How to pay doctors: Ethical challenges and practical considerations in the US

Matthew Wynia, MD, MPH
Disclosure and Disclaimer

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Has no relationships with any proprietary entity producing health care goods or services consumed by or used on patients.

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Before we begin, a reminder:

All policy is health policy

- Virtually every area of public policy has important links to health and health care reform...
  - Economic and tax policy
  - Agricultural and nutrition policy
  - Education policy
  - Environmental policy
  - Transportation policy

- It’s not just about payment reform!

*policy & politics*

Personal Responsibility, Public Policy, and the Economic Stimulus Plan

by Matthew K. Wynia

*Hastings Center Report*  
April 2009
Goals for Today

- Background on the drivers of efforts to reform physician payment
- Options for improving quality and constraining cost growth (Markets, Bureaucracy and Professionalism)
- Research on pay-for-performance
  - Equity
  - Efficiency
  - Reliability/Fairness
- How P4P can threaten, or bolster, professionalism
The Future without Reform
According to the CBO
“I want my coverage to stay the same.”

- Pre-ACA it was clear that significant change was inevitable
- 2010 Towers-Watson Employer Survey
  - “In 2010, 83% of companies have already revamped or expect to revamp their health care strategy, up from 59% in 2009.”
  - “A slim majority of respondents – 57% - are very confident that employers will continue to offer health care benefits 10 years from now.”
    - Released March 9, 2010
Annual Growth Rates, Health Spending vs. Inflation
United States, 1970 to 2010

Notes: Health spending refers to National Health Expenditures. The recent economic recession spanned the period from December 2007 to June 2009.


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Cumulative Changes in Health Insurance Premiums, Workers’ Contribution to Premiums, Inflation, and Workers’ Earnings, 1999-2010

Public and Private Health Expenditures as a Percentage of GDP, U.S. and Selected Countries, 2008


Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada,
<table>
<thead>
<tr>
<th>Overall Ranking (2007)</th>
<th>Australia</th>
<th>Canada</th>
<th>Germany</th>
<th>New Zealand</th>
<th>United Kingdom</th>
<th>United States</th>
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<tr>
<td></td>
<td>3.5</td>
<td>5</td>
<td>2</td>
<td>3.5</td>
<td>1</td>
<td>6</td>
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<tr>
<td>Quality Care</td>
<td>4</td>
<td>6</td>
<td>2.5</td>
<td>2.5</td>
<td>1</td>
<td>5</td>
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<tr>
<td>Right Care</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>1</td>
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<td>Safe Care</td>
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<td>5</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
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<td>Coordinated Care</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Pt-Centered Care</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>1</td>
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<td>5</td>
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<td>Efficiency</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>6</td>
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<tr>
<td>Equity</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>6</td>
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<tr>
<td>Healthy Lives</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4.5</td>
<td>4.5</td>
<td>6</td>
</tr>
<tr>
<td>Expenditures per Capita,2004</td>
<td>$2,876</td>
<td>$3,165</td>
<td>$3,005</td>
<td>$2,083</td>
<td>$2,546</td>
<td>$6,102</td>
</tr>
</tbody>
</table>
"Next, an example of the very same procedure when done correctly."
Medicare Spending, The Physician Workforce, And Beneficiaries’ Quality Of Care

Areas with a high concentration of specialists also show higher spending and less use of high-quality, effective care.

by Katherine Baicker and Amitabh Chandra

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

NOTE: For quality ranking, smaller values equal higher quality.

Health Affairs, 10.1377/hlthaff.w4.184, 2004
“...the value to U.S. employers and workers of the U.S. health system was 23 percent below that of the G-5 countries’ health systems. The bulk of the U.S. value shortfall was attributable to much higher spending in the United States to attain a level of workforce health and care quality that trails the G-5 by roughly 10 percent across 17 measures.”

The Business Roundtable
Health Care Value Comparability Study
February 28, 2009

The Newspaper Summary...

“If the global economy were a 100-yard dash, the U.S. would start 23 yards behind its closest competitors because of health care that costs too much and delivers too little.”

AP Report, March 12, 2009
“Employers are angry, fed up and desperately seeking relief from a system that ranks 37th worldwide in quality of care but costs more per capita than other industrialized nations.”

Bonnie Blackley
Benefits Director, Blue Ridge Paper Products

In testimony to the US Senate, 2008
Employees Pay for Rising Health Care Costs

**Figure.** Changes in Per Capita Health Expenditures and Average Hourly Earnings (Adjusted for Inflation), 1982-2005

Chart borrowed from Emanuel and Fuchs, 2008, *JAMA*

Data are from the Council of Economic Advisers and Catlin et al.
Wages, not corporate profits, are sacrificed to pay for health care.

Productivity and indexed wages 1972-2004

US Corporate Profits with Inventory Valuation Adjustments
(Seasonally-adjusted at annualized rates)

Adjusted corporate profits 1985-2006
How can we improve quality and control costs?

Financial Incentives, Guidelines and Professionalism
### Table 3. Adherence to Quality Indicators of Care and Function.

