For love or money?
Alternative methods of paying physicians.

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Abstract

The way physicians are remunerated has direct effects on the type and quality of health care provided. The type of remuneration scheme used depends on what it is trying to achieve and on what motivates physicians. Based on theory and current international evidence, it is argued that fee-for-service payment, as is used in Australia, can be inefficient and inflationary. A plurality of payment schemes and blended/mixed physician payment is proposed as the best way forward.

This is a short paper written specifically for this conference.

1. Introduction

A key area of health expenditure is the reimbursement of services provided by physicians. In 2004 1.2% of GDP ($9.2bn) was paid to physicians through Medicare fees. In per capita terms, this represents a nominal growth of 23% since 2000 or almost 6% per year. The treatment decisions made by physicians, such as prescribing, referrals and diagnostic tests, indirectly determines the level of most other types of health care expenditure. Cost control, even in an era of a large budget surplus, is a key objective of any government. However, cost control as an objective on its own does not guarantee efficiency, particularly where quality and outcomes are not routinely measured, and where there are incentives for government and health care providers to shift costs onto patients and other organisations.

The methods through which physicians are paid have been shown to influence the decisions they make, and therefore the quality and costs of health care provided. The existence of well recognised and researched variations in medical practice provides some evidence of the existing inefficiency in the health care sector (Anderson and Mooney, 1992). The existence of market failure in health care, particularly the imbalance of information between physicians and patients, places physicians in a potentially powerful monopoly position. The existence of fee-for-service payment plus the ability of physicians to set their own prices, and to a certain extent determine the volume of service provided, gives physicians in Australia full discretion to exploit this monopoly power if they so wish.

The aim of this short paper is to examine the role of FFS payment and suggest options for the reform of physician payment in Australia. The paper is concerned with how physicians receive their remuneration, rather than higher level funding arrangements. In practice, any type of third party payer, from the Health Insurance Commission to proposed managed care or social insurance models, can adopt different payment schemes for the physicians it contracts with.

2. Problems with FFS

There are a number of issues with FFS payment which deserve further attention. These can be illustrated with the following quote.

"That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity"

(George Bernard Shaw, The Doctor's Dilemma, 1911)

The first issue raised is the objectives of the patient when visiting a physician. What do patients want from their physician? Better health is a clear objective, depending on how it is defined, but there are other possible outcomes that can influence a patients' welfare, such as the provision of information and reassurance, and also the process by which treatment is delivered, such as whether a procedure is invasive or not. To link these objectives to a payment scheme requires that they can be both measured and attributed to the physicians' actions. A 'fee-per-health improvement' would be the ideal payment payment system. However, the health status of patients is not routinely measured before and after they receive a treatment. The only outcome that is routinely measured is death. Even if an improvement in health could be measured, it may be difficult to attribute this to the actions of the doctor, given the many other factors that influence health status. Attribution may be easier where there is good evidence from clinical trials that links a health intervention to better health. However, this evidence-base is far from complete. The number of services is the usual metric of FFS systems. This is easily measurable, but its relationship with quality and outcomes is uncertain, although is very strongly related to physicians' incomes.

The second issue that is raised by the above quote is the motivation of physicians. If they were purely motivated by self-interest and money and, in the above quotation, other

alternative treatments attracted a lower fee, then physicians would undertake many amputations. However, one would hope that some physicians also care about their patients' welfare, and would adopt a more conservative practice style that is more closely aligned with the patients' best interests. Some physicians would therefore trade off a higher income for the benefit of patients. This highlights the fact that many doctors are likely to act in patients' best interests anyway – they have intrinsic motivation. If this is the case, then there is no need for such a complicated fee schedule. The nature of ands variations in physicians' motivations should therefore determine the type of remuneration system used.

A key issue here is the absence of evidence for many health care interventions. In many disease areas there are a number of alternative treatments that could be pursued (including doing nothing) but there is little or no evidence to guide physicians' recommendations. In the case where there is discretion as to which treatment to recommend, then in a FFS system the physician is likely to recommend the most highly remunerated option. The absence of an evidence-base combined with FFS payment is a recipe for inefficiency.

