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## *I. Introduction*

In the recurring ebb and flow of health policy panaceas, the notion of rewarding health care providers—especially hospitals, physicians, or groups of

* The author is indebted to Professor Lawrence Casalino of the University of Chicago for his comments on an earlier draft of this Article.

physicians—with additional payments or bonuses for the attainment of high-quality services has achieved particular prominence in recent years. Such incentive payments were a priority recommendation of the Institute of Medicine (IOM) panel that produced the ground-breaking report, *Crossing the Quality Chasm: A New Health System for the 21st Century.*[1] The Centers for Medicare and Medicaid Services (CMS), which has enthusiastically endorsed the IOM approach, has already begun a demonstration project to pay bonuses to Medicare+Choice plans that meet certain standards in the care of patients with congestive heart failure.[2] Additionally, a coalition of private-sector purchasers has recently announced other demonstration projects along similar lines in three cities for care of patients with diabetes and congestive heart failure and for physicians' implementation of "patient care management systems."[3] This issue of the *Washington and Lee University Law Review* contains Dr. Robert Berenson's especially thoughtful article advocating such an approach.[4]

To date, the growing discussion in policy circles about the desirability of providing financial incentives for higher-quality care assumes that the idea is a good one prima facie and has focused almost entirely on the formidable technical obstacles to implementing such mechanisms in a way that is reliable, reproducible, and at least facially fair.[5] Most of the arguments by those opposed to or uneasy about such incentive programs, such as organizations of hospitals or physicians, have focused on these technical obstacles, without questioning the underlying premises.[6] The technical problems are indeed

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1. *See* COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., NAT'L ACAD. OF SCI., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 17, 181–206 (2001) [hereinafter QUALITY CHASM] (recommending that "[p]rivate and public purchasers . . . examine their current payment methods to remove barriers that currently impede quality improvement and to build stronger incentives for quality enhancements").

2. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., 45 DAY NOTICE FOR 2002 M+C RATES, *at* http://cms.hhs.gov/healthplans/rates/2002/45day.asp (last visited Sept. 2, 2002) (on file with the Washington and Lee Law Review).

3. KAISER DAILY HEALTH REPORT, GROUP OF LARGE EMPLOYERS TO OFFER PHYSICIANS BONUSES FOR QUALITY CARE (Apr. 10, 2003), *at* http://www.kaisernetwork.org/dailyreports/repindex.cfm?hint=3&DRID=17111 (on file with the Washington and Lee Law Review).

4. Robert A. Berenson, *Paying for Quality and Doing it Right*, 60 WASH. & LEE. L. REV. 1351 (2003).

5. *See, e.g.*, Laura B. Becko, *Special Reports: A Rewarding Relationship; Hospitals and Docs Eye Seeing More of Their Pay Tied to Performance Based on Quality Measures and Other Contractual Objectives*, 33 MODERN HEALTHCARE 28, 28–30 (2003) (discussing performance payments and noting the debate over effective implementation of rewarding quality).

6. *See, e.g.*, Majorie Beyers, *Viewpoint: Report Cards are Here to Stay*, 19 PATIENT CARE MGMT. 10, 10 (2003) (outlining criticisms of report cards including concerns over accuracy, comparability across different organizations, and the ability of the public to effectively use the information).

significant and may in fact be of such magnitude as to eventually limit the applicability of such incentives to a relatively small fraction of providers caring for a relatively small fraction of patients. But, this Article will not give much attention to those technical issues, which more appropriately should be considered in a journal of medicine or of health services research. Rather, I wish to argue that differential payment for medical services on the basis of the quality of those services (assuming, *arguendo*, that differences in quality can be appropriately measured), is an intrinsically bad idea. Adopting such methods will reinforce some of the most deleterious trends in the American health system, while diverting energy from—and possibly working against—other methods of demonstrated efficacy to improve quality.

In order to make this argument, this Article will first briefly describe the origins of the current infatuation with paying bonuses for quality. Describing the sources of this enthusiasm will help to illuminate some of the larger issues it raises. The Article then describes four conceptual problems in differential payment on the basis of quality, followed by a discussion of five problems with providing financial incentives for higher quality that are at once both practical and ethical. That will lead into a discussion of the more general issue that underlies the entire debate—the conceptual, practical, and ethical complexities of paying appropriately for professional services.

## *II. Origins of the Contemporary Enthusiasm for Paying for Quality*

Although lone voices have often cried out in the wilderness, widespread concern for the quality of care provided in the American medical system is a relatively recent phenomenon. During the last two decades or so, the following forces have converged, along with others, to create what might be called "The Conventional Consensus" about quality of care:

- The automation of health insurance functions, especially claims processing and particularly in the Medicare program, created large "administrative" databases which could be used to characterize patterns of care; more recently, the evolution of data processing technology has made such databases significantly more accessible and more manageable for researchers.[7]

7. Lisa I. Iezzoni, *Assessing Quality Using Administrative Data*, 127 ANNALS OF INTERNAL MED. 666, 670–73 (1997) (arguing that databases are useful in evaluating quality and that with new technology, their usefulness is improving).

- Beginning in the 1970s, for information about quality of care not ordinarily retrievable from administrative databases, Congress created organizations to review Medicare quality.[8]

- The emergence, over time, of the randomized clinical trial (RCT) as the "gold standard" for the evaluation of medical interventions has fostered a growing quantity of evaluative information about the relative benefits, or lack of benefits, of a myriad of medical activities.[9]

- Armed with data from RCTs, and spurred on by the National Institutes of Health encouragement of "consensus conferences" in areas of clinical controversy or confusion, specialty societies and other professional groups have developed and promulgated guidelines for appropriate treatment of literally hundreds of medical conditions.[10]

- Beginning with the pioneering studies by the RAND Corporation, Harvard University, and the University of Pennsylvania in the 1970s, an entire generation of researchers has been trained in the conduct of health services research centered on the quality of care, and a variety of methodological developments have become available to overcome some of the more significant problems in such research.

- Since the 1970s, Dr. John Wennberg and his colleagues have produced a continuing stream of research showing large variations in the utilization rate of many medical procedures and health care resources (such as inpatient hospital beds) across communities, with no apparent connection to differential health status in those communities.[11]

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8. Thomas Bodenheimer, *The American Health Care System: The Movement for Improved Quality in Health Care*, 340 NEW ENG. J. MED. 488, 489–90 (1999) (discussing organizations that are concerned with Medicare quality).

9. *See* Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?*, 76 MILBANK Q. 565, 574 (1998) (stating that the quantity of RCT articles has risen from 100 per year in 1966 to 10,000 in 1995).

10. *See generally* NAT'L GUIDELINE CLEARINGHOUSE, GUIDELINE INDEX, *at* http://www.guidline.gov/index.asp (last visited Nov. 8, 2003) (on file with the Washington and Lee Law Review).

