of a wrong plan to achieve an aim (error of planning)’’; ‘‘active failures that occur at the sharp end of a continuum of decisions, environmental factors, and actions that affect patient care’’;10 and ‘‘anything small or large, administrative or clinical, that you identify as something to be avoided in the future, that happened in your own practice that should not have happened, that was not anticipated, that you don’t want to happen again’’. These long definitions are summarized here—they become even longer and more detailed if readers go back to their sources. The longer a definition, the greater the chance something untoward and unhelpful will be included in it. The third of our examples, for instance, is a definition we developed while working with general practitioners and family physicians.6 It includes a phrase that became difficult: ‘‘… that was not anticipated’’. Many of the primary care doctors we worked with encountered medical errors so regularly and frequently that they had trouble identifying errors that were not anticipated. In fact, the reporting system we were developing aimed to capture exactly these regular, frequent, and anticipated errors, so we had to revise the error definition we used in later work to remove the offending phrase.

If the beginning of wisdom is knowing what to call things, defining ‘‘medical error’’ is a beginning that has not yet been completed. An internationally shared definition will be important because, just as the problems of mathematics are not the concern of any single country or constituency, neither are the problems of patient safety. Perhaps the most useful learning opportunities from overarching national reporting systems will come from international comparisons: there may be transferable characteristics of a country’s healthcare system that protect patients from certain kinds of harm and other characteristics that unnecessarily constrain patient safety. No country (let alone any organization or person) holds moral authority to unilaterally propose a ‘‘medical error’’ definition for general use. However, there are enough definitions already in circulation to inform fruitful discussions about what we are to report to national medical error reporting systems. Rather than more unilateral attempts to create the best definition, we look forward to consensus activities that will eventually deliver a sound definition we can all work with—patients, doctors, nurses, planners, policymakers, researchers, and others encountering medical errors in hospitals, primary care clinics, research units, government departments, ambulances, and anywhere else they occur.


Pay for performance

Pay for performance: the best worst choice

M L Millenson

A new concept in healthcare reimbursement that links payment and adherence to safety and quality standards

Pay for performance (‘‘P4P’’) is the latest catch phrase to cross over from the world of commerce to the work of clinicians. The basic concept is simple: rather than paying for care by the piecework method (fee for service) or using administered price arrangements (for example, daily rates, fee schedules and capitation), reimbursement should be linked at least in part to adherence to safety and quality measures.

According to the American Academy of Family Physicians, typical measures center on utilization and cost management (for example, average number of emergency department visits per patient per year); clinical quality/effectiveness (for example, the percentage of patients with asthma on controller medications); patient satisfaction (for example, the percentage of patients who would recommend the physician to a family member or friend); administrative (for example, the practice’s level of information technology); and patient safety (for example, the percentage of patients questioned about allergic drug reactions).1

P4P programs offered by health maintenance organizations (HMOs) in the US already affect more than 30 million people (or nearly a third of all HMO members), according to one survey. Physician practices participating in these programs find that 1–40% of their annual income is involved in a P4P bonus or withhold, with an average of 10%. More to the point, the percentage of state governments, employer coalitions, and health plans sponsoring these programs was projected to increase from 40% in 2003 to about 80% by 2006.2

Crucially, one of the new participants is likely to be the federal Medicare program. The Medicare Prescription Drug, Improvement and Modernization Act of 2003, which established a drug benefit for seniors, also directs the Institute of Medicine (IOM) to develop a strategy for aligning payment and clinical performance. Medicare and its sister programs for the poor and for children together account for close to a third of all US health care spending. In the UK, meanwhile, the National Health Service’s current contract for general practitioners provides financial

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incentives for the achievement of a set of 76 clinical quality indicators covering 10 disease groups.

The popularity of P4P can be credited to a combination of considerations. On a practical basis, efforts to force doctors and hospitals to practice in a certain way, rather than to provide incentives, have generally failed. In a consumerist society, meanwhile, the idea of paying for performance resonates with patients as well as providers. More broadly, P4P is being proffered at a time when soaring healthcare costs are regarded by many countries as a national crisis. As a result, all parties are more willing to explore new payment methods, particularly one based on the thesis that, in health care as in other industries, higher quality (or “better performance”) equals lower cost.