FFS also creates a culture where new technologies require new fees. Because some physicians are extrinsically motivated, this means they will not provide services even where there is clear benefit to patients. There is a propensity to add on services and fees as technology advances rather than replace services. This less likely to happen in other types of remuneration system.

The ability of physicians to determine the level of their own fees means that costs over and above the Medicare reimbursement are passed onto patients. Although patient charges are not new in Australia, there is much evidence to suggest that those who are deterred from using the health care system are more likely to be relatively poor and in worse health, i.e. those most in need of health care. FFS and physicians' ability to set fees and determine the volume of care provided, means that although user charges reduce demand, they do not reduce physicians' incomes. Health care costs are higher and fewer

patients are being seen. This also depends on the responsiveness of demand to changes in patients' out of pocket payments.

3. Alternatives to FFS

The economic theory of incentives argues that in complex jobs and where quality and outcomes are difficult to measure, then FFS payment is likely to be inefficient Prendergast, 1999; Burgess and Metcalf, 1999). This is because the costs of contracting and monitoring are too high, and because physicians will only do what they are paid for (Eggleston, 2005). In a complex job, it is therefore difficult to determine a fee schedule that will be efficient.

This largely theoretical literature is suggesting that a mixed system of payment or a salaried payment accompanied by subjective performance review, and with incentives for effort provided through the career and promotion structure, may be more efficient.

There have been almost 30 years of international empirical research into physician payment systems, and a number of reviews of this literature have been published (Gosden et al., 2001; Gosden et al., 1999; Robinson, 2001). Compared to salaried and capitation payment, FFS has consistently been shown to lead to a higher volume and intensity of care being provided. What this literature has yet to show, however, is whether this represents 'too much' care or overservicing. For this, it is necessary to examine the effect of different payment systems on the health outcomes of patients. This is a key area where the literature is lacking. Capitation payment, where physicians are paid according to the number of patients they are responsible for, has been shown to lead to low levels of health care provision and a more conservative approach to treatment by physicians. Salaried payment has again shown lower levels of treatment provided in comparison to FFS, although there has been no empirical research on the role incentives contained within salary scales and careers.

In order to avoid the more extreme opportunities to provide too much or too little care, blended or mixed systems of remuneration have been advocated as the way forward (Robinson;, 2001; Eggelston, 2005). This might involve a number of elements.

i) A proportion of income that is fixed, with an additional element to reflect experience or seniority. This may be paid to all physicians providing a 'core' set of agreed services and to minimum standards. Alternatively it could form the basis of a salaried system of payment. This fixed element could also be determined by capitation payment, which is perhaps more suitable for GPs rather than specialists.

ii) The addition of a FFS element is desirable if fees can be linked to health improvements (e.g. immunisation) or to evidence-based guidelines of good practice in certain priority disease areas (e.g. prescribing in coronary heart disease, chronic disease management), where they exist.

iii) The addition of 'non-core' payments for services that physicians can choose to provide, such as after hours care.

A further aspect of alternative payment schemes that has not been researched in health care is the role of the payment scheme in influencing the relative attractiveness of jobs for physicians. Workforce issues are a key area in Australia and other countries, and it is important to examine how the payment system can influence recruitment and retention. The level of expected future income has been shown to influence recruitment into certain specialties in the U.S. The type of remuneration scheme is also likely to influence recruitment and retention into geographical areas, as it will influence other non-pecuniary job characteristics. It may therefore be necessary to have a plurality of payment schemes in existence, such that physicians can choose to be salaried employees for example. This may be beneficial in rural areas and will help retention. It may also be beneficial for those physicians who desire more flexible working hours, or who do not want to run a small business or bear the costs of the red tape associated with FFS payment.

4. Conclusions.

Fee-for-service payment is widely regarded as being potentially inefficient and inflationary. Any proposed alternative payment system for physicians should follow a number of principles.

Where possible, remuneration should be linked to performance in terms of patients' health outcomes. This requires the linkage of evidence-based clinical guidelines and standards to the payment system. This will not be achievable for many disease areas. A blended or mixed system of remuneration should be used to avoid the extreme incentives of under or over-servicing. The remuneration system should also be tailored to reflect the different motivations of physicians. A plurality of payment schemes should therefore be available for all physicians. And finally, there should be experimentation and rigorous evaluation of any new payment schemes.

5. References

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