11. *See, e.g.*, Carol Ashton et al., *Geographic Variations in Utilization Rates in Veteran Affairs Hospitals and Clinics*, 340 NEW ENG. J. MED. 32, 34 (finding longer hospital stays in the northeastern United States than on the west coast). *But see* Bruce C. Vladeck, *Variations Data and the Regulatory Rationale*, HEALTH AFF., Summer 1984, at 102, 103 (concluding that "while variations may be a big part of the problem, they are of only limited help in designing the

- The growth of managed care in the late 1980s and 1990s spawned its own small sub-industry of research that sought to compare managed care plans' quality of care to that in the traditional fee-for-service system.[12]

- The failure of comprehensive efforts at health care reform in the Clinton Administration's first term led officials to seek out other areas of health care policy in which they might receive public attention and approbation for innovation; they chose health care quality.[13]

What I have called "The Conventional Consensus" has drawn on all of these developments to conclude that:

1. It is possible to draw on clinical guidelines and other products of professional consensus to establish defensible, measurable standards for quality of care.

2. Applying those standards, the quality of care provided in many settings, for many different kinds of patients, in most communities in the United States, falls far short of acceptable standards.

3. Moving more of medical practice into closer conformity with those standards would not only increase the quality of care (an almost tautological result) but, more importantly, would improve outcomes for patients, including reduced mortality and morbidity and improved functional status.[14]

Efforts to translate The Conventional Consensus into policies and programs have been occurring throughout this period, and frustration over the relatively slow pace of progress in improving care lies at the heart of much of the movement to add financial incentives. Improvements in data processing, research methodologies, the supply of researchers, and funding for research have produced an ever-widening torrent of studies and analyses documenting the gap between optimal and actual patterns of care.[15] The more sophisticated

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solution").

12. For an excellent recent review of this literature, see generally Robert H. Miller and Harold S. Luft, *HMO Plan Performance Update: An Analysis of the Literature, 1997-2001*, HEALTH AFF., July/Aug. 2002, at 63.

13. Confidential communications to author.

14. *Cf.* Mark R. Chassin et al., *The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Health Care Quality,* 280 JAMA 1000, 1000 (1998) (concluding that "[c]urrent efforts to improve will not succeed unless we deliver health care services, educate and train clinicians, and assess and improve quality").

15. For an especially widely-reported recent example of one such study, see generally

the research becomes, the more serious the problems seem to be. Yet, publication of clinical guidelines, in and of itself, does not appear to have much impact on changing the behavior of physicians whose practice patterns do not conform to those guidelines, and even more sophisticated educational efforts seem to have only limited effect.[16] Using the tools of The Conventional Consensus, quality appears to be reasonably poor and—more importantly—not improving very fast; hence the search for other, more powerful interventions to improve quality.

Although no one can argue with the proposition that the public would be best served if the quality of medical care improved as much and as rapidly as possible, one cannot help observing that at least some of the frustration surrounding the entire quality of care discussion may reflect the kind of simple impatience with complex problems that characterizes much of American culture, and perhaps especially American medical culture. To name, or even characterize, a problem is not to solve it, but contemporary American society and the political system embedded in that society, sometimes confuse the two. Significant social change—especially when that change requires alteration of strongly-imbedded behaviors among hundreds of thousands of highly-trained, highly autonomous professionals—frequently takes a fair amount of time. But, that does not mean it does not occur. Advances in clean air and clean water, as well as decreasing crime rates and adult tobacco use, suggest that change can happen over a sufficient period of time. Those concerned with the quality of medical care, however, seem unwilling to wait, even when the problem they are concerned with solving has been recognized only recently—and may not yet be fully understood. Thus, much of the argument in favor of employing financial incentives to improve quality takes the form of "we've tried everything else, and that hasn't worked," even though, from a distance, it would appear that a more accurate conclusion might be that "we've sort of tried many things, and it's too soon to tell which of them will work, and how well."

Frustrations over the putative failure of other mechanisms to improve quality also dovetails conveniently with a second source of the current enthusiasm for financial incentives—the growing hegemony of microeconomic modes of analysis in health policy discussions of all sorts. Despite the fact that efforts to introduce greater "marketplace competition" into the health care sector have produced primarily baleful consequences, and despite the powerful

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Elizabeth A McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635 (2003).

16. *See generally* Jonathan Lomas et al., *Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians*, 321 N. ENG. J. MED. 1306 (1989).

and growing body of evidence on the inapplicability of neoclassical microeconomic models to most of the health care sector,[17] the congruence between the ideological biases implicit in economic models of social phenomena and the interests of ruling elites leaves economics in a uniquely powerful position within American social sciences and its offshoot of public policy analysis.[18] Economic incentives are thus proposed as the solutions to most problems, from juvenile crime to reductions in marriage rates. Because health care services already generally (and perhaps increasingly) involve economic transactions, it seems only natural, within the prevailing *zeitgeist*, to attempt to influence those transactions using economic tools.

Identifying the cultural and ideological implications of a focus on financial incentives as a means of improving quality in the health care system also helps identify the third, and perhaps most troubling, source of the current enthusiasm for such approaches. The legitimization of economic incentives as a means of changing the quality-related behavior of health care providers would provide a mechanism for further shifting control of the health care system from those who provide health care to those who pay for it, or their intermediaries. Over the last decade or so, a number of perceptive observers of the American medical scene have made the argument that, in an implicit exchange for greater financial independence and self-control, American physicians, in contrast to their counterparts in other industrialized nations with some form of universal health insurance, have accepted greater interference with their clinical autonomy and practice organization.[19] Payors, both public and private, already exercise, or attempt to exercise, influence on how many patients physicians see in a given period of time, what tests and procedures the physicians order, which drugs they will prescribe, and so forth. To date, definition and assurance of the quality of care have been perhaps the most important dimensions of physician autonomy to have been shielded from payor interference and involvement.[20] Invoking arguments related to

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17. *See generally* THOMAS RICE, THE ECONOMICS OF HEALTH RECONSIDERED (1998) (examining over a dozen of the assumptions that need to be fulfilled to ensure that a free market results in the best outcome for society and finding that none of those assumptions applies to the health care industry).

18. *Cf.* THORSTEIN VEBLEN, THE HIGHER LEARNING IN AMERICA: A MEMORANDUM ON THE CONDUCT OF UNIVERSITIES BY BUSINESS MEN 221–22 (Sagamore Press 1957) (1918) (exploring the effects of corporate financial support on higher education).

19. Richard A. Culbertson & Philip R. Lee, *Medicare and Physician Autonomy*, 18 HEALTH CARE FIN. 115, 119 (1996). Culbertson and Lee state:

> The application of Reinhardt's law to the late-20th-century United States scene would appear to indicate a priority on the part of physicians to pursue economic betterment at the expense of clinical autonomy. If so, this would be critical in reformulating a definition of autonomy for the future, for this observation implies the willingness of physicians to sacrifice control of the division of labor.

*Id.*

20. *Cf. id.* at 128 (stating that managed care utilization control has been primarily focused

the quality of care has become, in one sense, the last refuge of the independent physician. Payors are eager to invade that refuge, and schemes that pay differentially on the basis of payor-defined and measured quality performance would permit them to do so.

