# Position Paper

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# Pay-for-Performance Principles That Promote Patient-Centered Care: An Ethics Manifesto

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Pay-for-performance programs are growing, but little evidence exists on their effectiveness or on their potential unintended consequences and effects on the patient–physician relationship. Pay-forperformance has the potential to help improve the quality of care, if it can be aligned with the goals of medical professionalism. Initiatives that provide incentives for a few specific elements of a single disease or condition, however, may neglect the complexity of care for the whole patient, especially the elderly patient with multiple chronic conditions. Such programs could also result in the deselection of patients, "playing to the measures" rather than focusing on the patient as a whole, and misalignment of perceptions between physicians and patients. The primary focus of the quality movement in health care should not be on "pay for" or "performance" based on limited measures, but rather on the patient. The American College of Physicians hopes to move the payfor-performance debate forward with a patient-centered focus one that puts the needs and interests of the patient first—as these programs evolve.

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Many initiatives are attempting to measure the clinical performance of physicians and health care facilities. When performance measurement is combined with financial incentives to bring about clinician and systems change, the result is pay-for-performance programs.

The linking of physician reimbursement to measures of clinical performance is growing in popularity among payers, including the federal government. It is also controversial. Although a body of literature is developing on the anticipated positive results of such programs—and we applaud innovations that improve care—little evidence exists on the current effectiveness of such programs (1, 2), and several potential consequences remain largely unexplored. This position paper explores 1 set of consequences: conflict between 2 interests—the physician's obligation to the patient and the rewards that will accompany favorable quality ratings.

The issues described in this article apply to any system that rewards or punishes physicians for adhering to measures of quality. Pay-for-performance focuses attention on ethical conflicts because it rewards good quality by improving the physician's income, but conflicts of interest exist with nonfinancial incentives to improve quality-only the incentives differ. Similarly, financial conflicts exist in every payment system, such as the incentives in fee-for-service payment to increase care or the incentives under capitation to do less rather than more. In all of these conflict-ofinterest situations, the ethical imperative is the same: Clinicians must ensure that the provision of a medically appropriate level of care takes precedence over personal considerations (3, 4). Additional American College of Physicians (ACP) position papers explore public policy, reimbursement, and other issues raised by pay-for-performance

(5, 6). This paper examines the ethical implications of payfor-performance and its potential unintended consequences for the patient–physician relationship.

As an organization of professionals dedicated to the care and best interests of patients, the ACP believes that pay-for-performance movements can lead to better health care. But we are concerned about using a limited set of clinical practice parameters to assess quality (7), especially if payment for good performance is grafted onto the current payment system, which does not reward robust comprehensive care.

The ACP is concerned that the design of pay-for-performance systems will lead to worse care despite measurements that imply good care ("the patient died, but the electrolytes were in balance"). Pay-for-performance initiatives that provide incentives for good performance on a few specific elements of a single disease or condition may lead to neglect of other, potentially more important elements of care for that condition or a comorbid condition. The elderly patient with multiple chronic conditions is especially vulnerable to this unwanted effect of powerful incentives (8, 9).

How will powerful incentives affect other, more global aspects of care? Will they enhance the patient-physician relationship? Will they address the measures of quality that are important to patients, such as access to and continuity of care with trusted physicians (10), effective communication and empathy, adequate time for office visits (11), coordination of treatment across all providers and settings, decision making about whether and how to accept treatment recommendations, and the role of the family in care? It is easy to make the case that a "if you can't measure it, it's not important" mentality would detract attention from

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these patient-centered measures of care. By the same token, pay-for-performance could help improve the quality of care if it measures what is important to patients and encourages professional behavior. We must evaluate all facets of health care, not just those that are easily measured.

Physicians have a professional duty to provide highquality care to each patient (3, 12). Pay-for-performance and other programs that create strong incentives for highquality care set up a potential conflict between this duty and the competing interest of trying to comply with a performance measure—whether the measure is a priority for that patient or not.

The ACP is concerned that pay-for-performance could lead to the following potential ethical pitfalls and unintended consequences:

Deselecting difficult patients: Strong incentives in a system that rewards good performance on specified clinical measures encourage physicians to improve their performance scores by dropping (or refusing to accept) difficult patients whose outcome measures (for example, hemoglobin  $A_{1c}$ ) do not meet the quality standard and therefore worsen the physician's profile. This behavior violates several ethical principles.