Although the high quality/low cost relationship in health care has yet to be conclusively demonstrated, it is hardly a novel concept. In the first part of the 20th century Boston surgeon Ernest Amory Codman defined a hospital’s “product” as the extent to which it reliably produced cured patients. Codman wondered why businesss men trustees did not make their institutions more “efficient” producers. In the early 1970s British epidemiologist Archie Cochrane placed efficiency into a wider social context. He considered that, because of limited societal resources, only healthcare services shown to be effective should be provided to patients. Cochrane’s work formed the basis for the evidence-based medicine movement. A strategy for translating efficiency theory into market place practice, however, seems first to have been articulated by Walter McClure, a Minnesota physicist turned health policy activist. His “Buy Right” program in the early 1970s enlisted corporate purchasers to the cause of quality improvement by insisting that incentives rather than doctor and hospital greed was the problem. He considered that providers would cooperate in meeting efficiency measures as soon as large purchasers—the employers who purchase health care on behalf of workers—threatened to either “buy right” or “buy cheap”.

Alas, most US purchasers still preferred to buy cheap—particularly since doctors and hospitals insisted that quality measures were unreliable. “Buy Right” was reborn only after the managed care backlash of the mid 1990s forced managed care organizations to back pedal on tough provider utilization controls and price negotiations. Renamed P4P or “value purchasing” (to differentiate it from “buy cheap”), it first surfaced with the formation in late 2000 of the Leapfrog Group, a coalition of large corporations. Leapfrog used highly specific purchasing requirements whose benefits were backed up with academic research—for example, the use of computerized physician order entry.

In 2001 a seminal report by the Institute of Medicine gave pay for performance an important professional endorsement. In their report “Crossing the Quality Chasm” they noted that “even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions”. They stated that private and public purchasers must modify their payment methods to “recognize quality, reward quality and support quality improvement”.? Quality problems—defined as overuse, underuse and misuse—were said to be both common and expensive.

Adding to the P4P momentum has been the growth of so-called consumer driven healthcare plans which combine large deductibles with better cost and quality information in order to persuade patients to make more value conscious purchasing decisions.

While P4P may seem like a fairy tale solution that leaves everyone living happily ever after, significant sticking points remain. Although some early research has shown that it is possible to quantify the health gain to a practice population of achieving quality targets,6 much more research remains to be done on program implementation, the design features that promote success, and those which serve as barriers.7 In addition, there is little standardization across plans in how quality improvement is measured, and incentive payments typically are modest in comparison with providers’ total revenue.8 Expectations also must be realistic; even a sympathetic researcher cautions that the task of transforming the current market place into one that promotes quality improvement is a difficult task that may not be completed until “well into the 21st century”.9

Along the way, deciding what to measure and how to measure it will be critical. The wrong measures or the wrong kind of measurement can easily erode trust and prompt widespread gaming of the system. Some physicians are optimistic, regarding P4P as an opportunity for broad scale collaboration to improve care.10 Others are more sceptical. For example, the chairman of the American Medical Association board denounced P4P as a “scam” designed by “multimillionaire CEOs of health insurance companies” to cut reimbursement by taking advantage of gullible physicians.11

Yet whatever the potential hazards of hastening down the P4P path, one cannot help but be reminded of Churchill’s often quoted remark that “democracy is the worst form of Government except all those that have been tried”. Every reimbursement system creates some sort of potential conflict of interest. As Rodwin has written, what is needed to reduce the clash between “medicine, money and morals” are policies that hold doctors accountable to patients for fulfilling the profession’s ideals.12

Pay for performance is no panacea and implementation challenges abound. Nonetheless, it offers the greatest potential yet for balancing the autonomy that is critical to the practice of medicine with the accountability that is equally critical to patients receiving safe and high quality care.


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