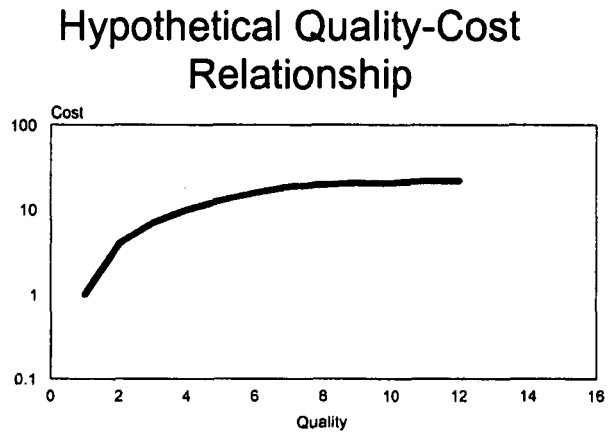
### *III. Conceptual Problems in Paying for Quality*

Given the formidable array of actors who have lined up in support of financial incentives for improved quality, one might reasonably expect that their arguments in favor of such an approach would have a strong grounding in either experience or theory. But arguments in support of financial incentives tend to rely on a number of faulty, sometimes self-contradictory, presumptions, preconceptions, or folk beliefs.

#### *A. The Relationship Between Quality and Cost*

The first of these arguments involves some fundamental assumptions about the relationship between cost and quality in the provision of health services. In a simple-minded economic model, the production function for "health care quality" would look like the production function for most things—a simple linear relationship with perhaps a start-up threshold at the left-hand end and a flattening on the right to reflect diminishing marginal returns—as depicted in Figure 1.

**Figure 1**




on economic issues rather than quality of care issues).

If this were an accurate depiction of the relationship between quality and production cost, then paying more for higher quality would be a matter of common sense. The empirical evidence we have, however, suggests that the relationship conforms to this model only sometimes, if at all. For cardiac catheterization and most forms of cardiac surgery, as the volume of procedures at a particular hospital increases, the quality of service, as measured by such outcomes as risk-adjusted morbidity and mortality, increases, while unit costs decrease.[21] More generally, the quality of care seems to increase as hospital-specific or physician-specific volume increases across a wide range of surgical procedures and some kinds of medical cases; although the volume-cost relationship is less well-studied, a fair assertion would be that unit costs may not always go down as volume increases, but they should rarely go up.[22] Similarly, in nursing home care and at least some acute hospital care, there appears to be a threshold level of staffing for nurses, and perhaps other clinical employees, below which it is impossible to attain even minimally satisfactory quality of care.[23] Above that threshold, however, the correlation between staffing levels and quality becomes considerably weaker, if not completely random.[24] And even the American Medical Association would be hard-pressed to argue that the best physicians are those who charge the highest fees.

In its argument in support of testing financial incentives for improved quality of care, the IOM committee argued that quality improvements often require up-front investments by health care providers and, more generally, that the incentives inherent in various payment schemes often fail to reward quality improvements.[25] Both of those assertions are sometimes true, although the IOM report itself acknowledges that they are not always true.[26] Other leaders in

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21. For a good summary on this issue, see generally Edward L. Hannan, *The Relation Between Volume and Outcome in Health Care*, 340 NEW ENG. J. MED. 1677 (1999) (discussing studies relating to the relationship of volume and outcome in hospitals).

22. For a full review of this literature, see generally Ethan A. Halm et al., *Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature*, 137 ANNALS OF INTERNAL MED. 511 (2002).

23. *See* ABT ASSOC., APPROPRIATENESS OF MINIMUM STAFFING RATIOS IN NURSING HOMES, PHASE II FINAL REPORT 3-2 (Winter 2001) (finding that 2.9 nurse aide hours per resident per day are necessary to provide "good" care, and that less than 2.0 nurse aide hours per resident per day is likely to result in "poor" care), *available at* http://www.cms.hms.gov/medicaid/reports/RP1201home.ASP (on file with the Washington and Lee Law Review).

24. *See id.* at ES-1 (finding that "no quality improvements are observed for staffing levels above these thresholds").

25. *See* QUALITY CHASM, *supra* note 1, at 191–95, 197–99 (finding that most common payment methods have insufficient incentives to fix problems of overuse and present great difficulty in fixing problems of misuse).

26. *See id.* at 193 (finding potential financial gain if under capitation or shared-risk

the last generation's efforts to improve the quality of medical care (especially those whom the experience in industrial process improvement influenced most) more often argue that quality improvement reduces production costs because it reduces the need for rework or starting over.[27] In fact, both of these propositions can be, and probably are, occasionally true. Sometimes higher quality care is more expensive, and sometimes it is less expensive. But, if that is the case, and higher payments are justified when higher quality is more expensive, then should not payments be *reduced* when higher quality is less expensive?

To complicate things further, quality is clearly multi-dimensional, but the various dimensions of quality do not always vary uniformly with one another. Moreover, the quality-cost relationship may not vary uniformly either, even in the instance of a single patient being treated for a single condition. Thus, more nursing care, especially in the intensive care unit, may improve the quality while increasing the cost of a hospitalization for cancer surgery, but having the operation performed by a more proficient, experienced surgeon may reduce the cost while also increasing the quality. In this instance, the statistical truism that, over time, things tend to even out probably provides a clue towards the most rational course of action. That is to say, over time and a sufficiently large number of cases, high quality and poor quality are probably about equally expensive, or inexpensive. Therefore, attempting to tie the level of payment to the level of quality cannot be justified in terms of relative costs.

### *B. Economic Incentives and Provider Behavior*

Just as the relationship between cost and quality is more complicated than the notion of paying more for higher quality would seem to imply, so the actual experience with provider responses to economic incentives is far more complicated than simple-minded models of income-maximizing perfect firms would suggest. When Medicare changed its method of payment for inpatient hospital care from retrospective cost-based reimbursement to per-case payment on the basis of DRGs, hospitals had a modest financial incentive to reduce length of stay and a powerful financial incentive to increase Medicare

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arrangement).

27. For a recent example, see Henry B. Simmons, *The Crisis in Health Care: The Time for Action*, Address at the Iowa Governor's Health Care Policy Forum 5 (Aug. 13, 2003) ("Any good businessman knows that if you don't pay attention to quality, you will end up wasting huge amounts of money."), *available at* http://www.nchc.org/materials/speeches/Iowa%20speech.pdf (on file with the Washington and Lee Law Review).

admissions. Consequently, length of stay fell dramatically, but admissions went down.[28] New systems of prospective payment have led to shifts in admissions patterns for nursing home patients (as they were designed to do),[29] but dramatic changes in relative Medicare physicians' fees (designed to shift utilization from "procedure-intensive" to "cognitive" services) do not appear to have produced any such thing.[30]

Hospitals, nursing homes, physicians, and nurses make treatment choices for many different, complicated, and interrelated reasons. Maximizing economic returns is clearly one goal, but only one. Training, organizational settings, the nature of relationships with patients, cultural and personal prejudices, habit, and simple distraction or preoccupation are also important influences. Mythology and simple misinformation may also contribute to an alarming degree. Over time, different providers respond differently to both different incentives and to the same incentives.

