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Compensation And Quality: A Physician’s View

Linking physician compensation to quality is akin to the quest for baby bear’s porridge in trying to get it just right.

by Eugene S. Ogrod

Does physician compensation affect quality? I think yes but do not know exactly how. The literature does not guide us. Published articles primarily describe payment methods or speculate as to their impact on quality. Much of the endless political debate is trading salvos by advocates for or against a particular mode of payment.

Practicing in a large multispecialty group practice has taught me that assembling the elements of a physician compensation package seems simple but is immensely complex. Nothing gets attention more quickly than the potential of a compensation package to alter the paycheck. Our latest compensation plan, adopted in January 1996, has already been modified with more than one major change. In February 1997 the primary care component was substantially replaced. The changing marketplace, unintended consequences of our calculations, inadequate data, and the need to reward special or new services that align physician behavior to patients’ needs and satisfaction all require adjustments to physician compensation. I have labeled the process “the quest for baby bear’s porridge,” trying to get it just right.

Factors That Affect Physician Compensation

Physician compensation is affected by factors that are unrelated to physician work effort, quality, or revenue. While workforce issues are a discussion for another time, the excess or scarcity of specific specialties in a geographic area profoundly affects the price and availability of physician services. When an insurance carrier negotiates a service for a large geographic area, that service’s rate may be economically sufficient in an urban community but inadequate to sustain the same service in a rural area with a lower volume of patients. Changing technology, shifts in patient demand, and alternative delivery structures all have some impact on the pricing and compensation systems for physicians—and presumably an impact on quality. The effect of technology can be profound. For example, endoscopic procedures have radically decreased hospital length-of-stay and moved procedures into a day-surgery approach. The result is fewer hospital stays and more physician time to perform more procedures or to see more patients.

Social trends affect physician work patterns and therefore compensation. Physicians today expect to have a life outside of patient care, which changes how hard and long physicians are willing to work. Different communities are at different stages of the new managed care environment. Some have even chosen different pathways in the development of managed care systems. These differing pathways and stages of evolution require new solutions to physician payment. We have a limited understanding of how these market changes and approaches to compensation affect the delivery and quality of care. Thus, before we even approach the question of quality, an extraordinary range of factors have already shaped how phy-

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Physicians are compensated and what elements of compensation can be adjusted for issues of quality.

**Definitions Of Quality**

What is quality? This question is endlessly debated in the literature. For our purposes, consider some definitions that are relevant to compensation.

1. **Technical quality** focuses on the intellectual or mechanical skill needed to achieve certain results from medical or surgical intervention.

2. **Outcomes quality** defines quality in terms of the ultimate impact on the patient.

3. **Process quality** is partly a reflection of our inability to measure some long-term outcomes. For example, we can require that diabetics have appropriate eye examinations to avoid the long-term effects of diabetes on the eye.

4. **Service quality** is increasingly being requested by plans and patients. Patients desire convenient service, politeness on the telephone, attention to their questions, and educational information. A key element of service quality is access. How many days does it take to get a routine appointment? How promptly is a referral obtained for subspecialty care? Can you get access to a physician at night and how fast? How many hours does it take for a physician’s office to return your call?

5. **Physician standards** refer to a minimum level of training or skill that is assumed to be a determinant of quality. One example is board certification, touted as an important factor. Yet, there is very limited data correlating board certification with long-term physician practice quality.

**Linking quality to payment.** If we are to pay for quality, which definition of quality is intended? Among the above definitions, which are the most important? Is there a clear, accurate measurement that is sound enough to make the paycheck depend on it? Which aspect of quality should receive the greatest reward? No one has complete answers to these questions. Outcomes quality, in theory, should be among the more important, but it is very complicated. The individual physician may be retired long before outcomes are known in some patients. Many patients have more than one disease or condition, which makes outcomes even more difficult to measure. Linking physician compensation to outcomes measurements is a desirable goal, but the long-term nature of many outcomes makes rewarding present behavior difficult.

A huge amount of research will be required to provide information that is practical in determining physician payment today. We are accustomed to measuring process quality for which a physician is paid for a certain episode of care or for providing a specific intervention such as health screening. Even service quality becomes complicated. Surveys of patient satisfaction must be constructed carefully. The outcome can vary significantly depending upon the structure or technique used. Office staff behavior may have a greater impact on a patient’s perception of service quality than physician behavior has. Good service might involve a physician’s staying after hours to take care of an extra patient or two who need to be seen that day. This sounds nice and responsive until you begin to translate an after–five o’clock decision into time-and-a-half for staff and employees. The increased cost of care that results may not be balanced by revenues to sustain it.

