COST EFFECTIVE MEDICINE *versus* PATIENT-ADVOCACY DRIVEN HEALTH CARE

By Richard O. Dolinar, MD

Pay for performance: treating physicians as pets

DOGS COMPETING each year at the Westminster Kennel Club Show are impressive. They represent the American ideal of what a pet should be, performing tasks expertly and on command while their trainers discreetly feed them treats at each turn. It is the essence of pay for performance – jump through a hoop and get a reward.

A pay for performance (P4P) approach to delivering health care will position U.S. physicians as pets – receiving compensation for jumping through bureaucratic hoops, rather than for using clinical judgment to provide quality patient care.

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By incorporating rhetoric such as "evidence-based medicine" and "best practices" into P4P schemes, proponents are creating the false impression that such an approach would improve the quality of healthcare, promote market-like competition and control costs. But the opposite is true, because the foundation of P4P is fundamentally flawed.

Let us begin with the concept of evidence-based medicine. The term "evidence," better suited to the practice of law, has inappropriately entered the lexicon of medicine. Lawyers use "evidence," but doctors use "data." The difference is more than semantics. When the term evidence is applied to medical data, it imparts a certitude to that data which it may not necessarily possess.

Evidence is decisive; it doesn't change. However, data can change and, in fact, is often very fluid and constantly evolving. An example of evidence would be a video of someone robbing another. That video isn't going to change. But data can change, as we develop more advanced instruments with which to gather it. More importantly, interpretations of data can not only conflict with one another but also change over time as our understanding of the human body advances. Data and statistical analysis never prove; they merely let you speak in terms of probabilities.

Based on this fluid and ever-evolving body of knowledge, so-called best practices and guidelines are being constructed in concrete and then promulgated as a standard for patient care. But how is "best" defined and who decides? The physician? The patient? A third-party payer? If a particular therapy is best for a group, does that mean that it is necessarily best for an individual?

Best practices and guidelines – based on so-called "evidence" – can actually put patients at risk and institutionalize mistakes. This happened a few years ago when one insurance company declared that based on "evidence," the "best practice" (and the only statin drug that it would cover when statin therapy was first initiated) was Baycol. Within two years, however, Baycol was removed from the market due to adverse events. Consider the large number of patients who were exposed to this drug, without choice, because of this "best practice" mandate.

Further flawing the P4P paradigm is a reimbursement system based on "outcomes measurements." Patient outcomes are not necessarily a sign of a physician's skill, because patients don't always respond in the same way.

For example, two patients with pneumonia treated exactly the same way with penicillin can have very different outcomes. One might respond favorably and recover; the other might have an anaphylactic reaction and die. Same disease, same treatment, but very different outcomes.

Nor do patients necessarily follow the treatments that their doctors prescribe. Some don't fill their prescriptions. Others fill them, but do not finish taking them. In a P4P scenario, the doctor's income is put at risk if the patient does not follow through. Doctors can't control their patients any more than weathermen can control the weather. What if weathermen were paid on a P4P basis, with bonuses for sunshine and deductions for hurricanes?

Even if it were possible for physicians to somehow force their patients to comply, would rewards really be effective? According to Alfie Kohn, author of Punished by Rewards, the answer is no.

"… not a single controlled study has ever found that the use of rewards produces a long term improvement in the quality of work," Kohn writes. "In fact, experimental simulations continue to suggest that the opposite is true…those individuals who are committed to excellence and likely to do the best work are particularly unlikely to respond to financial incentives. Financial incentives regularly produce short-term quantitative gains in performance (how many, how fast, etc.) but only if the tasks are simple." Kohn also found that those gains disappear if one looks at quality.

Physicians are already under many immense pressures to do their best. The first and most powerful is that they are treating a fellow human being who has come to them seeking relief from pain and suffering. They face the intellectual challenge of finding the best treatment for that patient. There is also pride and reputation – rising to the occasion and proving to yourself and to others that you are skilled enough to solve the diagnostic riddle or correct the problem. And if that were not enough, there is always a plaintiff's attorney with a "retrospectroscope" waiting to critique your every decision.

Given all of this, will throwing the physician an extra financial bone make performance even better? As a practicing physician, I think not. In fact, such financial rewards could make physician performance worse. Basing payment on behavior will add another layer of complexity to the patient-doctor relationship. After evaluating the patient, the doctor will invariably consider the impact of this patient on his own livelihood. Will this patient have a positive or negative impact on his "rating?" If a poor outcome is likely, and could negatively impact his personal income, would that doctor be more likely to refer the patient to someone else?

With compensation hinging on adherence to protocols and guidelines, physicians will be pressured into becoming highly skilled at adhering to them. Automatic practitioners of government-prescribed behaviors, focusing on the specific tasks that are linked to financial rewards, will replace doctors who are skilled in combining multiple sources of knowledge with their best medical judgment in providing patient care. They will jump through the hoops and receive their treats.

Pay for performance may be effective in developing the ideal pet. But it is a far cry from developing the ideal health care system. AM

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Dr. Dolinar has testified before the U.S. Senate Subcommittee on Consumer Affairs and has also given Congressional briefings on Capitol Hill regarding healthcare issues. He represented the American Association of Clinical Endocrinologists (AACE) at the public hearings regarding the Medicare Modernization Act of 2003 and the Medicare Drug Benefit. He has also presented to State Legislators as well as various healthcare industry professionals. Dr. Dolinar has been interviewed by both the local and national media, including CNN, CBS and PBS regarding his opinions on healthcare issues.

A published author, in both professional and consumer publications, his articles and opinion pieces have appeared in *The Wall Street Journal*, *USA Today*, *The New York Times*, *The New England Journal of Medicine*, *JAMA (Journal of the American Medical Association) Diabetes Research* and the *Indiana Health Law Review Journal*. His articles have also appeared on various web sites including The Heritage Foundation. He is co-author of the book, *Diabetes 101*.

Dr. Dolinar is a member of the Board of Directors of AACE and serves on its National Legislative and Regulatory Committee. He is the Chair of its Future of Healthcare Committee. Dr. Dolinar serves as a Senior Fellow in Healthcare Policy at the Heartland Institute and has held leadership positions in other professional organizations including the Juvenile Diabetes Research Foundation and the American Diabetes Association. He is also on the Editorial Advisory Board for *Endocrine Today*.

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