CALLS FOR PHYSICIANS PREPAID AND PROMISED INCENTIVES

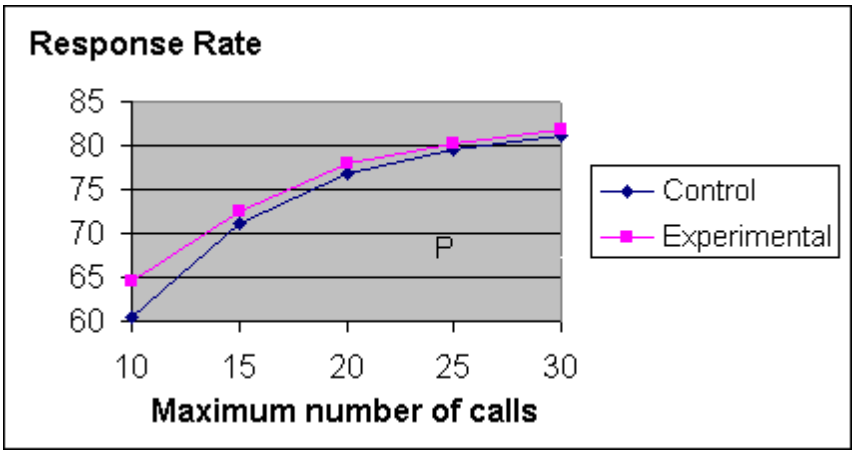
(PERCENTAGES)

Maximum Number of calls	Type of Incentive	
	Prepaid	**Promised Incentive**
Ten	64.6	60.5
Fifteen	72.5	71.2
Twenty	78.0	76.9
Twenty-five	80.3	79.5
Thirty or more	81.9	81.1
Sample size	2,571	3,564

Note: The response rate is the ratio of completed interviews and ineligible physicians to the total number of physicians sampled in each group

FIGURE 1

CHANGE IN RESPONSE RATE BY NUMBER OF CALLS



The added cost of prepayment is based on an estimate of the impact of cashed checks by physicians who did not complete interviews. Since records of individual checks were not readily available, we estimated this cost. For Round 2, when all checks were paid after the respondent completed the interview (promised payment), the cost of incentives per completed interview was $24.95. This cost is based on the amount of checks mailed, less checks that were not cashed, divided by the number of completed interviews. Assuming the cost of promised payments in Round 3 for completed interviews also was $24.95 per completed interview (a reasonable assumption given the size of samples and comparable procedures), the difference between the total cost of Round 3 cashed checks and the product of $24.95 and Round 3 completed interviews is $7,545. Dividing $7,545 by the 2,571 physicians receiving prepayment results in an added cost of $2.93 per sampled physician in the panel from cashed checks by physicians who did not complete interviews. These could be either ineligible physicians who may have felt that their compensation was for the brief screening questions or nonresponding physicians. Since checks typically were mailed to physicians' practices rather than home addresses, office staff may have cashed checks without checking with physicians to see if they completed the interviews. Overall, the net impact of reduced calls and cashed checks by ineligible and nonresponding physicians was negligible – an additional cost of $.08 per sampled physician.

CONCLUSION

Mailing a $25 check to physicians in the panel component of the CTS survey instead of promising payment had a minimal impact on both response rate and cost, but may have slightly increased the eligibility rate and the representation of physicians providing patient care on a part time basis. Since the physician survey is designed to track change over time, even a small change in sample composition resulting from a procedure that has a negligible impact on cost

and response rate is not desirable. It is also likely that the cost of prepayment would increase if the procedure were applied to physicians sampled for the first time or nonrespondents sampled for the next round, since eligibility and response rates are lower for these groups. Consequently, we recommend against prepaying physicians for subsequent rounds of the Community Tracking Study.

However, telephone surveys with accurate information on physicians' addresses and eligibility may benefit from prepaying physicians, particularly if they impose a lower limit on calls. We observed fairly large differences in response rates between prepaid and promised payments if the number of calls were capped at 10.

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EXHIBIT 1

LETTER TO PREPAID PHYSICIANS

Dear Colleague:

Approximately two years ago, you participated in the Community Tracking Study Physician Survey, a major project sponsored by The Robert Wood Johnson Foundation and conducted by The Gallup Organization for the Center for Studying Health System Change (HSC). The study focuses on changes in the health care system and the practice of medicine and how these changes affect patients and physicians. Your willingness to respond to our physician survey helped ensure that our research reflected the views of doctors throughout the country, and I'd like to thank you very much for your assistance.

You may be interested in how the survey is affecting the health care debate. The growth of managed care, changing practice arrangements, and new medical technology are forces that may be increasing the role of primary care physicians. In a recent article in the December 23, 1999 issue of *The New England Journal of Medicine*, HSC researchers used results from the physician survey to report on the changing scope of care expected of primary care physicians. The study found that many physicians – specialists and non-specialists alike – believe the scope of care provided by primary care physicians is increasing. Nearly one-fourth of primary care physicians felt that the scope of care they are expected to provide is greater than it should be. Studies like this one provide policy makers and physicians with the data and analysis to frame appropriate responses to pressing health care issues.

Using data from surveys of physicians, employers, and the general public, we are able to provide sound analysis on a growing body of policy issues. To give you a sense of the health concerns addressed by the study, we have enclosed a brief summary of the work that was later published in *The New England Journal of Medicine*, as well as background about the project. You also may want to view our results by visiting the HSC web site at www.hschange.org**.** If you would like to be added to our mailing list for future research results, please fax your name and address to 202-484-9258.

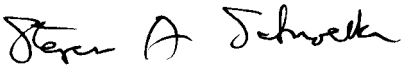
Since the main objective of the Community Tracking Study is to understand changes in the health care system, it is particularly important that we conduct follow-up interviews with physicians who participated in previous surveys. A professional interviewer from Gallup will be contacting you shortly to ask you to participate in the third round of the survey, and I hope that you will agree to do so. The telephone interview takes about 20 minutes and will be conducted at a time convenient for you. If you would like to contact Gallup directly to set up an appointment, please call Donna Stetler at 1-800-274-5447. Although we cannot compensate you for your time, we have enclosed an honorarium of $25 as a token of our appreciation. I hope we can count on your participation.

As I mentioned when we last interviewed you, several physician organizations support the survey and urge members to participate:

American Medical Association
American College of Physicians—American Society of Internal Medicine
American Osteopathic Association
American Academy of Family Physicians
American College of Surgeons
American Academy of Pediatrics

If you have any questions about the study, please call Maureen Michael at The Robert Wood Johnson Foundation at 1-800-719-9419. Thank you in advance for your time and cooperation. I know you are extremely busy and appreciate your willingness to help inform the public debate on health care.

Sincerely,



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Steven A. Schroeder, M.D.

EXHIBIT 2

LETTER TO PHYSICIANS PROMISED PAYMENT

Dear Colleague:

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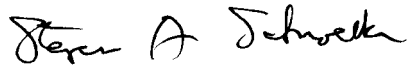

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