

CASE 10

Employers, government, and insurance companies have tried various techniques to control health care costs and to improve quality of care, including pay-for-performance (dubbed P4P for short). Under P4P for doctors, physicians are paid more if their performance measures up to some preset benchmarks, or less if it fails to meet the standard. Physicians may get a year end bonus (or financial penalty if they fail to meet objectives) if they, for example, document that 75% of female patients received mammograms; use electronic medical records; see a set number of patients per day; order 10% fewer MRI's; or if their diabetic patients make 20% fewer visits to the emergency room. Few good scientific studies have been conducted to discover if P4P actually does increase quality.

Payer frustration, spiraling costs, and little progress in improving outcomes or decreasing medical errors, have made quality and cost top health care priorities. Proponents of pay-for-performance medicine point to the well-respected financial reward for corporate executives whose companies do well. In recent years, a variety of quality control measures have been unsuccessful in overcoming the lack of incentives in American health care for quality and cost control. Payments to US doctors and hospitals, traditionally based on provider costs, provided few incentives to improve quality and efficiency. Although the US spent \$2 trillion on health care in 2005, over 40 million Americans do not have health insurance.

Experts disagree on whether the standards should be actual outcomes of care (did the patient get better, survive, etc.) or a list of processes to be followed. Critics and supporters alike ask who should determine criteria and whether performance should be publicly reported. Employers, health plans, quality organizations, physician group practices, and the government currently sponsor over 100 very different P4P schemes, with nearly that many sets of criteria for determining performance quality. All agree that data collection and processing is expensive and that adequate programs for analysis are not yet available. Where should the funds to pay provider bonuses come from? Medicare and Medicaid and private insurance companies insist that they must come from existing funds (to avoid tax or premium increases), but this prospect leads to concern that all of health care will be negatively affected if regular payment to physicians is cut back to fund P4P.

Critics of P4P fear that doctors may be forced to pit their own financial well-being against what is medically best for the patient. Clearly some criteria (increased screening, immunization, education) could improve care for patients. However, other criteria might have the opposite effect (limiting services, seeing more patients), even while they decrease system cost and increase efficiency. Doctors may avoid patients who threaten their 'performance' (e.g., non-compliant, non-paying, or medically complex patients) thereby limiting access to care. If diabetic patients' emergency room visits depress performance scores, doctors might decide not to treat diabetic patients. The doctor-patient relationship may be affected if patients know treatment decisions may impact doctor

compensation adversely. Keeping a bonus in mind, will the doctor decide the MRI is unneeded?

In some plans, the incentive is not just a bonus (about which patients might never know) but also involves a public reporting of the doctor's performance score. One plan noted in its network list which doctors had received good performance scores, in this case based to a great extent on practice efficiency. In addition to raising concerns about fairness, accuracy, and objectivity, this practice can adversely affect performance scores that don't take into account the complexities of individual cases. For example, the performance outcomes of a hospital that specializes in difficult pregnancies and neonatal medicine may have a much higher rate of complications and mortality, despite extremely competent medical care, because the patients present with complicating conditions.

In an article in American Medical News, Dr. Edmund Blum, an internist from Brooklyn, argues that P4P "involves an 'irresolvable conflict' with the ethical standards of the medical profession." He quotes Dr. Faith Fitzgerald who said, "We must not servilely accept gratuities for doing our duty."