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of Indicators</th>
<th>No. of Participants Eligible</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall care</td>
<td>439</td>
<td>6712</td>
<td></td>
</tr>
<tr>
<td>Type of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>38</td>
<td>6711</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>153</td>
<td>2318</td>
<td></td>
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<tr>
<td>Chronic</td>
<td>248</td>
<td>3387</td>
<td></td>
</tr>
<tr>
<td>Function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td>41</td>
<td>6711</td>
<td></td>
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<tr>
<td>Diagnosis</td>
<td>178</td>
<td>6217</td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>173</td>
<td>6707</td>
<td></td>
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<tr>
<td>Follow-up</td>
<td>47</td>
<td>2413</td>
<td></td>
</tr>
</tbody>
</table>

Total: 6,465

* CI denotes confidence interval.

### Table 4. Adherence to Quality Indicators, According to Mode.

<table>
<thead>
<tr>
<th>Mode</th>
<th>No. of Indicators</th>
<th>No. of Participants Eligible</th>
<th>Total No. of Times Indicator Eligibility Was Met</th>
<th>Percentage of Recommended Care Received (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter or other intervention</td>
<td>30</td>
<td>2843</td>
<td>4,329</td>
<td><strong>73.4 (71.5–75.3)</strong></td>
</tr>
<tr>
<td>Medication</td>
<td>95</td>
<td>2964</td>
<td>8,389</td>
<td><strong>68.6 (67.0–70.3)</strong></td>
</tr>
<tr>
<td>Immunization</td>
<td>8</td>
<td>6700</td>
<td>9,748</td>
<td><strong>65.7 (64.3–67.0)</strong></td>
</tr>
<tr>
<td>Physical examination</td>
<td>67</td>
<td>6217</td>
<td>19,428</td>
<td><strong>62.9 (61.8–64.0)</strong></td>
</tr>
<tr>
<td>Laboratory testing or radiography</td>
<td>131</td>
<td>5352</td>
<td>18,605</td>
<td><strong>61.7 (60.4–63.0)</strong></td>
</tr>
<tr>
<td>Surgery</td>
<td>21</td>
<td>244</td>
<td>312</td>
<td><strong>56.9 (51.3–62.5)</strong></td>
</tr>
<tr>
<td>History</td>
<td>64</td>
<td>6711</td>
<td>36,032</td>
<td><strong>43.4 (42.4–44.3)</strong></td>
</tr>
<tr>
<td>Counseling or education</td>
<td>23</td>
<td>2838</td>
<td>3,806</td>
<td><strong>18.3 (16.7–20.0)</strong></td>
</tr>
</tbody>
</table>

* CI denotes confidence interval.
More Than Two-Thirds of Opinion Leaders Say Current Payment System Is Not Effective at Encouraging High Quality of Care

“Under the current payment approach, payment is given to each provider for individual services provided to each patient. How effective do you think this payment system is at encouraging high quality and efficient care?”

- Not sure: 2%
- Very effective: 2%
- Effective: 5%
- Somewhat effective: 22%
- Not effective: 69%

3 Basic Ideologies to Drive Quality Up and Costs Down

- Markets – disclose information, give patients greater financial stakes in decisions, and they will choose higher quality, lower cost producers (a.k.a., consumerism)
- Bureaucracy – government establishes quality standards and sets prices (a.k.a., socialism)
- Professionalism – professionals set standards and act as stewards of shared resources

- In reality, we use all three in combination
Consumerism: What happens when patients have more skin in the game?

...families that shifted to high-deductible plans significantly cut back on preventive health care such as childhood immunizations, cancer screenings and routine tests for diabetes.

Markets in Health Care

- Econ 101: Requirements for “perfect” market
  - No imbalance of power (buyer vs seller)
  - Easy entry and exit
  - Complete information about products
  - Known and stable preferences
  - No “externalities” in purchasing decisions

- Also …
  - Increase profits by selling more product
  - People generally want more of the product
“But I don’t WANT to be an informed medical consumer. I liked it better when my only medical responsibility was to stick out my tongue”

Dave Barry
July 12, 1998
Bureaucracy: The Challenge of Government Setting Rules

- Very complex work and products
  - Bureaucratic tools are often blunt
  - Physician and patient discomfort with “cookbook” medicine

- Many interested parties & lots of $$ at stake
  - Near-death experience for one federal agency (AHCPR, now AHRQ), which had been charged with creating guidelines
Professionalism: What is it?

- **Profess**: (v) To speak out in public, openly declare
- **Profession**: A group speaking out, together, about their shared standards and values
- **Professional**: (n) An individual member of the group; (adj) acting in conformance with the standards and values of the group
- **Professionalism**: (n) a belief system (an “-ism”), holding that professional groups are uniquely well-suited to organize and deliver certain social goods.
Professionalism posits that medical professionals, acting together, can monitor and improve quality and constrain costs
- Or at least can do so better than consumerism or the state

What does “professional autonomy” mean?
- Each professional, once qualified, may practice as he/she sees fit, setting their own standards
- The profession, as a group, sets and enforces standards of practice
Pay-for-Performance (P4P) and Guidelines

- P4P is an extra payment for hitting performance targets (or penalty for failure)
- Explicitly or implicitly based on guidelines
  - “Soft” enforcement of guideline, using financial incentives
- Payment can go to an individual, an organization or a group

What are the concerns?
Assigning responsibility (attribution)

- Medicare beneficiaries see a median of 2 PCPs and 5 specialists working in 4 different practices per year
  - Those with DM see 8 MDs in 5 practices
  - Those with cardiac disease see 10 MDs in 6 practices
- 35% of patients’ visits are with their assigned physicians
- 33% change PCP each year
- A PCP’s “assigned” patients are only ~39% of the Medicare patients they see
  
  (Pham et al. 2007)
Equity: What do physicians say?

