What Other Nations Can Teach Us About A More Patient-Centered Health Care System:
Panel III - Using Financial Incentives to Promote Quality Improvement: The U.K. Experience
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ED HOWARD: Just for getting us in position to move to this next level of discussion of not only from David but also we heard from Sir Liam, the need to align proper incentives to improve safety and for quality in general we turn now to the question of to how to use financial incentives both in the UK and we get a little bit of insight into how its happening in the United States as well. To set the stage and give us the background that we need we're going to hear from Dr. Martin Marshall, who is head of the Division of Primary Care and a professor at the University of Manchester, and I might add an alum of the Commonwealth Fund Harkness Fellowship several years ago. He is a possessor of very strong policy in the quest of quality of care. He is also the Head of the European Society for Quality Improvement and Family Practice. He's going to give us an insight into the UK's Quality Purchasing Initiative.

DR. MARTIN MARSHALL, M.D.: Thank you very much and good morning to everybody. They say a rather popular joke that is resounding around the corridors of the NHS at the moment. And like all British jokes, it has a little bit of self-depreciation in it and a little bit of irony as well. The joke goes something like this, it says, "How do you hide a 10-pound note from a general surgeon?" Answer: "You hide it in a book." "How do you hide a 10-pound note from an

orthopedic surgeon?" Answer: "You hide it in the patient's records. "How do you hide a 10-pound note from a general practitioner?" "You can't hide a 10-pound note from a general practitioner.

[Laughter]

Shall I call the joke has a certain touch, which irritates people because it has, I guess, an amount of truth to it, as well. I can't actually see my--I've got it. I think I've got it. Okay, thank you. What I'm going to be doing in this presentation is finding out whether there's a touch of truth to that joke. And particular whether GP's are the classic example of homoeconimicus, which is something that certainly they've been described as. I'm going to be describing the GP Financial Incentive Scheme. I'm going to be presenting some hot of the press evaluative data about this scheme and looking at some of the lessons that I think we can learn internationally from that data. But first of all, what I'd like to do is to put financial incentives into some kind of context.

And I'm still having trouble using this. Are you uploading it for me? Okay. Thank you. How effective, sorry, I'm going to have to be an operative from here, so—could you show me? Okay. Thank you very much.

So how effective are Financial Incentive Schemes? Surely, this is the most important and fundamental question

that we need to ask ourselves. Well, I guess the first answer to that question is, well there are lots of people who say they're effective. In 1761, Benjamin Franklin an amazing polymath, who not only discovered the lightening conductor but also contributed to the American Declaration of Independence, said that, "God heals, but the physician take the fees." More recently, this rather fine looking gentleman who some of you might recognize as Kenneth Clark. He was secretary of state for health under the Thatcher government and was responsible in the late 1980's for introducing a similar kind of incentive scheme to the one I'm going to be describing to you, said, "Ask GP's to do anything new, and you'll have them clutching for their wallets." So people say that they work. Is there any evidence to suggest that they work as well? And the answer to that is at a microlevel, yes there is some evidence. Certainly there is some very good evidence and this international evidence from a range of different countries, a range of different health systems. That the way in which you pay doctors seems to have influenced their patterns of behavior. If I could summarize that in a fairly kind of tabloid and populist way, pay doctors from salary, and you tend to encourage them to do as little as possible for as few people as possible. Pay them by capitation and you tend to encourage them to do as little as possible for as many of people as possible. Pay them fee

for service and you tend to encourage them to do as possible for only carefully selected people. And that's fairly convincing evidence and fairly consistent evidence across a whole range of different health systems. So the macro evidence is quite convincing. But in a microlevel, if you look at individual studies, I don't think the same story emerges.

In your pack here, you will see a summary of the Incentive Style paper that came out in JAMA. A study that supported by the Commonwealth Fund and I had a fascinating experience there. Just within hours of that paper being published a couple of weeks ago; I got an E-mail from a very admirable and trusted colleague of mine, who happens to be a strong advocate of incentives. The E-mail said, "Isn't this great! We've got in evidence that incentives work!" Literally two minutes later, I got another email from another colleague of mine who I equally find very trusting who happens to be an opponent of incentives and said, "Isn't this great! We've got evidence that incentives don't work!" That in many ways categorizes the sort of evidence that we're looking at. There's one particular study, which I think is very interesting which suggests that the effects side of incentives might actually be quite small. This is a study undertaken by the Rand Corporation in 2002 and it compared a range of different quality improvement initiatives in the air

of improving immunization uptake. Compared organizational change with provider information with patient reminders and financial incentives.

The columns you see here are adjusted on ratios and the bars are 95 percent confident intervals and what you see is a large effect size for organizational change and a much smaller one for provider education and patient reminders and a very small effect size for financial incentives. An effect size, which actually the 95 confident intervals suggest that it even isn't specifically significant. So the evidence is not that convincing there. The other bit of evidence that I would like to create is-I'd like to present to you, is the evidence around unintended consequences. And there's a fair amount of evidence from a lot of different sectors, that when you use financial incentives or any other form of performance management, it tends to introduce a lot of unintended and sometimes quite dysfunctional consequences. Those ones again are well described. A preoccupation with what's being measured, often at the expense of what isn't being measured. A focus on the short incentive cycles, annual payments, annual attention, gaming and crowding out of internal motivation. So the evidence I think can be summarized, at the moment that the incentive schemes that have been used to date, particularly in health care, are not particularly convincing and the incentives probably are fairly blunt and a

