Payment for Performance in Perspective

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"All things recur eternally…."
Friedrich Nietzsche, *Thus Spake Zarathustra*

ABSTRACT

The purported intent of payment for performance (P4P) is to improve quality of medical care by rewarding it better. This goal cannot, however, be achieved by the method proposed.

Given the history of governmental programs, it is likely that the certain failure of P4P to have the promised result is not just a matter of good intentions gone awry. Rather, the true purpose is probably the achievement of the probable result: reducing expenditures by limiting availability of care, instead of by the economically sound method of restoring a free-market pricing system—while deflecting criticism from government to the private sector. This will expand government control and further corrupt the medical profession. Like previous examples of government-directed science, P4P could have severe adverse consequences.

Past Government Behavior

Before accepting government's stated intentions at face value, physicians should note the observations made by Charlotte Twight:

> Conventional wisdom often views dependence on government as an inadvertent byproduct of benign legislative intent reflecting the will of the people. To the contrary government repeatedly uses transaction costs to achieve results initially inconsistent with actual preferences….
>
> Lying about the nature and consequences of proposals to expand federal authority is clearly one way of raising the costs individuals must pay in resisting them.[1]

It is quite reasonable to suspect that payment for performance (P4P) does not mean what it purports to mean.

Why P4P Cannot Mean Payment for Quality

In practice, P4P must mean payment for compliance with guidelines for the treatment of various conditions. This can constitute payment for quality only if the physician has made the correct diagnosis, and the recommended guidelines constitute the best treatment for the particular patient.

P4P effectively trivializes the prolonged and arduous schooling required of medical doctors. They spend years learning how to diagnose disease, and how to interpret the medical literature in order to tailor specific therapies suited to the unique circumstances of each patient. Professional schooling that inculcates a medical way of thinking, which is indispensable to solving medical dilemmas, is not required to follow the directives of P4P. Technicians can do that—as they must and will in order to judge how to pay the doctor. But the idea that medical care can be packaged into neat boxes, easily sorted out by technicians, displays a lack of understanding of the "knowledge problem" facing physicians.

The knowledge problem is not unique to physicians. Economist Friedrich Hayek wrote extensively about the impossibility of having a committee, such as one envisioned by the proponents of P4P, assimilate the knowledge required to solve any societal problem. He contended that solutions are best left in the hands of individuals who have access to the unique circumstances of "time and place."[2] In the case of medical care, decisions, by his reasoning, are best left in the hands of individuals possessing intimate medical knowledge, namely, one's personal physician.

Recent evidence supporting Hayek's insights has been detailed in an article published in the *Journal of the American Medical Association*. The authors found that P4P guidelines in patients with comorbid diseases recommended 19 doses of medications given five times daily. The recommended nonpharmacologic interventions included monitoring chronic diseases as often as daily, or as infrequently as every 2 years. Some recommendations, such as weight bearing, canceled each other out, being called for in one disease but discouraged in another.[3]

The difficulties in jettisoning Hayek's wise counsel and replacing it with top-down robotic thinking should be apparent.

Arguably, the proponents of P4P got it all wrong when they chose to emphasize treatment guidelines rather than diagnostic acumen. After all, if doctors could unerringly diagnose disease at the bedside or in their offices, multiple referrals to subspecialists and much diagnostic testing could be averted. Demanding greater diagnostic acumen of doctors might yield better results (either in quality gains, or cost savings) than incoherent therapeutic guidelines.

By contrast, proponents of P4P fail to recognize that diagnoses and treatments are not cut-and-dried. Proponents of P4P evince no qualms about their abilities to direct physicians. They profess, haughtily, to know what is best. Worse yet, because P4P stresses therapy rather than diagnoses, doctors whose practices are riddled with erroneous diagnoses might be paid more than peers who are virtually free of diagnostic errors. This logically follows from the fact that treatment, rather than diagnostic skill, determines payment. Scrupulous adherence to the P4P paradigm does not impart diagnostic acumen to a physician, but it may yield hefty undeserved profits.

In short, P4P proponents assume, despite much professed concern over rampant medical errors, that physicians are for the most part error-free when it comes to making diagnoses. In addition, they assume that a diagnosis is a black-and-white given, rather than a fuzzy continuum impacted by innumerable factors that must be taken into account when devising a therapeutic plan. In reality, even a straightforward diagnosis such as cataract presents complications. The therapeutic implications of a moderate 20/50 cataract for a healthy pilot and an elderly nursing home patient are very different.

The concept of P4P as a quality tool is intrinsically flawed because it presupposes that diagnoses can be neatly determined and categorized, and that therapeutic guidelines can therefore be ascertained with confidence. P4P supplants the reality of the human condition with utopian wishful thinking.

The Cost Problem

If P4P doesn't mean payment for quality, what does it mean, and what is its true purpose?

From a practical standpoint, it means pay for compliance, or punishment for noncompliance. Given time, the economic incentives of the P4P initiative will blossom into payment for outcomes. As a practical matter, that means that doctors who fail to achieve government-approved outcomes will be financially punished. What better way for doctors to achieve targeted outcomes

than to avoid the truly sick? This government-sponsored behavior modification program is fundamentally similar to the managed-care paradigm. Both are cost-containment initiatives that place doctors at financial risk for treating the sick.