“Dr. Brook correctly states that the use of physician-specific outcome data would radically change how we practice medicine. Based on his system, I would assess each patient's risk. If it differed dramatically from the "sickness" scale that he proposes, I would consider asking the patient to seek care elsewhere.”


“If my pay depended on A1c values, I have 10-15 patients whom I would have to fire. The poor, unmotivated, obese and noncompliant would all have to find new physicians.”

- Physician in a 2005 survey on P4P (Casalino et al 2007)

“39% of physicians in this study were willing to discharge hypothetical patients who were nonadherent or questioned the physician’s decision-making.”

- Farber et al. JGIM 2007
Could P4P *harm* quality?

- **How:** Neglect of the unmeasured
  - “Incentives based on a handful of measures of quality may encourage physicians to focus their efforts on improving quality in the areas targeted by the programs, neglecting other important aspects of care” (Epstein et al. 2004)
  - Few data to date …
Pay for Performance, Quality of Care, and Outcomes in Acute Myocardial Infarction

Glickman et al, JAMA June 6, 2007

“... the pay for performance program was not associated with a significant incremental improvement in quality of care or outcomes for acute myocardial infarction.”
Effects of Pay for Performance on the Quality of Primary Care in England

Stephen M. Campbell, Ph.D., David Reeves, Ph.D., Evangelos Kontopantelis, Ph.D., Bonnie Sibbald, Ph.D., and Martin Roland, D.M.
Average Overall Performance In Pay-For-Performance And Control Hospitals, Fiscal Years 2004–08.

Werner R M et al. Health Aff 2011;30:690-698

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The long term effect of Premier pay for performance on patient outcomes

AK Jha et al, NEJM, March 28, 2012
Could P4P *harm* quality?

- *Boyd et al:* 79 yo woman with DM, COPD, HTN, osteoporosis and osteoarthritis
  - Follow relevant guidelines: 12 meds, $406/month, complex lifestyle modifications, possible interactions… ?? top quality

- *Fee and Weber:* Of patients not receiving antibiotics within 4 hours for pneumonia, 58.5% not diagnosed before leaving the ED
  - Could prompt overuse of antibiotics
Effects of P4P aimed at hitting target performance level

- Organizations in this area have little hope of gaining the bonus.
- Organizations in this area have an incentive to improve.
- Organizations in this area will get the bonus with no additional work.

Quality

P4P Target
How should we pay doctors so that they will be motivated to provide high-quality care?
How should we pay doctors so that they will be motivated to provide high-quality care?

Assumptions
- The reason we suffer from poorer than desired quality is that physicians aren’t motivated enough.
- Financial incentives will increase physicians’ motivation.
“people expecting to receive a reward for completing a task, or doing it successfully, simply do not perform as well as those who expect nothing.”

- Alfie Kohn, 1994

4 meta-analyses have confirmed “tangible rewards [have] a significant negative effect on intrinsic motivation…”

- Deci and Ryan, 1999

This is a “major anomaly” in economics.
Will monetary rewards increase physicians’ motivation?

- Temporary: Results achieved with monetary incentives don’t “create an enduring commitment to any value or action.” (Kohn 1993)
- Can reduce intrinsic motivation through “external shifting” or “crowding out.”
- Monetary incentives can, and do, backfire if…
  - Interesting work
  - Small rewards
  - Externally controlled reward system
“Increasing external incentives reduces internal motivation… [so the worst problem with P4P would be] “if you ended up with a system where… doctors only did anything because they were paid for it and had lost their professional ethos.”

Martin Rowland, NHS (Health Affairs interview, Sept 2006)
“This is a second opinion. At first, I thought you had something else.”
Conclusions

- Payers won’t keep paying for unclear quality
- Have to pay practitioners and providers somehow…nothing is perfect
- Need to maintain professional locus of control over measure development
  - Physician Consortium for Performance Improvement
We need to study...

- Quality success stories (e.g., VA)
  - Measures of organizational climate?

- Can P4P avoid some problems by...
  - Risk-adjustment
  - “Exception reporting”/exclusions
  - Pay for data collection/reporting
  - Pay for improvement versus hitting targets
  - Pay for QI initiatives - process rather than outcomes
  - Pay for equity, pt-centeredness, safety
As P4P is used, measure...

- Other important outcomes
  - Health outcomes and costs
  - Inequities/disparities
  - Patient trust
  - Physicians’ sense of professionalism
  - Organizational climate
“Paper or plastic?”
Thank You

What questions do you have?

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