

# Issue Brief

## Findings from HSC



### PHYSICIANS MORE LIKELY TO FACE QUALITY INCENTIVES THAN INCENTIVES THAT MAY RESTRAIN CARE

by Jeffrey J. Stoddard, Joy M. Grossman and Liza S. Rudell

Concerns that physician financial incentives may lead to withholding needed care have caught the attention of legislators, regulators and even the U.S. Supreme Court. While the spotlight has been on how health plans reimburse physician practices, this Issue Brief provides unique nationally representative data on physician practices' use of incentives, which have a more direct effect on physician behavior. According to 1999 data from the Center for Studying Health System Change (HSC), physicians are more likely to be subject to incentives that may encourage use of services, such as patient satisfaction (24 percent) and quality (19 percent), than to financial incentives that may restrain care, such as profiling (14 percent). The complexity of physician financial incentives and their relatively low prevalence raise questions about effective regulation and public reporting of their use.

#### Intent of Incentives

With the growth of managed care, health plans and physician organizations have adopted formal financial incentives to influence physician clinical decision making. Critics contend incentives can create a conflict of interest between physicians' personal financial gain and their patients' best interests, which could compromise quality and patient trust. Supporters counter that incentives to encourage cost-effective care are necessary to hold down overuse of services that fuel runaway costs. Approaches such as capitation—a fixed monthly per-patient payment—and profiling are the most controversial because they can potentially lead to the denial of necessary services.

While much attention has been focused on how health plans pay

physician organizations, little is known about how physician organizations pay individual physicians. But, the financial incentives used by practices to determine individual physician compensation are likely to have stronger effects on care delivery, particularly when they are based on the physician's own clinical performance rather than the financial performance of the group as a whole.<sup>1</sup> Physician practices use such approaches to align the interests of individual physicians with those of the group.

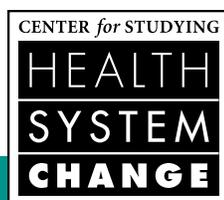
This Issue Brief examines four factors used to adjust base compensation and/or bonuses that reflect how physicians treat their patients. These are productivity (a standard measure) and three performance-based measures: results of patient satisfaction surveys, quality of care measures and profiling

that compares a physician's pattern of medical resource use to that of other physicians.

#### Trends in Use

Most physicians are not directly subject to the types of incentives that are perceived to conflict with patients' interests (see Figure 1). In 1999, physicians in practices of two or more said they are less often subject to financial incentives based on profiling (14 percent), which are more likely to restrain use of services, than incentives based on patient satisfaction (24 percent) and quality (19 percent), which are more likely to encourage use.