**Measuring quality.** Payment for quality presumes availability of data for measurement of quality. What measurements are required to assess quality of care? We clearly need some measurements of patient behavior and characteristics. Does a patient tend to be compliant in following medical advice? How old is...
the patient, how sick, and what other illnesses does he or she have? We need diagnostic subcategories that define subsets of patients and a way to measure illness severity. Severity indices are complicated to develop. Those in existence are still new in their development. Defining an episode of illness may seem simple but is not easy in patients who have ongoing chronic disease or multiple diagnoses. Such data are necessary before we can determine whether physician intervention makes a difference in the course of a patient’s illness or life. We also need to measure physician behavior. This may mean how skilled they are and how often they see a patient, as well as the range of illnesses or types of patients they see. Services also need to be linked to the specific physicians providing care. This means that we have to tease out the data when a physician on call sees a patient for another partner or a patient is seen by the physician’s nurse practitioner. Tracking both patient and physician behavior becomes a monumental task.

To create another layer of difficulty, insurance plans’ rules and benefits determine to some extent what services are provided to a specific patient. And, unfortunately, we may not even know from month to month whether a patient is still enrolled in a particular plan. In our group practice we recently developed a series of reports on physician activity looking at frequency of patient visits, cost-effectiveness in terms of referrals, scheduled hours and availability, revenue generated, and capitated panel size—all in an effort to define a physician’s practice. Even with all of these data, we found interesting differences among physicians for which we do not have good answers. Cost-effectiveness in terms of physician referrals for a group of our physicians in the Foothills is different from those in the urban part of Sacramento. We assume that this is in part because we have a greater availability of group specialists downtown and a slightly higher cost associated with the need to refer outside of the group in the Foothill region. A compensation system that is meant to encourage a specific cost-effective referral pattern would need a geographic modifier.

- **Rewarding physician behavior.** Physicians are data-driven. They want a compensation system that clearly defines the behavior that is expected and bases the reward on accurate information reflecting that behavior. Unfortunately, a system for rewarding all of these different aspects of quality and behavior creates a very complicated assessment and series of calculations. How do we adhere to the “keep it simple” rule, with complicated data and conflicting demands? We still struggle with the basic and simple question: In paying physicians, which specific behaviors do we wish to reward?

With concern about the total cost of care, demand reduction has become one of the buzzwords for controlling costs. Patients sometimes ask for things that are unnecessary. They may read a newspaper article and ask for a test that is not appropriate for their individual situation. They may have a limited understanding of their disease or condition and seek medical services, when additional reassurance or education is the correct approach. Most compensation systems pay physicians for production, not for patient education or time spent keeping patients from unnecessary care. One of the anxieties we have when we discuss demand reduction is that a line will be crossed and quality will be diminished because patients will not get access to needed services. Demand reduction has a tension built into it that has been recognized but not resolved.

**Physician Payment Methods**

- **Fee-for-service.** Methods of physician payment have been described in many publications. In brief, the fee-for-service approach may include full or discounted pricing. The coding that defines physician work under a fee-for-service system delineates specific episodes of care or behavior, such as a surgical intervention. The resource-based relative value scale (RBRVS) approach has taken the fee-for-service model to a higher level of so-
Phistication. It defines care in terms of total physician work effort as well as overhead costs. However, the kind of work done in modern managed care systems is not encompassed in that coding process. Further, the fee-for-service work-based model takes time to respond to evolving technology, and the RBRVS research effort to refine the process is expensive to maintain. But at this point we have no good alternatives for the measurement of physician work.

We have heard many discussions regarding the inflationary effect of the fee-for-service model. Its one advantage is that there is generally no restriction on patient services, except in terms of ability to pay. In other words, it motivates physicians to provide rather than to minimize care. However, there is an argument that it overemphasizes that dimension.

- **Capitation.** Capitation models are a budget-based system. A global amount of money is set aside, and physicians work within that budget. In my opinion, the greatest risk with both discount fee-for-service and capitation is to have either system overly focused on an individual physician or a specialty. Variations in health care demand are great. By simple luck, an individual physician can be placed at great risk and put under substantial pressure to restrain patients’ access to services while working within a budget or a discounted payment structure. We can try to compensate physicians for some of the variability in demand by accounting for the age and sex of the patient. But that does not account sufficiently for variability in patients’ illnesses. Risk-adjusted systems are as yet quite primitive. Chronic illness may become a better predictor of demand and workload. Despite all of the theory, no one has figured out a severity index that accurately delineates all patients and their illnesses. If a good severity index could be developed, physician payment would move away from global budgeting to payment based on work effort and work intensity.

