Ethical physician incentives - from carrots and sticks to shared purpose

Biller-Andorno, Nikola; Lee, Thomas H

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Ethical Physician Incentives — From Carrots and Sticks to Shared Purpose

Nikola Biller-Andorno, M.D., Ph.D., and Thomas H. Lee, M.D.

As health care reform’s focus turns to change in U.S. health care delivery, concerns about the use of incentives for physicians are intensifying. One fear is that incentives will undermine physicians’ professional ethos, leading them astray from the primacy of their duty to patients. Another fear is that incentives will be ineffective and merely cause confusion and irritation among patients and clinicians alike, without actually improving outcomes or efficiency. These fears characterize the perspectives of the ethicist and the manager, respectively; we believe that a synthesis of these perspectives is not just possible, but strategically valuable for implementing health care reform.

It seems clear to us that incentives are omnipresent and unavoidable in health care delivery. In any context, decisions are influenced by whatever decision makers stand to gain or lose — not just in economic terms but also in psychological and social terms. Accordingly, the debate over incentives should focus not only on the effect of individual elements (e.g., pay-for-performance bonuses) but also on the full array of financial and nonfinancial incentives used by a health care delivery system. The challenge for the leaders of health care organizations is to shape and align this web of incentives in ways that promote the institution’s goals while avoiding unintended harmful consequences, such as over- or underprovision of services.

The importance of this process is increasing as financial risk begins to be shifted to provider organizations along with responsibility for patient outcomes, as is currently occurring in accountable care organizations (ACOs). For ACOs to be successful, they must improve the efficiency of care. But they must also maintain or increase their market share, which means that they need to fulfill patients’ expectations regarding experience and outcomes. At the same time, to attract and retain excellent clinicians, ACOs must be places where top-quality professionals want to work. Incentives, like targets and performance measures for quality and efficiency, are management tools for steering toward these goals.

How can incentives be developed that are both effective and ethical? Given the complex realities of health care and human behavior, we believe that a simple carrot-and-stick model won’t do. The economist and sociologist Max Weber offered a typology of motives for social action that might be useful in the design of a more appropriate incentive scheme (see table). As Weber stressed, these categories — which a widely used adaptation has labeled “traditional,” “self-interest,” “affective,” and “shared purpose” — are ideal types, and real-life actions will frequently result from mixed motives. But we believe this typology provides a useful framework for health care organizations to apply in considering their incentive strategies.

Incentive mechanisms that are based on these four types of motives vary in their development as well as their ethical implications. For example, some provider organizations were formed explicitly to deliver most or all care for a well-defined patient population. Such organizations may invoke a culture emphasizing stewardship of resources to motivate clinicians to practice efficiently. The incentive for clinicians in this context consists in being part of the group and its tradition.

Financial incentives typically employ the instrumentally rational mode of self-interest, in which individuals and groups judge actions by their likely consequences. Examples include financial rewards for achieving quality- or efficiency-related targets. These incentives must be used with great care, since any such incentive, carried to an extreme, has potentially perverse consequences. Financial incentives in particular can introduce conflicts of interest that threaten a trusting patient–physician relationship; they also provide ready targets for external and internal critics who are unhappy with pressures for change.

Affective motives are frequently used in nonfinancial incentive schemes, such as performance rankings that are openly discussed in group settings, potentially leading to peer pressure. These techniques can be highly effective and can result in colleagues’ learning from one another — for example, when data on variation in outcome or utilization of resources causes physi-
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cians to reexamine their care. However, peer pressure is a powerful tool that can shape behavior. To ensure that physicians engage in ethical behavior, incentives must be designed carefully.

<table>
<thead>
<tr>
<th>Motive</th>
<th>Corresponding Incentive</th>
<th>Mechanism</th>
<th>Example</th>
<th>Ethical Implications</th>
<th>Implications for Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional</td>
<td>Be part of a community; increase social status</td>
<td>Habituation (e.g., an organization’s cultivation of stewardship of public resources as part of clinical excellence)</td>
<td>Routine review among colleagues of appropriateness and outcomes of procedures</td>
<td>Emulation rather than critical reflection and conscious approval of customs or routines</td>
<td>In isolation, not likely to drive improvement from status quo in outcomes or efficiency</td>
</tr>
<tr>
<td>Self-interest</td>
<td>Reach individual, rationally defined ends (financial or nonfinancial)</td>
<td>Offering rewards conditional on reaching certain targets</td>
<td>Pay-for-performance program with financial incentive for achieving predefined quality or efficiency benchmarks</td>
<td>Potential for conflicts of interest, loss of trust, and compromised performance in areas that are not the focus of incentives</td>
<td>Limited scope — incentives usually focus on relatively few issues that are under the direct control of the individual or group</td>
</tr>
<tr>
<td>Affective</td>
<td>Receive positive emotional responses, feel appreciated</td>
<td>Individualized feedback on performance, peer pressure</td>
<td>Unblinded data on quality or efficiency presented in peer-group settings</td>
<td>Risk of manipulation through psychological or social techniques</td>
<td>Effective peer pressure requires social context in which clinicians are aware of having peers</td>
</tr>
<tr>
<td>Shared purpose</td>
<td>Realize goals that are considered intrinsically valuable</td>
<td>Joint commitment to achieve a valued and agreed-upon goal</td>
<td>Organizational commitment to address crisis (e.g., worse-than-expected mortality with cardiac surgery) or to sustained improvement of value (e.g., using performance report cards developed by clinical teams)</td>
<td>Potentially works with rather than against ethical standards, reinforcing physicians’ sense of moral agency</td>
<td>Unlikely to be effective in driving improvement from status quo without use of other motives of social action</td>
</tr>
</tbody>
</table>

Weber’s Motives of Social Action.
Ethical Physician Incentives

Eric C. Stecker, M.D., M.P.H.

The Affordable Care Act (ACA) and the Center for Medicare and Medicaid Innovation emphasize accountable care organizations (ACOs) as mechanisms for achieving cost savings while ensuring high-quality care. ACOs are expected to contain costs through improvements in health care delivery and realignment of financial incentives, but their effectiveness remains unproven, and there are reasons for concern that they may fail.1 Oregon has embarked on an ambitious

The Oregon ACO Experiment — Bold Design, Challenging Execution

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