It is also important to remember how economic incentives actually work in real situations, including those in health care, which is intrinsically, in some ways, a profoundly uneconomic activity. In real economies, most of the action takes place on the margins. To use my favorite example, if the price of pigs goes up relative to the price of cattle, farmers will tend to raise more pigs and fewer cows, but they will not seek to turn their cows into pigs. Likewise, if reimbursements for endoscopies go up relative to payments for screening fecal occult blood, gastroenterologists may be willing to work longer hours doing procedures, but primary care physicians may be no more willing to try to convince their patients to have those procedures done, nor willing to start doing the procedures themselves. Over time, changes in those relative prices will encourage a shift towards the higher-priced procedure; however, this result only occurs if relative prices remain roughly the same and the technology remains constant, a scenario which hardly ever arises.

Thus, although proponents of providing financial incentives for higher quality may be advocating such an approach because of their frustration with

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28. *See* Bruce C. Vladeck, *Medicare's Prospective Payment System at Age Eight: Mature Success or Midlife Crises?*," 14 U. PUGET SOUND L. REV. 453, 458–60 (1991) (noting an incentive in the Medicare payment program for hospitals to reduce length of stay and increase admissions, but finding that although length of stay decreased as expected, admissions also decreased).

29. *See* Nelda Mccall et al., *Reforming Medicare Payment: Early Effects of the 1997 Balanced Budget Act on Postacute Care*, 81 MILBANK Q. 277, 290 (2003) (finding a significant decrease in home health care visits after implementation of the prospective payment systems).

30. *See* William B. Weeks & Amy E. Wallace, *Medicare Payment Changes and Physician's Incomes*, 29 J. HEALTH CARE FIN. 18, 18, 23 (2002) (discussing changes and noting that the results did not accord with the anticipated effect).

the apparent lack of efficacy of other measures, they may very well end up just as frustrated with the effects of such incentives. Rather than seeking to more fully understand why physicians or other providers may fail to provide care of optimal quality, and then seeking to design interventions that address those causes, advocates of economic incentives have focused, almost anecdotally, on those instances in which payment methods may provide a disincentive for higher quality. Proponents of economic incentives have then leaped from there to a solution for what may be the wrong problem.

### *C. Economic Incentives in Real Payment Systems*

The impact of financial incentives on the actual behavior of providers is attenuated, if not entirely counteracted, not only by other influences on provider behavior, but also by other characteristics of the payment systems themselves. For example, Medicare determines the fee that it pays a particular physician for a particular service primarily by the exact nature of that service, but it also significantly adjusts to account for relative practice expenses in that physician's specialty. Factors that figure into the payment determination include the costs of rent, malpractice insurance, and labor in the metropolitan area in which the physician practices, and the rate of growth in total Medicare physician expenditures relative to some sort of exogenous budget target.[31] Medicare adjusts payments to hospitals to account for such factors as relative wage levels in the hospital's market, the number of interns and residents on the hospital's payroll, the amount of care the hospital provides to low-income people, and the size of the metropolitan area in which the hospital is located.[32] A complex formula, which will become substantially more complex in the near future as more sophisticated models of risk adjustment are applied to it, determines even monthly capitated payments to HMOs participating in Medicare.[33]

The complexities in the payment systems that public insurance programs employ are perhaps an inevitable effect of the nature of the American legislative process,[34] but the often-simpler process in which private payors

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31. *See* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 17–20 (2002) (defining how Medicaid determines physician payment rates).

32. *See id.* at 10–15 (discussing how Medicaid determines hospital payment rates).

33. *See id.* at 31–32 (explaining how Medicaid determines payment rates for Medicaid+Choice plans).

34. *See* Bruce C. Vladeck, *The Political Economy of Medicare*, HEALTH AFF., Jan./Feb. 1999, at 22, 30–31 (discussing politics of Medicare). Vladeck argues:

> Medicare suppliers occupy a political territory of classic dimensions in American political science: narrowly focused interest groups with an enormous specific stake

negotiate fees with providers generally employs at least the relative prices in Medicare payment systems as the starting point for price-setting. Thus, the economic "signals" embodied in any particular pricing arrangement are multiple, complicated, interacting, and confusing. Adding in an additional signal relative to quality may or may not convey a message powerful enough to get heard, let alone acted upon.

In my own experience, although analysts and policymakers love to devote considerable attention to even the most minute details of payment formulae, the characteristic of payment systems that has far and away the greatest effect on providers is the absolute level of payments. If, on average, across all patients that a particular payor covers, that payor's payments are relatively generous, providers are happy and more willing to respond to other agendas that the payor might have. To the extent that payments are, on average, thought to be too low, providers will be unhappy and uncooperative no matter what else the payor does. The clearest evidence of this phenomenon is provided by the experience under Medicare+Choice since the implementation of the Balanced Budget Act in 1998. For all the hundreds of hours of effort and disputation that went into formulation of the exact details of the Medicare+Choice payment system, the budget neutrality-imposed constraints on year-to-year growth in payments rates have driven a large proportion of plans out of the system altogether—at which point, they are, of course, impervious to even the most powerful marginal incentives.

Further, money is fungible, so that revenue a provider receives in response to finely-tuned policy incentive *x* can—and likely will—be spent on some other component of the provider's expenses altogether; conversely, failure to meet an incentive target that might increase overall revenue by one or two percent can be overcome in any number of alternative ways, whether from other aspects of performance for which the provider is overpaid, other sources of revenue, or related or unrelated foregone expenses. CEOs and Boards of Trustees tend to focus on the bottom line precisely because worrying about the relationship of revenue to cost for every patient or every department is not only an impossible task, but is ultimately foolish.

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> in issues about which the rest of the body politic could really care less, seeking benefits of enormous importance to themselves, but almost invisible in the total aggregate of the federal budget. They thus have succeeded in resisting almost every effort to improve Medicare's purchasing by enlisting key members of Congress to defend their constituents from the depredations of the "big bad federal bureaucracy."

*Id.*

One could posit a hypothetical world in which all providers were paid on the basis of their actual costs or charges, and financial incentives for higher quality were then made available as an explicit add-on. One would expect that, in such a world, the impact of incentives would be greater than it is likely to be under today's circumstances. In that hypothetical, providers would know that they would break even if they performed at some average quality level but could make a profit by improving quality (because the relationship between production cost and quality is rarely linear). But, despite its obvious advantages, the very notion of any form of cost-based reimbursement is currently so antithetical to conventional wisdom in health policy that such a discussion is almost certain to remain in the realm of the hypothetical for many years to come. Therefore, adding quality incentives to existing payment arrangements may be roughly as effective as adding a comedian's skit to a burlesque review—some of the audience will pay attention, but others will remain mentally focused on the more visually-compelling acts.

### *D. The Problem of Suboptimization*

Although the initial notion of paying more for higher quality care seems simple enough, actual efforts to do it are likely to encounter problems of suboptimization in addition to those described above. These problems arise because quality has many dimensions and many components, and both measurement processes and financial incentives must generally rely on measures that are partial or intermediate at best. Thus, in its initial payment demonstration for Medicare+Choice plans caring for patients with congestive heart failure (CHF), CMS uses two process measures: the proportion of CHF patients whose left ventricular function has been appropriately evaluated; and the proportion for whom ACE inhibitors have been prescribed, or whose records indicate the reasons for forgoing ACE inhibitors.[35] These are both perfectly valid indicators drawn from state-of-the art medical literature, but they surely constitute only a fraction of all the things an optimally-performing health system would do for CHF patients. Efforts to prevent the onset of CHF, for example, although almost certainly not economically rational for most Medicare+Choice plans—given the turnover among enrollees, the difficulties of prevention, and the time lags involved—are not encouraged by these incentives and, to the extent that providers "teach to the test," may even be discouraged by default.

35. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 2, at 11.

Conceptually, the only way to avoid suboptimization in providing incentives (financial or otherwise) for quality improvement would be to base rewards and sanctions on "ultimate" outcomes, such as morbidity and survival rates in the relevant population. But, there are many good reasons for not doing so. The most important are the inherent variability in human populations and the partial, and at times tangential, nature of the causal relationship between medical care, however comprehensive, and health outcomes. Providers should only be held accountable for things that they can influence. On the other hand, the more partial, narrow, and specific the measures on which any system of rewards is based, the greater the danger of suboptimization will be, and the logic of financial incentives suggests that such systems will be more prone to that danger than other more subjective and multidimensional efforts to characterize and promote high quality services.

## *IV. Practical and Ethical Problems in Financial Incentives for Improved Quality*

### *A. Setting Thresholds*

Even if all of the conceptual problems briefly described above could be adequately addressed, at least five problems with the design and implementation of financial incentives for improved quality of care have both practical and ethical dimensions that may not be resolvable. The first of these problems is the question of where one sets the threshold, or thresholds, above which incentives will be paid.

Even though attention to the quality of health care in the United States has increased dramatically in recent years, a general concern with the quality of care is hardly a recent phenomenon, nor are efforts to insure that patients receive care of at least minimally adequate quality. Historically, quality assurance efforts focused on establishing a minimum, or floor, below which the quality of care is presumed to be entirely unacceptable, and historically those minima were defined in terms of provider qualifications and basic structure and process measures.[36] Thus, the primal quality assurance and quality improvement measure in the United States, as in most other countries, was the professional licensure of physicians and other health professionals, followed by

36. *See* COMM. TO DESIGN A STRATEGY FOR QUALITY REVIEW & ASSURANCE IN MEDICARE, NAT'L ACAD. OF SCI., MEDICARE: A STRATEGY FOR QUALITY ASSURANCE 46–47 (Kathleen N. Lohr ed., 1990) [hereinafter STRATEGY] (stating that quality assurance programs may have many goals, including working with providers to bring care to an acceptable level).

the development and implementation of licensure and accreditation standards for hospitals and other health facilities. More recently, for most categories of health facilities other than hospitals (where legally sanctioned private accreditation still dominates), Medicare Conditions of Participation define the de facto minima in facility characteristics and operations.[37]

Although some experts appropriately have criticized licensure and accreditation for providing inadequate incentives for quality improvement, as opposed to establishing minimum standards, at least some of the problem clearly can be attributed to the ways in which these standards are enforced, or not enforced. More to the point, to use what has become the dominant metaphor in quality discourse, such efforts can remove the low-end tail of the distribution of provider quality but conceptually cannot move the median of the distribution to the right—towards higher quality. It is improvements in the average level of quality—shifting the distribution to the right—that are the focus of most discussions of financial incentives for quality.[38]

But, to say that financial incentives should be designed to increase the proportion of providers meeting upper-level standards for optimal care begs the question of just where one should set the threshold for paying incentives, a problem that is fundamentally insoluble. If only the rarest and most accomplished providers are capable of meeting the targets, then even relatively generous incentives are unlikely to have much effect on providers with a realistic assessment of their chances. But, if the threshold is set too low, not only is payment of incentives likely to be very expensive, but it risks rewarding mediocrity.

More importantly, reasonably-qualified providers must be able to reasonably attain targets describing optimal quality; otherwise, the targets are inadequately-defined or overly particularistic. Assuming that one can define such targets, and a significant fraction of providers are already meeting them, then Medicare or any other payor will increase its costs with no incremental benefit to its beneficiaries until those providers who have historically not performed as well improve. But, assume that relatively few providers now meet the targets, and that in the real world, the rate at which they improve will vary considerably from one provider to another, even when all are operating under the same financial incentives. At some point in time, under this hypothetical, roughly half of the providers will be receiving extra payments. But, there will then be a serious question as to whether those who still have not

37. *See id.* at 119–24 (discussing the adequacy of the Conditions of Participation as they relate to quality assurance).

38. *Cf.* Berenson, *supra* note 4, at 1319–22 (discussing why Medicare needs to pay for improved quality).

met the targets should be paid at all. If half the providers can meet some standard of optimal care, why should not that standard be a floor below which patients should not drop, a floor that can now be empirically defined as substandard care?

That the quality of care is not randomly distributed among providers at any particular point in time, but that there are in fact both significant geographic variation and some correlation between the quality of care that physicians and facilities in certain communities provide and the relative affluence of those communities, substantially exacerbates the threshold-setting problem.[39] A relatively standardized incentive for achievement of a standard score on quality measures will, in the short run, send extra Medicare dollars to Vermont and Minnesota but not Louisiana or Texas, even if the overall level of quality does not change at all. The rich would literally get richer.

Alternatively, one could define financial incentives not in terms of meeting some absolute threshold but in terms of an individual provider's improvement from some baseline: doing *x*% better in year *t* than year *t-1* might produce an additional payment of *m*; doing 20% better would produce an additional payment of *2m*. But then, providers who were giving the best care before the incentives were put into place would get nothing, while those providing the worst care would have the greatest—and perhaps easiest—opportunity to cash in. Again, this problem—and ineffectual potential solution—applies not just within a given community, where its insolubility is obvious, but across communities, where the political (and perhaps intellectual) problems are much greater.

These are not just technical problems of policy design. For the administrator of a public program, such as Medicare, if a substantial proportion of providers can reach quality thresholds that make them eligible for incentive payments, the moral defensibility of permitting those who cannot to continue serving program beneficiaries *at all* is a serious problem, particularly when the correlation between quality and input costs is as tenuous as it is. It is also not clear a priori whether the substandard providers should be punished or "rehabilitated," that is, whether they should be paid less (or nothing at all, if they are excluded from the program), or paid more in the form of supportive services to help them meet the thresholds in the future.

The problem of how to design fair payment systems in a world in which, at any given time, providers differ from one another in all sorts of ways—both

39. Steven F. Jencks et al., *Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001*, 289 JAMA 305, 307–08 (2003) (summarizing, by chart, quality indicator averages by state).

economic and non-economic—is not confined to the issue of incentives for quality; it is a generic problem. But, I would argue that it is particularly problematic, ethically if not conceptually, when applied to quality. If one is concerned only about financial incentives for cost-effectiveness and efficiency in the provision of care, then one accepts the best compromise one can fashion between horizontal equity, vertical equity, economic efficiency, and political constraints. But, when the quality of medical care is at stake, then so are issues of life and death. All other things being equal, patients with certain conditions treated by low-quality providers are less likely to survive than those treated by high-quality providers (although mortality is only one very crude measure of quality). Especially when a public agency is doing the purchasing, equitable treatment of providers must take a back seat to the payor's responsibility to help assure the health and safety of beneficiaries. If, in that enterprise, one can identify an adequate supply of providers who exceed any given qualitative standard, then no other providers should be permitted to participate in the program at all until they too can meet those standards. "Adequate supply" is a significant constraint, but the general principle still holds. If some relatively representative group of providers consistently provides care of a higher quality, then those operating at a lower level of quality should be expected to improve within some reasonable period of time or find another line of work.

