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Pay-for-Performance in American Medicine:A Real Solution to the Ills of Healthcare?

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Pay-for-performance in medicine is rooted in a very simple and easy-to-grasp concept: create a financial incentive for physicians and you will see an improvement in the quality and efficiency of healthcare. Barely five years old, pay-for-performance strategies abound across the United States, welcomed by hospitals, physicians and employers as well as large corporations. The media and other leaders are preaching it as a solution to the ills of healthcare.

But does pay-for-performance (P4P) offer a realistic means for improving quality and efficiency in healthcare? Doubts remain about whether this system will actually positively impact quality. The current metrics of pay-for-performance are, by any standard, rudimentary – basic enough to raise doubts about their real impact and the long-term buy-in by physicians and hospitals. And are radiologists really in a position to help the development of these standards to ensure that this system is an equitable one with long-term reach? This article explores the fundamental issues further.

History of P4P

In response to the 1999 Institute of Medicine report about the state of quality in American medicine, companies such as General Electric, IBM, General Motors, and Boeing launched the Leapfrog Group with the aim of disseminating information about quality and creating a payment mechanism that rewarded value and efficiency. The Leapfrog Group settled on three standards for judging hospitals: computerised physician order entry, full-time intensivist staffing of intensive care units, and referral to hospitals with high-volume surgical practices. Hospital compliance with these voluntary standards is published annually in the group's Hospital Quality and Safety Survey.

A second major project began in 2003, when Premier, Inc., a medical centre purchasing alliance, partnered with Medicare in a pilot project following patients with myocardial infarction, knee and hip replacement, congestive heart failure, community-acquired pneumonia, and coronary artery bypass surgery. This project aimed to improve quality in healthcare.

Premier, Inc.'s Hospital Quality Incentive Demonstration (HQID) programme, which began in October 2003 in 260 hospitals, using 33 quality measures in five clinical conditions allowed for plus/minus 2% in Medicare payments. For the first time, there was a concrete incentive for participation. Hospitals in the top 10% will receive an additional 2% in payments, the second 10% will earn an extra 1%, and the lowest 10% can be docked as much as 2%.

Bridges to Excellence, originated by General Electric in 2003, goes one step further by creating a financial bonus system for physicians caring for patients with diabetes and heart disease. By adhering to National Committee for Quality Assurance guidelines, a physician can earn 80 dollars for diabetic patients and 160 dollars for heart patients per year.

However, on February 1, 2005, Dr. Mark McClellan, the Director of the Centres for Medicare and Medicaid Services, announced that ten physician groups would be enrolled in a pay-for-performance trial, dubbed the Medicare Physician Group. Dr. McClellan has estimated that, by 2012, 20 - 30% of federal provider payments will be made on the basis of pay-for-performance, a resounding endorsement for the system.

Pitfalls of P4P

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The worries about pay-for-performance are growing. For example, the new Medicare Physician Group Practice Demonstration proposes paying physicians more for better results in treating patients with congestive heart failure, asthma, diabetes, depression, and other conditions. In the descriptions of the individual project goals, much emphasis is placed on collaborative care. Why then is no mention made about compensating other members of the healthcare team? In a profession in which teamwork is the cornerstone, how will this be justified and how will this impact the morale of colleagues?

Also, most physicians practice at more than one hospital, and nearly all participate in multiple insurance plans. If each pay-for-performance programme necessitates an incompatible information system, this could pose an insurmountable burden, particularly on small practices. Further, the very hospitals struggling to keep up with information system investments and human resource needs may be the ones receiving less compensation.

In addition, computerised physician order entry and intensivist staffing are expensive, and without tangible returns, hospital executives were reluctant to invest in these programmes. It is simply unrealistic to expect that low-volume surgical hospitals are going to answer a survey that recommends diverting their patients to higher volume facilities.

Additional Pitfalls Pose Problems

Socioeconomic status means that the poor are much more likely to have lower baseline scores on measures such as breast, cervical and colorectal cancer screening, hypertension control and immunisation rates. How then will these populations meet the targets of most pay-for-performance programmes? Is it fair to financially punish the physicians and hospitals who care for these patients?

Also, in the Hospital Compare database, facilities are compared based on the time between the diagnosis of pneumonia and the initiation of antibiotic therapy. Who makes the call on the diagnosis of pneumonia? The paramedic? Senior resident? Attending? Does someone in the emergency room trigger a stop watch? And what about patients with other infections. Will hospitals shortchange other patients in their race to meet targets? Clearly, there remain significant holes in the P4P proposition.

Conclusion: Is P4P the Answer?

The arguments for pay-for-performance are persuasive, and as with any process, determining whether or not the pros outweigh the cons can only be an ongoing process. But many outputs of the healthcare industry are difficult to define, much less measure. P4P programmes have the potential to reward radiologists not only with direct bonuses, but through increased referrals from primary care physicians who may need to order tests to meet their own P4P criteria. However, it is unclear how P4P will evolve in the next few years or even how it will impact healthcare in the long term.

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