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Carrots and sticks for quality health care

Everyone agrees that the medical care physicians deliver and the public purse pays for should be of the highest quality. Yet quality is constantly being called into question: reports of preventable adverse events in hospitals, nosocomial outbreaks, unnecessary prescriptions of antibiotics for viral illnesses, excessive laboratory investigations and outmoded management of common illnesses leave professionals and payers alike impatient for faster, measurable, improvement.

Until recently, our approach to quality has relied almost exclusively on evidence and the education of physicians and other health care providers. Our expectation was that if health care professionals were given the necessary information to provide quality care, quality care would result. This approach relies on the providers' inner motivation to do the best they can for their patients — to do no harm, and as much good as possible. In essence, this approach to quality is an appeal to individual professionalism.

Because of the rapid expansion of information needed to deliver high-quality care, and because providers need to spend most of their time seeing patients, "keeping up with the literature" has been helped along with systematic reviews, clinical practice guidelines and consensus statements and has been encouraged (or prodded) by requirements for mandatory continuing education and re-certification. In this issue (see page 1057), Colin Dormuth and colleagues report on a randomized controlled clinical trial showing a 30% improvement in prescribing quality achieved by simply sending physicians short evidence-based updates on specific drugs. Quite a spectacular result for a small intervention.[1] But such strategies by themselves may not be enough. Health care providers and payers are now turning toward other methods to improve quality.

Businesses have long stoked their employees' resolve with "external motivators" such as bonuses for meeting targets in production, quality or profits. Similar incentives are becoming the way of the world in medicine as well. In the UK, the National Health Service recently implemented a huge expansion of payment-for-performance.[2] A large number of quality indicators in 10 broad areas will be used to award "points" that will determine up to one-third of a general practitioner's income. In the US, prepaid health maintenance organizations have been using similar financial incentives for some time. Recently, an expert committee in the US called on the federal and state governments to set quality standards for 15 common conditions and to require health professionals to measure and publicly report performance in achieving the targets.[3] The report recommends financial rewards for success that are 5% to 15% higher than current fees. In Ontario, contract negotiations between the provincial medical association and the government are considering a scheme to make an additional $50 million available for physician services if spending under the Ontario Drug Benefits Program is reduced by $200 million over 4 years.[4] This approach is seen by some as a "smart" incentive to reduce overprescribing for elderly patients; others view any attempt to motivate appropriate practice by such means as distasteful.[5] Paying for performance will not be without risks, costs or controversy, and the specific contexts in which this strategy is used will determine whether it affords patients more, or less, peace of mind.

The new health care quality and performance management tools bring existing internal motivation (professionalism) into conflict with external motivation (money). Setting specific quality and performance targets will, in some cases, motivate practitioners to be more discerning about the market and more selective in the patients they accept into their practices, potentially excluding those who don't communicate well (or don't speak English) or who are elderly, obese, have co-morbidities, or have other problems that make them less efficient as patients. Careful attention will have to be paid to the balance between professionalism and financial rewards.

In addition, these new systems are costly. To accurately measure quality requires investment in information systems that themselves are of high quality and take into account the complexity and diversity of individual patients and of variations in patient populations across different practices. And, if they are to be effective, financial rewards can't be trivial. They will have to involve a large proportion of the patients in a practice in order to generate sufficient financial motivation to compensate physicians (and governments) for the additional time and technology costs involved.

Although the size of the carrot and the stick are important, neither should be so large that they dislodge, discourage or disrupt the underlying professionalism and internal motivation that all health care providers bring to their practices. Financial incentives may reveal the invisible hand to be excessively double-gloved and self-protective, a barrier that prevents inefficient patients from accessing quality care. — *CMAJ*

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