### *B. The Idea of Quality Improvement*

The principle that the floor is, at least for operational purposes in public programs, on par in importance with the ceiling actually dovetails in interesting ways with the second practical-ethical problem with quality incentives. The inconsistency of such incentives with the logic of Continuous Quality Improvement (CQI), the philosophy derived from the manufacturing sector (and especially the Japanese manufacturing sector) that now supposedly underlies both public and private quality strategies.[40] As applied to medical care, the idea of CQI is that one attains optimal quality not by standardizing practices and procedures to hit a set of fixed targets, but by a process of continual self-examination and self-monitoring to detect problems, analyze and understand their sources and components, take remedial action, and maintain feedback loops to evaluate the effectiveness of those remedies—all in a series of continual loops in which providers are always in the process of identifying new problems while turning attention away from prior problems that appear to

40. *See* Chassin, *supra* note 9, at 585–86 (suggesting that hospitals with high-volume for procedures produce better quality results).

have been at least partially remedied. As the basis for a quality improvement strategy, CQI is especially applicable to health care, an industry in which many different individuals and organizations are generally involved in the "production process," the level of technical complexity is especially high, and the rate of change in technology and scientific knowledge is also especially high. For hospitals, JCAHO Accreditation Standards and Medicare Conditions of Participation already require hospitals to maintain CQI processes, although at most institutions such processes are in relatively primitive stages of development.[41]

In organizations with effective CQI processes, the issues on which the organization focuses at any given time are—and should be—constantly changing. Meeting performance targets relative to one measure only suggests that that measure is already passé. Rewarding HMOs—or physicians or hospitals—in 2005 for improvements in performance in 2003 and 2004 on measures promulgated in 2002 would seem to operate in exactly the opposite direction. More to the point, a commitment to CQI would seem to suggest that organizations that were doing particularly well in managing, for example, congestive heart failure in 2002 should be focusing their attention on something entirely different—perhaps diabetes, depression, or colon cancer screening rates—in 2003 and 2004 (while doing whatever necessary to prevent backsliding in the congestive heart failure performance levels).

### *C. Zero Defects*

In principle, the process of reducing medical errors should be an intrinsic part of any quality improvement process, something the IOM reports clearly envision.[42] But, as attention has focused specifically on reduction of medical errors, as opposed to other forms of quality improvement, conceptual developments have also moved away from notions consistent with financial incentives for increased quality. The appropriately prevailing notion in the medical error reduction process, one again borrowed from successful industrial models, is that of "zero defects." As Professor Mark Chassin articulated in an especially influential article, that approach, as exemplified in the quality improvement practices of General Electric, for example, establishes a target error range of six standard deviations from the mean of our familiar normal

41. *See* STRATEGY, *supra* note 36, at 125–28 (laying out the development of the Quality Assurance Condition of Participation).

42. *See* QUALITY CHASM, *supra* note 1, at 122–23 (discussing the three-part strategy the IOM report outlined for creating health care process for safety).

distribution—the goal should be to avoid preventable, harmful errors in the production process 99.99% of the time.[43] In many instances, it should be noted, doing so will reduce production costs as well.[44]

In this "six sigma" process, accepting a level of performance that is only three or four standard deviations better than the mean—for example, by paying some financial bonus for its attainment—would be to settle for a level of performance far below what should be attainable, and therefore to undermine the very error reduction process itself. More importantly, in every organization, the norm should not be the median, but continuing efforts to eliminate all defects. To establish anything less than ideal performance as the basis for incentive payments would be self-contradictory; yet once the "ideal" is reached, the goal should become exceeding that ideal.

In reducing medical errors, in other words, it is important to establish as lofty a goal as possible; to complacently accept, let alone reward, anything short of that goal should be unacceptable. Commitment to such goals should be expected of all participants in the health care system. To the extent that payment is, or should be, a consideration at all, it should be conditioned on efforts to achieve the normative level of performance—which is to say, a level which no existing organization ought to be able to achieve. Such efforts, if not such achievements, should be a minimal expectation for being paid at all, not the basis for supplementary rewards.

### *D. The Reality of Quality Improvement*

Given the problems with constructing defensible, workable systems to reward quality improvements with financial benefits, those concerned about the quality of health care provided to Medicare beneficiaries or other Americans would seem to really be in the soup were it not that quality, at least in the Medicare program, appears to be improving quite rapidly in the absence of financial incentives. As Steven Jencks and others recently reported, quality of care for fee-for-service Medicare beneficiaries, as measured by twenty-two agreed-upon indicators, improved on twenty of those measures (by an average of 12.8%) in the relatively short period of two years ending in 2000–2001.[45]

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43. *See* Chassin, *supra* note 9, at 567 ("Six sigma quality means setting tolerance limits for defective products at such high levels that fewer than 3.4 defects occur per million units (or opportunities).").

44. *See* Chassin et al., *supra* note 14, at 1002–03 (concluding that "substantial opportunities exist to increase quality and decrease cost simultaneously by ameliorating problems of overuse and misuse").

45. Jencks et al., *supra* note 39, at 309.

Using measures over a longer period—seven years—Sehgal reported that the proportion of Medicare dialysis treatments that met four basic quality criteria doubled—from 43% to 86%—between 1993 and 2000.[46] Others had reported similar results earlier for inpatient hospital care of Medicare patients who had experienced uncomplicated, acute myocardial infarctions (AMI).[47] All of these results were associated with programs in which a set of indicators was developed through professional consensus and a process of systematic periodic measurement of those indicators was implemented in conjunction with mechanisms to feed back to individual providers data on their performance, and that of their peers, over time.[48] In conjunction with a variety of educational and informational activities, continuing progress reports were routinely provided.[49] No program ever offered explicit financial incentives.[50]

Although in all of these areas, even after dramatic improvement, the quality of care remains far below the optimum, and although it is unlikely that the pace of change reported in these articles can be sustained over time, as additional increments in quality become more difficult to achieve, these are nonetheless dramatic results achieved in a relatively short time. It is difficult to see how the introduction of financial incentives could have produced any better results, and given physicians' mistrust of payors and the complexity of payment systems, it is easy to imagine scenarios in which efforts focused primarily around financial incentives would have produced worse results. At least in these instances, appealing to the professionalism and pride—and professional competitiveness—of practicing physicians appears to have worked as a motivation for quality improvement. These results would certainly seem, at a minimum, to call into question the necessity of financial incentives and also to suggest that the case for quality improvement through educational methods may

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46. Ashwini H. Sehgal, *Impact of Quality Improvement Efforts on Race and Sex Disparities in Hemodialysis*, 289 JAMA 996, 998 (2003).

