

Patient-Centered Pay for Performance: Are We Missing the Target?

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To date, the pay-for-performance dialog has been driven largely by payers, working with the advice of clinicians intent on improving the technical performance of healthcare providers. The overarching premise has been that there is a misalignment between what we, as a society, pay for healthcare and what we get, as measured by clinical outcomes or adherence to clinical guidelines. Another assumption is that financial incentives can be used to drive better outcomes. While hard outcomes are the gold standard, they are hard to measure. Therefore, process measures, such as providing the right drug at the right time, are thought to be the best indicators of a good outcome.

Are good outcomes really what patients think about when they seek a good care provider for themselves or their family? Clearly, patients expect good outcomes just like they expect safe car trips and airplane rides, but will they pay more or less if they get outcomes that are outside of what they expected? Presumably, patients who pay for performance will pay differently for providers whose performance they value. Healthcare providers who expect payment to be linked somehow to performance need to assess if the elements of performance they are focusing on are the ones that will drive real economic differentiation. Based on this reasoning and the research that has been done to-date, it is unclear whether current pay-for-performance initiatives live up very well to a patient-centered pay-for-performance world.

PATIENTS ARE THE ULTIMATE PAYER

Healthcare today has an indirect payment system. Patients pay 13 percent of all national healthcare expenses and pay about 23 percent of all privately insured care out of pocket (Smith et al. 2006). Also, they pay about 15 percent of physician care out of pocket, but only 3 percent of hospital expenses (Smith et al. 2006). However, these third-party payers ultimately reflect the will of employees or taxpayers, who in turn reflect patients' values. For example, one has only to look at the demise of the gatekeeper as a cost-containment strategy to see that patients' desire for direct access to specialty care trumped the payers' best advice on how to contain rising healthcare costs. Similarly, employers that offer insurance with a limited choice of providers are faced with unhappy employees, even if those providers are shown to be more cost-effective and better performers than the employees' preferred doctors or hospitals.

Government payers face the same challenge of balancing what the public (beneficiaries) think they are "entitled" to with what they are willing to pay for through

their taxes. The current pay-for-performance world principally reflects the priorities of the proximate—the third-party payer. Any substantial pay-for-performance program must embrace the values of the ultimate payers—the patients. This issue is even more confounded by the fact that patients often confuse payment of insurance premiums with direct payments to healthcare providers.

WHAT DO PATIENTS WANT?

Historically this question has been approached from three directions: “What is good healthcare?” “What is a good healthcare provider?” and “What is good-quality healthcare?” Although the context of the questions influences the answers, a great amount of consistency in the dominant themes emerge.

When asked about good healthcare, patients largely think about their physician care first. In fact, in a 2005 survey of 20,000 households, 39 percent of respondents identified a good physician as the most important factor in defining quality healthcare. Only 21 percent cited best treatment options, and 6 percent said good hospitals (Solucient 2005).

There is a long history of social science inquiry into the question of what patients want. An excellent summary of work in this area is presented by Carl Schneider (1998), a professor of law and internal medicine at the University of Michigan, who argues that patients want both care and compassion. When the question is posed specifically in terms of the patients’ perception of their hospital experience, the emphasis shifts to issues of respect and communication. A 2004 J. D. Power and Associates study of 2,350 patients found that satisfaction with the hospital experience was driven (in order of importance) by dignity and respect, speed and efficiency, comfort, information and communication, and emotional support.

In 2004 and 2005, the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services convened 16 focus groups in six cities to ascertain what consumers perceived as important attributes of quality of care in hospitals (Sofaer et al. 2005). They found that consumers favored four domains:

1. Doctor communication skills
2. Responsiveness of hospital staff
3. Comfort and cleanliness of the hospital environment
4. Nursing and hospital staff communication skills

Consumers rated three areas as less important:

1. Pain management
2. Avoiding problems with medications
3. Avoiding problems after leaving the hospital

Findings from this survey were used to guide the development of the Consumer Assessment of Healthcare Providers and Systems—Hospital Survey (H-CAHPS). This standardized assessment of patients' perspective on hospital care is now being voluntarily collected by Medicare and is under consideration for becoming a mandatory requirement for all Medicare-participating hospitals.

When taken as a whole, these results indicate that the metrics of care currently used in pay-for-performance schemes—right care at the right time and place, for example—are not what patients think of as primary drivers of a good hospital experience. In fact, a recent RAND study of adults over 65 years old shows that respondents' global ratings of the quality of care they experienced were not associated with the measures of technical care they received (Chang et al. 2006). Given that patients want both competent care and compassion, the technical aspects of care appear to fit into the competence sphere. Perhaps most patients assume that healthcare providers work at a generally high level of competence. The healthcare industry's long-standing preoccupation with promoting licensing, accreditations, and board certifications among its care providers as proxies for quality supports that patient assumption. Consumers likely would accept a gradient of compassion, but not a range of competence. In other words, technical care is seen as a given characteristic of competence, so any differentiation on quality really reflects factors like communication and respect received.

DOES PAY FOR PERFORMANCE HAVE THE WRONG TARGET?

If patients ultimately pay for care and determine levels of quality largely on attributes such as respect and compassion, not technical proficiency, will they be impressed with current pay-for-performance initiatives? Probably not. In the short run, third-party payers, whose primary goal is cost management, will be given the latitude to use financial incentives to improve technical performance until these efforts impair provider access. Expect patients to be supportive of any effort to lower cost or to improve quality as long as they can see the provider of their choice.

However, basic levels of payment will not be influenced by this dialog. The base payments reflect the value of healthcare compared to the value of non-healthcare services. They are set broadly by the marketplace. In the long term, however, payment is much more likely to align with value as perceived by the patient, rather than by technical proficiency. Patients are likely to assign a minimal acceptable threshold value to technical competency—that is, you can either serve as my provider or you cannot. The real incentive to improve technical care will be to get paid at all. Variable compensation will be tied to the quality of the professional interaction. Passengers who buy a plane ticket expect a high level of proficiency from the pilot, the aircraft, and the ground crew regardless of how much they pay for the ticket. Passengers, however, willingly pay more (i.e., first class) for wide seats, good food, and the right to get on and off the plane first.

FUTURE OF PAY FOR PERFORMANCE

In a more patient- or consumer-centered healthcare world, expect pay for performance to thrive. However, in the future, performance will be defined much differently than it is today. Regardless of how much society pays for healthcare out of pocket, expect that more attention will be paid to nontechnical aspects of care. If doctors and hospitals want to know what the pay-for-performance system of the future will be like, all they need to do is imagine how they personally treat other service providers today and then ask whether they are ready to treat themselves that way.

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