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Tipping the Scale. The Norms Hypothesis and Physician Behavior

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The current fee-for-service systems that dominates payment in the US has been roundly criticized as providing incentives to provide more services with a failure to emphasize value over volume. Consequently, payment reform is among the most prominent of multiple strategies being used to encourage more efficient use of health care services. In particular, global payment and other risk-based strategies are designed to counteract fee-for-service incentives and promote the efficient delivery of health care services by putting physicians and physician organization at risk for excess health care spending, but the results so far have been underwhelming.¹

Although there are many elements that might have contributed to these results, ranging from inadequate incentives to poorly developed tools to effectively manage care, a key requirement for these new payment models to be effective is that they lead to physician behavior change. Although it is certainly true that a physician practicing purely under global payments likely will develop a more value oriented overall approach to care that differs from a physician practicing in a fully FFS environment, what is not known is under what circumstances and to what extent physicians practicing under both types of incentives will alter their behavior. One hypothesis to explain the limited success of payment reform experiments to date is that their scope has been insufficient to motivate such a change in behavior.

There are competing hypotheses about how physicians might respond to changes in incentives. One school of thought suggests that physicians will customize their decision making for each patient based on the incentives associated with that patient's payer. For instance, a physician seeing a FFS patient might choose to order more tests or refer more frequently because they then have more time to see (and bill for) other patients, and it might make their patients more satisfied. In contrast, for a patient for whom she bears risk for excess spending, she might choose to invest more time or thought and not order the test or make an unnecessary referral. An alternative model of physician behavior is that physicians will develop a relatively uniform approach to care that is consistent with their overall financial incentives without customizing their treatment decisions based on the payment

arrangements for the patient in front of them. Such an approach might be more consistent with their professional norms as it enables providing a relatively uniform approach to care for all their patients, rather than adapting their approach purely based on their incentives.

From a clinical perspective, it is clear that physician frequently adopt such standardized approaches to guide their clinical decision making, whether by following clinical algorithms or guidelines, or creating their own typical approaches to common clinical situations such as for instance, by adopting preferred first- and second-line medication choices for hypertension or diabetes. Such clinical rules of thumb allow physicians to better navigate the complexity of current practice. Physician behavior consistent with such a strategy, referred to by economists as the *norms hypothesis*, results in treatment decisions that are responsive to the needs and preferences of their patients on average, without physicians having to devote time and cognitive capacity to customizing each decision.²

Although the norms hypothesis applies to purely clinical decisions, such as initiation of treatment for hypertension, the incentives version of the norms hypothesis suggests that this approach to practice also can be in response to financial and/or insurance coverage issues. For instance, when patients faced the same copayment for brand and generic medications, many physicians simply found it easier to continue to use brand name drugs because their patients perceived them as higher quality and the out of pocket costs were identical. As insurers began charging much higher copayments for brand-name drugs, many (or most) physicians altered their practice style to start with generics because their patients now preferred the clinically equivalent lower cost option. Thus, rather than checking incentive formulary arrangements each time they wrote a prescription, physicians adapted their practice style to a “generics first” strategy that best suited the insurance coverage of their population of patients.³

But we also can postulate a *supply* side version of the incentives norms hypothesis that directly relates to the issue of payment reform, and might explain the limited impact of payment reform efforts to date. Under this version of the norms hypothesis, physicians will adopt a practice style that best conforms to the payment incentives that *they* (and not their patients) face across all of their patients. Thus, although we would expect physicians to change their clinical practice style as they engage in risk-based contracts, such a change in behavior might not be seen until a high enough proportion of their patients were in such contracts so as to make the change in behavior worthwhile, as long as they were still providing care comfortably within their professional norms. Indeed Glied and Zivin found that physicians were more likely to adopt a cost conscious practice style overall for patients when more of their patients were enrolled in managed care arrangements.⁴

Where this gets tricky, however, relates to how we define the average incentives related to a physician’s panel—because the “average” patient often will represent one of two extremes. Under traditional fee-for-service reimbursement, physicians benefit from more frequent visits (in the case of PCPs at least), testing, and procedures and doing more rather than less. In contrast, as risk-based incentives are added into the mix, providing fewer services in the form of face-to-face office visits, referring less frequently and to specific specialists, and optimizing work-ups of new problems now present new opportunities for shared savings.

Moreover, incorporating other team members and non-visit based care also might be financially rewarding as well as quality enhancing when care is reimbursed under risk arrangements, but the incremental expenses of additional team members and non-visit-based care are difficult to justify under a pure FFS system when they are not paid for.

Thus, an implicit goal of such contracts is to “tip the scale” towards a practice style focused on value. What is not known, however, is the point (i.e., mix of patients under FFS v. risk-based incentives) at which a typical practice will reach the tipping point, or even whether such a tipping point exists. In addition, it is also possible that there will be a graded change as the incentive mix changes. From the perspective of payers and policy makers, however, achieving a shift in approach is a major goal of new payment arrangements, and the failure to reach a tipping point might be one explanation for the limited impact to date of payment reform experiments.

A final complicating factor is that physicians are increasingly becoming employees of larger organizations. In these settings, they may not directly experience the incentives associated with risk contracts. For instance, many large organizations involved in risk contracting continue to pay salary or salary with some adjustment for productivity, with less focus on quality outcomes, panel size, or efforts to control spending.⁵ Nonetheless, these larger organizations might use other approaches including audit and feedback, utilization tracking, and monitoring both adherence to quality measures and avoidance of care seen as low value to promote a shift in group culture and norms.

As risk contracting expands, the supply side version of the norms hypothesis suggests that physicians will alter their overall practice style in response to these incentives. How external incentives are transmitted to internal compensation arrangements within groups and other influences such as group norms or culture will also influence how physicians respond to such incentives. Nonetheless, a crucial underpinning of the norms hypothesis suggests that changes in behavior will flow from larger changes in the payment arrangements for a physician’s patient panel, rather than physicians responding individually to the incentives associated with a particular patient. And those changes in practice style that result therefore will spillover to their remaining FFS patients, thus increasing the importance of such a change in approach. But the trick will be for practices to determine at what point their scale is tipped such that a change in behavior is justified financially and for payers to increase the use of such contracts in order to reach that point.

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