Observations from the Field

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DEFINING AND MEASURING QUALITY WITHOUT paying attention to cost is not feasible in the real world, where the issue is what quality can be achieved at a defined cost. Purchasers of health benefits have clearly shown that they can effectively use prepayment ("capitation" of the plan) to leverage wider benefits (e.g., preventive services and drugs), at lower cost both to themselves and their subscribers, while imposing extensive requirements for documentation of performance, including structural, process, and outcomes quality indicators. No other funding mechanism has been able to achieve this level of value, or "cost-adjusted quality." Indemnity financing has all but disappeared. Even if we could agree on the definitions and measurements of quality, comparisons of prepayment and indemnity are no longer relevant. Prepayment by purchasers clearly extracts greater value from plans, end of story!

When health plans, in turn, purchase services, they link financial and nonfinancial incentives, like various risk arrangements (e.g., capitation), benefit designs, copayments, network structures, bonus incentives, and utilization controls, in order to change the behavior of both providers and patients. The research that was reviewed by the conference participants fails to demonstrate an unequivocal increase or decrease in the

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quality achieved by plans that have used these “managed care tools.” We need more narrowly focused research that would tell us whether these financial incentives succeed and how they work. Do they really only control costs? Do they work in synergy with evidence-based practice standards to produce value? If quality is to be maintained when providers are at financial risk, which incentives really make a difference? We do know that these mechanisms reduce choice and create hassles for providers and patients.

The potential for good or harm that derives from financial incentives needs to be clarified and better documented. How well do these incentives help physicians balance population needs against those of individual patients? Large, organized physician groups, including those attached to the “old line” HMOs, develop group behavioral and cultural norms, regardless of how they are paid individually, perhaps because of shared financial risk. The meager research and limited supply of anecdotes that support higher quality and better value under capitation have come from these groups. We are less clear, however, about how to influence the behavior of individual physicians in loosely organized entities, who are generally paid through a discounted fee-for-service system. Persuading this group becomes particularly difficult when efforts to achieve quality threaten to place some portion of their total income “at risk.”

Little attention has been directed to the possible impact on quality of financial incentives for patients. For example, do high deductibles deter patients from preventive screening and other services that may avert serious illness? What is the impact of copayments or dollar maximums (for example, in the case of mental health or emergency services) on patients’ seeking care when they should? These questions are particularly important because health plans, in the face of real increases in medical costs and the demand for greater choice, are turning increasingly to various cost-sharing mechanisms (e.g., three-tier pharmacy copays rather than closed formularies). Such mechanisms place a greater burden on patients to decide how and when to spend their health care dollars.

The most important question may not be the impact of financing mechanisms on quality in the general population, but their effect on “vulnerable” populations, like, for example, the chronically ill or disabled. Here, quality may be much more easily defined and measured and more directly related to the patient’s health outcomes. We must also address concerns that risk-financed managed care leads to denial of care

and inadequate services to those who are most ill. Although risk adjustment may mitigate some of these concerns, it is critical to understand better how financial risk incentives affect care of the sickest and most vulnerable. For example, cost-containment mechanisms that may not compromise quality in a general population may adversely affect vulnerable populations. Perhaps the financial incentives, not just the payment levels, need to be adjusted for these patients. Research that looked at outcomes in selected vulnerable patient populations with well-defined clinical episodes, examining the impact of multiple variables, like payment methods for primary care, specialty referral rules, and acute and emergency care access, might help to answer these questions. Because multiple creative financing mechanisms are rapidly developing (e.g., specialty contact capitation), this may be the time to initiate such studies.

Finally, we must decide whether our definition of quality includes distributive justice. Will quality be achieved if the outcomes apply only to those who can afford insurance? The most important contribution of financial incentives may be to force appropriate use and cost of services, thus making it possible for employers and the government to cover more of the population with the same available dollars. Creating new funding sources for universal coverage without reducing the cost per person would push the health care share of the GNP to unacceptable levels. The challenge is to provide access to quality for all at the same, or at a lower percentage, of the GNP. This will not happen unless quality care can be demonstrably maintained at a fixed cost.

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