Overall, physicians are much less likely to face performance-based

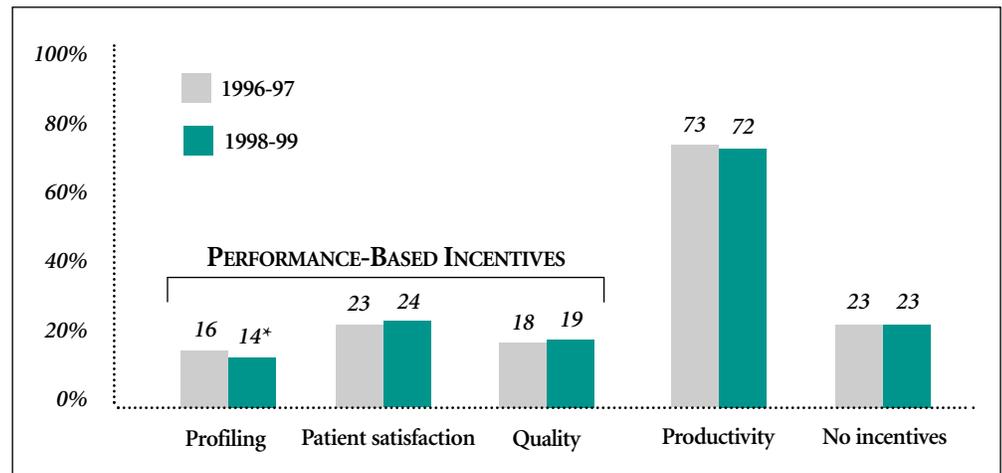




## Data Sources

This Issue Brief presents findings from HSC's Community Tracking Study Physician Survey conducted in 1996-97 and 1998-99. It is a nationally representative telephone survey of non-federal, patient care physicians who spend at least 20 hours a week in direct patient care. The 1996-97 survey included 12,528 physicians and had a 65 percent response rate. The 1998-99 survey included 12,304 physicians and had a 61 percent response rate.

**Figure 1**  
**Percentage of Physicians in Practices of Two or More Whose Compensation Is Affected by Selected Financial Incentives**



\* Significant change at  $p < 0.05$  between 1996-97 and 1998-99.

**Note:** Sample excludes full owners of solo practices, physicians spending less than 60 percent of their time in patient care and physicians practicing in community health centers and city-, county- or state-owned hospitals and clinics. Physicians may be subject to more than one incentive.

Source: Community Tracking Study Physician Survey, 1996-97 and 1998-99

incentives (32 percent) than the productivity incentives that have traditionally been used to determine compensation (72 percent). Performance-based incentives are often used in combination with each other and almost always in combination with productivity incentives. The prevalence in the use of financial incentives has remained remarkably stable between 1997 and 1999, with a modest but statistically significant decline in profiling.

## Differences Across Practice Type

Productivity incentives are widespread and exist across all practice arrangements (see Table 1). While performance-based incentives have not been widely adopted, they are much more prevalent in certain types of practices. Physicians in group/staff-model health maintenance organizations (HMOs) are more than three times as likely to be subject to profiling incentives as those practicing in small or medium-sized groups and are even more likely to be subject to patient satisfaction and/or quality incentives. Physicians in large groups of 30 or more and those in hospital-owned and medical school practices are also significantly more likely to face these incentives than physicians in smaller groups,

but are only about half as likely as group/staff-model HMO physicians to do so.

Pressures to implement formal incentives may be stronger for group/staff-model HMOs, large groups and hospital-owned and medical school practices than for small and medium-sized group practices. This may be because these practices:

- are larger and may have more difficulty monitoring individual physicians informally;
- have greater need to align group and individual objectives since physicians are more likely to be salaried employees; and/or
- are more likely to have health plan contracts with capitation or similar incentives and have more resources and data to develop performance-monitoring systems.

## Capitation and Individual Financial Incentives

Physicians working in practices with higher levels of capitated revenue are more likely to be subject to performance-based incentives than those with less capitated revenue (see Table 2). Those in practices with more than 50 percent capitation are three times as likely as those in practices with no capitation to use

**Table 1**  
**Percentage of Physicians Whose Compensation Is Affected by Selected Financial Incentives by Practice Arrangement, 1999**

PRACTICE ARRANGEMENT	PERCENT OF PHYSICIANS IN PRACTICES OF TWO OR MORE, BY PRACTICE ARRANGEMENT	INCENTIVES BASED ON INDIVIDUAL PHYSICIAN PERFORMANCE		
		PERFORMANCE-BASED PROFILING	PATIENT SATISFACTION AND/OR QUALITY	PRODUCTIVITY
SMALL GROUP (2-9 PHYSICIANS)	42%	10%	16%	72%
MEDIUM GROUP (10-29 PHYSICIANS)	10	10	18	70
LARGE GROUP (30+ PHYSICIANS)	8	14*	32**	81**
STAFF/GROUP HMO	7	33**	70**	65*
HOSPITAL-OWNED, MEDICAL SCHOOL OR OTHER	33	16**	37**	72
ALL	100	14	29	72

\* Significantly different from small groups at p<0.05.

\*\* Significantly different from small groups at p<0.001.