47. *See* Thomas Marciniak et al., *Improving the Quality of Care for Medicare Patients with Acute Myocardial Infarction: Results from the Cooperative Cardiovascular Project*, 279 JAMA 1351, 1356 (1998) (stating that quality of care for AMI improved in program states between baseline and follow-up periods of the study).

48. *See* Jencks et al., *supra* note 39, at 306–09 (discussing methods used in gathering data); Marciniak et al., *supra* note 47, at 1352–53 (same); Sehgal, *supra* note 46, at 996 (same).

49. *See* Marciniak et al., *supra* note 47, at 1352–53 (discussing the feedback and educational opportunities provided to practitioners); Sehgal, *supra* note 46, at 997 (stating that performance data, educational materials, and workshops were provide to clinicians).

50. *See* Jencks et al., *supra* note 39, at 306–09 (discussing the methodology of the study which lacked any mention of financial incentives); Marciniak et al., *supra* note 47, at 1351–54 (discussing the design and feedback features of the study); Sehgal, *supra* note 46, at 996–97 (discussing the design and intervention features of the study).

be much stronger than is generally acknowledged in the literature advocating financial incentives.

The ethical implications of these findings, and others like them, are immediately apparent. If improving the quality of care is a shared goal among providers and payors, then opportunities exist for truly collaborative efforts in pursuit of a common goal, with no intrinsic ceiling on attainment of that goal. Embodying quality goals in an economic transaction, on the other hand, attaches an arbitrary (and potentially incomprehensible) value to an exchange. The implication of the economic transaction is that quality is something the provider would withhold in the absence of payment, and that there is some level of quality less than perfect that the payor deems not only satisfactory but is the most for which he is willing to pay. In the context of the preceding discussion, it is difficult to imagine that this is the message we really want those public agencies that are, among other things, payors to convey.

### *E. Incentives for Quality and the Tiering of Insurance Benefits*

Perhaps the most frightening contemporary manifestation of the movement towards incorporating incentives for higher-quality care into provider payments is embodied in some health plans' recent efforts to establish "multi-tiered" systems of insurance.[51] Under such arrangements, insurance plan beneficiaries would pay differential coinsurance for hospital care (and, eventually, presumably for other types of services as well) depending on the "tier" to which the insurer assigned the hospital or physician group.[52] Use of hospitals or physicians in more expensive tiers would require higher out-of-pocket payments from patients. Significantly, even though the insurance plans that have already implemented such systems claim that they will incorporate quality measurements into their tiering process, none have yet done so.[53]

The development of multi-tiered hospital networks is perhaps an inevitable outgrowth of contemporary trends in which employers and insurers, faced with rapidly-increasing premium costs, are seeking to shift as much of the cost of health insurance to employees as they can, sugarcoated (or disguised) with rhetoric about "consumer choice" and "greater consumer involvement" in their

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51. *See* James C. Robinson, *Hospital Tiers in Health Insurance: Balancing Consumer Choice with Financial Motives*, HEALTH AFF. WEB EXCLUSIVE (last visited on Jan. 14, 2004) (noting the emergence of tiered hospital networks), *at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.135v1/DC1 (on file with the Washington and Lee Law Review).

52. *Id.*

53. *Id.*

own health care.[54] It is also a response, of course, to the continuing frustration on the part of payors over the extent to which the costs and prices of inpatient hospital services continue to vary so much, even within specific communities, and often for reasons that are hard to identify or explain. In part, tiering strategies are the insurers' response to hospital administrators' assertions that costs and quality are more highly correlated than they are.

But if insurers do, in fact, incorporate quality information into their tiering process, it would presumably be done so that patients would not have to pay more money out-of-pocket to receive care at a hospital that had higher costs but also higher quality. The insurer would then be in the position of telling its beneficiaries that they would face the same out-of-pocket cost at a high-cost, high-quality institution as they would at a low-cost, low-quality one. That is hardly an incentive for quality, or a signal that insurers would seem to want to send.

More likely, insurers will seek to mollify high-quality, high-cost providers by charging consumers more to use them, but also making comparative quality information available so that consumers will themselves have the "choice" of how much more they are prepared to pay to reduce the likelihood that they will be maimed or killed during the course of their hospitalization. At this point, the tiering of hospitals becomes both morally and practically indefensible because the marginal utility of a consumer's discretionary dollar is directly proportionate to the amount of disposable income that the consumer has. Wealthy people will then be able to buy all the quality that the market is capable of providing, while lower-income people will have to make practical tradeoffs between the quality of their medical care, rent, and utilities.

Of course, Americans have long accepted a health care marketplace that distributes access to health care at least partially on the basis of socioeconomic and ethnic status.[55] But, no matter how reprehensible that practice may be, accepting, or even encouraging, differentials in the quality of care available to individuals on the basis of their purchasing power crosses another moral divide altogether. To the extent they are minimally safe and functional, we countenance enormous disparities in this society on the basis of income or wealth in the quality of housing or transportation or clothing people are able to

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54. *See* Humphrey Taylor, *From the Field: How and Why the Health Insurance System Will Collapse*, HEALTH AFF., Nov./Dec. 2002, at 195, 195 (noting a trend in the health care industry to offer more "consumer directed" health plans).

55. *Cf.* INSTITUTE OF MEDICINE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE 59–100 (2001) (discussing the socioeconomic and ethnic factors that make a person more or less likely to be insured), *available at* http://books.nap.edu/html/coverage_matters (on file with the Washington and Lee Law Review).

obtain, but the underlying premise of the movement to improve health care quality is that quality effects outcomes—that is, health and illness and life and death. Although the correlation between income, health status, and life expectancy is already very powerful, advocating policies that would have the effect of making that relationship stronger runs directly counter to all the moral and religious principles that supposedly underlie American society.

### *V. The Root Problem: Paying for Professional Services*

Health care *is* different. Even in a society as thoroughly market-oriented as modern America—with an intelligentsia totally besotted with a potent mix of market ideology and market mythology—we subsidize, regulate, and finance health care services in ways that reflect the profound differences between how we view health care and other services and goods in the economy. Health care is different because it involves matters of life and death, pain and suffering, and the relief of pain and suffering. But, it is also different from most, but not all, sectors of the economy and society because it is provided largely through the activities of highly-trained professionals.

In his most recent book on professionalism, the sociologist Eliot Freidson writes: "The two most general ideas underlying professionalism are the belief that certain work is so specialized as to be inaccessible to those lacking the required training and experience, and the belief that it cannot be standardized, rationalized, or . . . 'commodified.'"[56] The first aspect of medical professionalism is precisely what the payors, health services researchers, and government officials are, of course, trying to invade, or at least circumscribe, under the rubric of improving quality in the health system. It is what Freidson identifies as the second idea, however, that poses the greatest challenges in the relationship between the health professions and the rest of society, and the greatest obstacle to schemes to affect the quality of health services through payment incentives.

For the practice of medicine—or nursing, physical therapy, clinical psychology, or any of the other health professions—is not solely a matter of the rational application of scientific knowledge and data from the latest literature. There is an important subjective component to human health and illness, and important intersubjective interaction exists in the patient-health professional encounter. Moreover, not all of medical knowledge can currently—or, I would argue, ever—be expressed in objectively reproducible scientific information. A

56. ELIOT FREIDSON, PROFESSIONALISM: THE THIRD LOGIC 17 (2001).

good physician can, and must, rely on subjective observation, experience, and practiced intuitive judgment. The combination of scientific knowledge with training and experience in the experiential and subjective aspects of the client's situation is precisely what we mean in defining professional roles in our current society.