- **Salary.** Physicians can be paid on a straight salary. Most groups in the private sector have found this approach to be a disaster. Production goes down when there is a straight salary; physicians are guaranteed a level of income that is not tied to performance expectations. Most salary systems now include production and performance standards, hours to be worked, and availability for patient care. Some even include linkages to community involvement and patient satisfaction. In our group practice we are trying to focus on the behaviors we wish to reward, even on a salary. Under a salaried system, individual physicians expect a paycheck on a regular basis. If there is a major change in access to a particular contract in a community, the practice suddenly may have an inadequate number of patients, and yet the physicians will continue to expect their salary. Salaried systems, although they free physicians from the need to over- or underprovide services, do not respond well to rapid environmental change.

- **Global capitation.** The more successful models seem to be global capitation systems. In this model a global capitation budget passes to a physician structure that is usually a large, multispecialty structure spread over a large geographic area. This can be a large integrated health care system, a large single-plan group practice like Kaiser Permanente, or an individual practice association (IPA) with multiple contracts. The key is an ability to spread risk across a large number of physicians so that no one physician is placed at too great a risk economically or in terms of pressure to deal with a particular patient’s illness.

These systems probably have the best ability to provide rational physician compensation while diminishing day-to-day practice hassles and responding to necessary budget restraints. By taking on a global risk, physicians gain some ability to redirect resources in an efficient way to provide appropriate patient care. In some cases we can provide more innovative systems. Global budgeting allows resources for more patient education, specialized services or clinics, case management, and transition programs for patients going from hospital to home. Much can be done to provide and improve the quality of care in set-
tings or programs that reduce overall costs.

**Physician Compensation And Quality: Is There A Link?**

In each of the many kinds of large physician groups, we are still struggling to figure out how to reward specific elements of physician behavior, and compensation arrangements are complex. There are old-style capitation systems that try to capitate individual doctors or pay physicians on a modified fee-for-service basis and then watch them like hawks. Such systems are likely to be unsuccessful in the long term. Four IPAs in the past year and a half have gone bankrupt or were sold in financial distress in northern California. Physicians, whether in a group practice, an IPA, or an integrated system, have to be tightly organized and attentive—not just to managing the quality of care but also to managing the resources for care.

Despite the public debate, there is little objective information that suggests that patients are greatly disadvantaged in one model of practice versus another. Despite incredible pressures with physician workload and diminished availability of resources, patients continue to get good care. To some extent this is explained by an internalized physician ethic regarding the provision of high-quality care. A concern in defining physician compensation has been that we will develop systems that do not recognize the value of this internalized physician culture. More importantly, the values of the profession have to be passed on from one generation to another. These values focus on patient-based concerns, the caring profession, and scientific standards. No compensation model has evolved with enough focus on rewarding the maintenance of these values. So often, time does not even exist to meet some of the junior members of our clinic, much less to assist them in understanding the importance of these values.

Today’s medical environment is still oriented to creating profitability for segments of the health care system, rather than to looking carefully at how to motivate physicians or run a system that considers the physician a focal point for managing the process of care. The global capitation approach returns to the physician a certain amount of responsibility but also flexibility in providing care. Perhaps in that environment, it is possible to preserve what is a fragile culture, despite the revolutionary changes in the medical profession. But we will have to move far beyond the current efforts to fill hospital beds and specialists’ waiting rooms. That is an oft-quoted phrase, but it still determines much of the functioning of our health care system.

It is critical to recall that at the center of this debate are patients. For physicians, interaction with patients is elemental to determining how we feel about ourselves and our workday. When patients are upset and angry about their health plan or access to care, it can be a difficult day. When patients’ experiences with us have been positive, and they reflect that in a quick compliment, that can be a good day. As a practicing physician, I can look at all of the theories about physician compensation and quality and yet understand that to some extent the theory is irrelevant to my day-to-day life. As a physician, I think in terms of what goes on in the office and my waiting room. I am simply concerned that somehow the resources be made available so that I can be permitted to do what I do best, and that is, take care of the folks. In our complicated environment, that is no longer easy.

Physician compensation may affect quality, but, more critically, whatever compensation we provide should not interfere with the basic values of the profession or our ability to develop positive relationships with the persons for whom we are responsible. I tell my young physician partners one simple rule: Just take care of the folks; that is why you became a physician. All the rest will follow.