**Note:** Sample excludes full owners of solo practices, physicians spending less than 60 percent of their time in patient care and physicians practicing in community health centers and city-, county- or state-owned hospitals and clinics. Physicians may be subject to more than one incentive.

Source: Community Tracking Study Physician Survey, 1998-99

profiling and more than twice as likely to use patient satisfaction and/or quality incentives.

Under capitation, practices have incentives to use profiling to promote cost-effective patterns of care. Patient satisfaction and quality incentives, on the other hand, may be implemented to offset the potential risk under capitation to withhold medically necessary services.

### Policy Implications

Although there is little evidence that financial incentives result in the withholding of necessary care, many states have passed laws governing physician incentives, and Medicare has issued regulations barring

health plans from paying physicians to reduce or limit medically necessary services to individual patients. Additionally, various patient-protection proposals pending in Congress mirror Medicare regulations governing physician incentives.

However, there is some evidence that incentives may be compromising patients' trust in physicians because of potential conflicts of interest.<sup>2</sup> As an alternative to barring such incentives, some patient-protection laws require health plans to disclose financial incentives or allow lawsuits when incentives are alleged to have resulted in withholding needed care. Many consumer advocates believe patients are entitled to disclosure and that they can make better choices about



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 between 1997  
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 significant growth  
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Given this outlook,  
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 consider whether  
 intervention is  
 warranted.

**Notes**

1. Magnus, S.A., "Physicians' Financial Incentives in Five Dimensions: A Conceptual Framework for HMO Managers," *Health Care Management Review*, Vol. 24, No. 1 (Winter 1999).
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**Table 2**

**Percentage of Physicians Whose Compensation Is Affected by Selected Financial Incentives, by Percentage of Practice Revenue from Capitation, 1999**

PERCENTAGE OF PRACTICE REVENUE FROM CAPITATION	PERCENT OF PHYSICIANS IN PRACTICES OF TWO OR MORE, BY AMOUNT OF CAPITATION	INCENTIVES BASED ON INDIVIDUAL PHYSICIAN PERFORMANCE		
		PERFORMANCE-BASED	PATIENT SATISFACTION AND/OR QUALITY*	PRODUCTIVITY*
NONE	39%	8%	19%	71%
1-24	30	13	27	74
25-49	14	22	34	77
50+	17	25	50	67
ALL	100	14	29	72

\* All comparisons are significant for linear trend at p<0.001.  
**Note:** Sample excludes full owners of solo practices, physicians spending less than 60 percent of their time in patient care, and physicians practicing in community health centers and city-, county- or state-owned hospitals and clinics. Physicians may be subject to more than one incentive.  
 Source: *Community Tracking Study Physician Survey, 1998-99*

selecting physicians and treatment decisions if they are informed about the nature of the financial incentives.

Nevertheless, existing regulations focusing on health plans do not take into account incentives established by physician practices, even though they are more powerful and may augment or blunt plan incentives, particularly in large practices. However, policy makers need to think carefully about whether regulating physician organizations and incentives at the practice level makes sense, given their low prevalence and the challenge of implementing regulation at that level.

Instead of direct regulation of incentives, another approach is public disclosure of their use. Comprehensive disclosure of incentives at both the physician and practice level is very complex. Incentives can differ in terms of their relative importance and, in some cases, even conflict with each other. For example, profiling or other cost-control incentives could conflict with quality incentives, and productivity incentives with patient satisfaction incentives. Moreover,

the effects of all of this on patient care are uncertain. Finally, communicating this information coherently to consumers is an enormous challenge.<sup>3,4</sup>

There was almost no change in the use of incentives by physician practices between 1997 and 1999, and significant growth in their use seems unlikely in the short term. Furthermore, the managed care backlash has driven a decline in primary care physician employment in group/staff-model HMOs<sup>5</sup> and a slowdown or decline in capitation<sup>6</sup> (although these trends may be offset to some degree by continuing growth of the number of physician employees and growing practice size). Given this outlook on the use of incentives, policy makers need to carefully consider whether intervention is warranted. ●