First, pay-for-performance programs should not use incentives that encourage physicians to discriminate against a class or category of patients (for example, elderly patients with multiple chronic medical problems or patients with low health literacy).

Second, incentives should encourage physicians to care for the sickest and most vulnerable patients.

Third, society should insist that health care systems do the most—not the least—for patients who need care the most. It should hold health care systems accountable for solving such problems as language barriers or poor health literacy.

"Playing to the measure" or "gaming the system" rather than focusing on the patient: Some physicians may focus on getting good scores on a few performance measures and give less attention to important aspects of care that are not measured. This problem is especially acute when performance measures are in an early stage of development and focus on only a few aspects of care. At present, many aspects of care go unmeasured.

A system that judges performance according to a limited but easily measured set of standards does not serve the interests of comprehensive care. Quality measures should identify excellent comprehensive care. They must recognize successful management of multiple complex chronic conditions, meeting the counseling and communications needs of patients, and providing continuity of care and other attributes of comprehensive care. All measures must sustain and enhance appropriate patient care and the patient– physician relationship (13).

The structure and processes of care in a community are essential for high-quality comprehensive care. Therefore, performance measures should evaluate the infrastructure of care in a community.

Misalignment of perceptions between patients and physicians: Patient care depends on trust. A patient must believe that her physician is acting in her interests, not his own. If the patient is aware that the system of care creates conflicts of interest, the system can undermine trust—even when the physician is acting only in the patient's interests. The best way—perhaps the only way—to avoid this problem is to measure and report quality in achieving patient-centered objectives, such as continuity, communication, and access.

Increase in unnecessary care and medical costs: Physicians have an ethical obligation to use resources responsibly and to help ensure equitable access to resources for all patients (3). Some patients need more resources than others. All patients with diabetes, for example, do not require the same intensity of care. Pay-for-performance programs that apply the same quality standards to all patients—which would imply that all patients have the same needs—could encourage unnecessary care.

#### RECOMMENDED ACTIONS TO OFFSET THE ADVERSE EFFECTS OF STRONG INCENTIVES FOR GOOD PERFORMANCE

The best way to avoid these pitfalls is to acknowledge their potential to induce unwanted behavior and develop systems that ensure accountability for professional behavior. We describe key principles to achieve this end.

#### **Ensure Transparency**

Patients must know about incentives that might work against their interests. Transparency increases the risk that patients will not trust their physician, but secrecy would have far worse consequences. Patients must also know how their physician performs on quality measures and what financial incentives he is subject to.

#### Measure What Is Important to Patients

This principle acknowledges the human tendency that leads a person to place the highest priority on taking actions that will place him or her in a favorable light. Developing objective measures of continuity, communication, respect for patient preferences and confidentiality, and access will be more difficult than developing measures like the current ones, which are based on good evidence but have a narrow focus. It will be even more difficult to develop comprehensive measures of care for complex patients with several chronic illnesses. But the work must begin. Even weak measures will provide the public with evidence that the physician is making their needs her first priority.

#### Monitor Unwanted Behavior and Intervene

Increased administrative oversight of physicians is 1 of the prices of access to better compensation for better care. Administrative procedures will be necessary to prevent deselection of challenging patients or unwillingness to accept them as new patients.

#### CONCLUSION

Pay-for-performance programs and other strong incentives can increase the quality of care if they purposely promote the ethical obligation of the physician to deliver the best-quality care to her or his patient. However, on current evidence, the architects of pay-for-performance are not placing sufficient emphasis on protecting the interests of patients. Ignoring the needs of patients risks a crisis of public confidence. Current incentives could result in deselection of patients, "playing to the measures" rather than focusing on the patient as a whole, loss of trust between physicians and patients, unnecessary care, reduced access to care and continuity of care, and worse care for patients with complex chronic conditions. These consequences are avoidable, but only if the architects of the health care system try to avoid them.

Pay-for-performance can improve patient-centeredness of care, but only if we learn how to measure it. The ACP hopes to move the debate on incentives for quality forward by insisting on a patient-centered focus—one that puts the needs and interests of the patient first—as pay-for-performance programs evolve.

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