In general, acquiring the non-objectified skills and experience necessary for effective professional practice is a primary focus of professional training, which is customarily a demanding and prolonged experience that is expected to inculcate a set of values and behaviors in the future professional as well. This indoctrination is as true for lawyers-to-be, architects-to-be, and teachers-to-be as it is for aspiring medical students, interns, and residents. And this inculcation of values and beliefs is especially important, not because it reinforces a sense of professional identity and "us versus them" in aspiring professionals, but because it is essential for the protection of the clients whom the professional will ultimately serve and for the benefit of the broader society.[57] By definition, lay people cannot adequately judge or evaluate all aspects of professional performance; the rule of *caveat emptor*, which is sovereign in an American-style market, cannot apply. No matter how much we try to describe or measure or circumscribe the domain of professional experience and professional judgment, at the end of the day we have to trust the professionals. There really is no other choice.

Of course, not all professionals behave professionally all of the time, and the failure of the professions to adequately police themselves has led, unavoidably, to all sorts of mechanisms to regulate the boundary between professional sovereignty and broader social control. In general, modest financial incentives are not among the most effective of such mechanisms, but for the purposes immediately at hand, that is somewhat beside the point. What is critically important is the fact that the protection of patients' interests and the provision of the highest possible quality care are among the central values—if not *the* central values—of medical professionalism. No matter how much individual professionals, or the health professions as a whole, may fail to uphold those values in individual instances or in general, promoting and reinforcing those values must be the heart of any strategy to improve the quality of medical care.

On several occasions, I have heard Dr. Uwe Rinehardt of Princeton University, the distinguished health economist, pose the following question to groups of physicians: Imagine you have agreed to perform a certain operation

57. *See id.* at 18 (discussing how specialization is needed for survival because few can do all they need to be self-sufficient).

and to accept a fee of $5000 from the patient's insurer. On the day of surgery, you are in the operating room, the patient is fully anesthetized, and you have begun the procedure when you receive a telephone call informing you that you will be paid only $3000 for the operation. Will you do it any less well?[58] Regardless of how physicians might envision themselves actually behaving, most will appropriately take umbrage at the very question Reinhardt poses and insist that their actual performance in surgery would be no different at the lower fee than the higher. They might pursue a variety of forms of redress from the insurance company or the patient after the operation was successfully concluded, and they would certainly be well within their rights to refuse to operate ever again on that insurer's patients. But, under the circumstances immediately at hand, most physicians would argue—sincerely—that their obligations to their patient and to their profession itself would require the best professional performance that they could possibly provide. Similarly, it is hard to imagine that a thoughtful physician would argue that his colleague who volunteers to provide free services at a local clinic or in a third world refugee camp is performing at a lower professional level, or providing a lower quality service—although the practice environment may be of lower, or at least different, quality.

Professionals, in other words, are paid (or not paid) to do what they do, and what they do should entail, at all times, their best efforts. This idea is not just a matter of exhortation; it is instead a principle integral to the ethics of any profession. To assume, or imply, that a professional paid $2x$ will perform significantly better than if he is paid $x$ is to describe behavior that is inherently unprofessional. In order to systematically and significantly improve the quality of care in the United States, we are going to have to increase the professionalism of those who work in the health care system, not ignore or destroy it.

Paying appropriately for the services of professionals is an intrinsically difficult task. In the American context, it is certainly not clear that we have done substantially better in figuring out payment systems for lawyers, research scientists, or teachers than we have for physicians or nurses. For a variety of historical reasons, American physicians—and perhaps to an even greater degree, other American health professionals—are extremely well compensated in comparison to other professionals, non-professional workers, and their counterparts in other countries. For that reason alone, it might be reasonable for the rest of us to expect higher-quality performance than we frequently get—although, again, there is a growing body of evidence that shows that appeals to

58. Author's personal observation and paraphrase of hypothetical.

professional motivation, when combined with appropriate data systems, feedback mechanisms, and educational efforts, can indeed appropriately mobilize professional aspirations.[59] But, getting professional compensation right is hard enough without at the same time overlaying a potentially distorting quality agenda.

## *VI. Conclusion*

At the outset of this Article, I suggested that the conceptual issues involved in providing financial incentives for higher-quality health care were so important that they should be considered on their own merits, apart from the very real issues of whether developing appropriate measurement devices, data systems, and incentive structures would prove feasible in the first place. There has been so much progress over the last twenty years in defining and measuring the quality of care that it would be a mistake to be too pessimistic about the technical problems in quality measurement or reporting, although some of those problems may indeed be insoluble as a result of the remaining uncertainty intrinsic to much of medical practice. But, the avidity with which payors and policymakers are rushing to adopt financial incentives for quality before the technical issues can truly be said to have been satisfactorily solved suggests that this may indeed be more a matter of ideology and public relations than part of a thoughtful, long-term strategy to improve quality.

Whatever the technical issues, though, two things should be clear by this point. First, there are numerous conceptual, practical, and even ethical problems in establishing systems to pay health care providers differentially on the basis of variances in the quality of care they provide—whether those differences are "real" or the artifact of some inadequate measurement system. Second, the quality of care can be improved without financial incentives. One would think that at a minimum the burden of proof would lie with advocates for financial incentives and that it is fair to say that, to this point, they have not adequately shouldered that burden.

In specific reference to Medicare, Berenson argues that the program would better serve beneficiaries and taxpayers alike if it operated more like an aggressive "purchaser" and less like a passive payor of bills.[60] As one who

59. *See* Jencks, *supra* note 39, at 305 (citing the progess that has been made with respect to improving the quality of care); Sehgal, *supra* note 46, at 996 (finding that the improvement seen in this study was due to the Medicare quality improvement project that provided feedback and education opportunities for physicians).

60. *See* Berenson, *supra* note 4, at 1322–28 (discussing why Medicare should be active and not passive).

personally helped formulate and advocate for some of the earliest efforts to implement a "purchasing" strategy for Medicare, I can hardly disagree, especially with such proposals as establishing prices through competitive bidding, recognizing and rewarding (through patient volume, not financial incentives) centers of excellence, and excluding low-quality providers from participation in the program to the extent that access considerations permit. But, acting as an aggressive and prudent purchaser does not require paying differentially for quality. Indeed, most of this Article has been devoted to arguing that such incentives are about the last thing that a prudent purchaser would want to adopt.

Medicare can maintain its position of leadership in promoting higher quality care without distorting its payment systems by implementing the addition of extra payments for providers exceeding some quality threshold. It can act as a more effective purchaser by adopting any of a number of strategies. These two approaches are not incompatible. Public programs and public agencies can do more than one thing at once; they do multiple things, many of them successfully, all the time. But financial incentives for quality are one bandwagon on which Medicare should not jump. Sometimes asserting leadership and being progressive means resisting the temptation of the latest fads. After all, the first principle of medical professionalism is: Do no harm.