There is of course a cost problem (or, more accurately, a spending problem), which will be alluded to in most discussions of P4P. This began in the 1940s, when government allowed employers to exclude the cost of medical insurance from employees' taxable income. Employees then erroneously perceived much of medical care to be free. Predictably, spending mushroomed. Correcting the government-created problem by reestablishing transparent prices was probably deemed politically unacceptable. An alternative solution was sought.

President Nixon in 1972, with the strong support of Sen. Edward Kennedy, turned to HMOs to rein in spiraling medical expenditures. This ill-conceived solution initially targeted non-Medicare patients. When it was offered to Medicare recipients it was, by and large, rejected. But government does not readily accept rejection. P4P appears to be an alternate way to place doctors at financial risk for treating the truly sick. Instead of having doctors submit to the "performance" standards of the managed-care industry, they are to adhere to the one-size-fits-all treatment guidelines of P4P.

If government is clever in a Machiavellian sense, it probably recognizes that only a genuine free-market pricing system can solve the problem of cost. It is also probably aware that in the absence of free markets, there is only one substitute: regimentation. But in order to expand its power and continue to dupe the electorate into believing that medical care can be "free," it must extinguish all attempts to restore the market.

How will P4P restrain spending? Expenditures for physician services constitute about 20 percent of national health spending.[4] However, after meeting overhead, physician pay absorbs less than 7 percent of expenditures. This may be approximated from the average pre-tax income of physicians ($150,000), given 660,000 physicians, a GDP of $10 trillion, and health expenditures of $1.5 trillion (G. Smedinghoff, personal communication, 2006). Thus, common sense suggests that physician pay is not the driving force behind the P4P initiative because additional reduction in physician income, even if inevitable, will in itself have little impact on total medical spending. The effect of P4P would be very significant, however, if it altered physician behavior in such a way that the truly sick receive as little treatment as possible.

Government undoubtedly knows that the draconian regimentation methods used by Canada's socialized system would bring the wrath of the electorate to bear on legislators. To avoid the political problem, government devised this seemingly new means of controlling costs while transferring the blame for its eventual failure onto doctors. Spending might be contained, but when disgruntled patients express their dissatisfaction to legislators, the latter can blame doctors because it is they, not legislators, who are crafting the unworkable P4P guidelines.

Shifting blame is nothing new for legislators. For example, government used similar tactics when setting up the Environmental Protection Agency,[5] and with the Federal Reserve. As George Melloan wrote: "Coming out of the travails of the 1970s, politicians began to realize that their careers were safer from voter vengeance if they could escape blame for economic policies gone wrong."[6]

The Corruption of Medicine and Science

But there is a potentially more sinister aspect to the blame game. Doctors who shirk their responsibility can always claim that they were simply following the guidelines. In other words, P4P has the potential of creating medicine's version of the "I was only following orders" excuse for inadequate treatment. Doctors will have an incentive to blindly follow potentially harmful guidelines rather than assume the transaction costs (take the time and expend the effort) required to convince an unwieldy bureaucracy that P4P directives do not apply to a particular patient. If the patient is harmed, the doctor can conveniently transfer the blame to the guidelines. In other words, doctors, just like bureaucrats, will have an incentive to avoid assuming responsibility.

Additionally, P4P has the potential to bankrupt noncompliant doctors. Innovative doctors could be marginalized by governmental exercise of the "power of the purse." We have already seen examples in science. As Michael Crichton explains: "Scientists adjusted their research interests to the new policies. And those few who did not adjust, disappeared."[7, p 578]

Additionally, Crichton expounds on the dangers of politicized science, of which P4P is but another example, citing eugenics and Lysenkoism. "In both cases," he writes, "a preconceived 'public policy' objective drove and therefore corrupted the 'science.' What occurred had the appearance of science … but in fact bore no relation to actual scientific activity." In the case of eugenics, "prominent figures … including Theodore Roosevelt, Winston Churchill and Alexander Graham Bell … approved of the faulty science. The eugenics movement was a social program masquerading as a scientific one."[7, pp 575-580] Likewise, P4P is a social program (i.e. cost containment) having the pretense of being based on rational, objective, quantifiable standards. Like eugenics and Lysenkoism, it is based on the assumption that it is possible to overcome the limitations of the human condition and biology.

Crichton concluded, "The intermixing of science and politics is a bad combination with a bad history."[7, p 580] The problem was not that faulty theories were proposed, but that government was so easily able to convince the majority of scientists, both in the West and in the former Soviet Union, to realign their scientific conclusions with government-approved goals. It may be reasonable to ask whether present-day physicians are not in fact marching in the footsteps of prior generations of misguided scientists who embraced eugenics and Lysenkoism.

Conclusions

Neither diagnostic excellence nor therapeutic guidelines can achieve the desired spending controls. Only genuine free-market prices can rationally allocate scarce resources. By destroying the free-market pricing system, the government created a vacuum that had to be filled. The only known alternative to real prices is government dirigisme. The latter has been put into practice by implementing managed care, which places doctors at financial risk for providing care; coding initiatives, which criminalize physicians for normal business behavior; and P4P, which supplants professional thinking with robotic thinking. The first two pseudo-solutions failed to make an end run around the necessity of a real free-market pricing system. If history is any guide, P4P will also fail.

Regrettably, most doctors have failed to heed the lessons of history. As a result, they have been reduced to putty, which government is unscrupulously molding into non-thinking clones, to sacrifice good patient care and ethical medicine to the government's bottom line and social objectives.

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