fairly unsophisticated tool. So the question I think we need to ask ourselves is, in the policy audience is, “Is it possible to design incentive schemes that are more sophisticated and more effective?” And that I think is what we’ve attempted to do, with an ENGB [misspelled?] contract in the UK. Let me give a very quick description of that contract. The contract is with the practice rather than individual doctors so it’s a team based contract. Up to twenty percent of the family doctor’s income or practice’s income is based on the series of 136 mostly new-evidenced based indicators. Of those indicators can be divided into three varying groups. The main ones relate to clinical care. There’s a smaller group relate to practice organization and the smallest percentage apply to patient experience. When you achieve an indicator, you get points. There’s a total of just over a thousand points that are available. You get more points for achieving outcomes or processes than structures; you get more points for a higher level of achievement from a lower level of achievement. These are the clinical areas that the indicators are based in. You can see there the most common most important in policy terms conditions that are available. Particularly for heart disease and asthma and diabetes and stroke. It’s worth mentioning very quickly that there’s an issue called Exception Reporting. The professional negotiators for this contract argued that

certain patients are more difficult to achieve a high quality of care than others and that those patients ought to be allowed to be exempted from figures. So this idea of exception reporting for patients that satisfy those criteria was allowed. I'll come back to that point in a second. The organization indicators were in these areas, things like the quality of patient records, the quality of information for patients, and such like. These are the patient experience indicators, very few and very weak. I won't even do them the service of reading them out because they are so weak. We'll come back to that in a few seconds. So, the most important question. Has the contract been successful? What I'm going to be doing here is presenting some data, first of all routine administrative data, that's available as part of the payment system for practices. But I'm also going to be presenting some data from interrupted time series evaluation that we're conducting. The National Primary Care Research and Development Center in Manchester. And also some linked qualitative studies and also some miscellaneous data sources mostly from the Department of Health. This shows the overall performance. I said there was a total of over 1,050 points, this graph shows a number of practices achieving each of these points and what you can see is an actually a really, remarkable high level of achievement. Overall, 91.3 percent points were achieved by the practices. Two point six percent

of practices achieved a maximum score of 1,050 points. And this contrasts with the expected level of achievement when the Department of Health designed this scheme, which is thought to be around 750 points. So a high level of achievement. So, I guess the first conclusion that you might draw, is this incentive scheme a highly successful one. The question you have to ask, however of course is, was it because of this scheme that these improvements took place? What was the level of achievement prior to the introduction of the contract? And that's something that we didn't actually know anything about. We didn't have any systematic national data about how well practices were performing before. But as part of our interrupted time series evaluation and I hesitate to present two points of what again to be a four point time series. But I can't restrain myself from doing so. This shows quality improvement for three conditions. And what you can see is a dramatic improvement in quality between 1998 and 2003. The contract was introduced in 2004. So a dramatic improvement in quality particularly for diabetes and heart disease that happened before the contract was introduced. Suggesting I think, one of the interpretations is all the other things we've been doing in the UK. Like professionally owned audit, like clinical covenants, like national service frameworks, all the things that were introduced in the late 1990's might well

have had a much bigger effect that we thought they had. There are a number of changes that we thought might happen alongside the introduction of a major performance management incentive scheme like the new contract. For example, we predicted that it would be easier for large practices to achieve high scores than lower practices. So, what we expect for the contract to do was to cause structural changes like the merger of practices. This shows a total number of practices in the UK between 1994 and 2004. You can see a gradual decline in the number of practices because there's been a trend over the last thirty years in terms of practice mergers and particularly the loss of single-handed practices. And what you can see is a step-wise reduction in that trend as a result possibly of the contract. So, it looks as if the contract has induced some structural changes. It's also introduced some changes in terms of the staff employed within practices. And again, these are ones that we hypothesized would happen. We expected that practices would be more successful if they employed more nurses and if they employed more administrative staff. And again, we can see trends in terms of increasing number of staff for practice employed and not so notable for nurses probably because of recruitment problems, but certainly for administrative and support staff, we can see a step-wise increase in the number of staff employed by practices around the time of the introduction of

the contract. A qualitative evaluation is also introduced as shown as some interesting findings. For example, we can see that people are working differently within practices. We see GP's and our folks in much more on complex problems, on complex patients. We see practice nurses now providing most of the routine chronic disease care. We see nurse practitioners providing most of the care for self-limiting acute conditions. We see nurse assistants now doing what practice nurses used to do, things like taking blood pressure, air syringing, taking blood samples. We see administrative stuff within practices. We see the practice staff meeting more and talking about what they're doing. We certainly see more bureaucracy, what we also see is probably, and this is based on qualitative findings at the moment. We've lacked to get the results of a survey that's been undertaken at the moment. We see that GP's are happier. As cynicals say that because GP's are wealthier. There's no doubt that they are. The average GP income now in the UK is somehow between 100-120 pounds sterling. That makes them the highest paid family doctors in the work. And for the first time and I say this with a certain smiling glow to my face, it means that family doctors are paid much more than specialists for the first time in history. Which I think says a lot about the value that's placed on family practice within the UK. This has been in evidently an intended

consequence. I said there are inevitable consequences of any performance management regimen. What we don't know is we don't have any systematic data on the prevalence of the unintended consequences or necessarily on the significance of them. But there are some interesting examples of unintended consequences, which I think, should ring alarm bells. For example, one of the targets, one of the incentives around was in proving access. A significant payment was made to practices that managed to achieve a high proportion of their patients being able to see a clinician within 48 hours. What we saw was a high level of achievement against that indicator, but the patients found it increasingly difficult to book appointments in advance. In a recent survey by the Healthcare Commission has determined that they are very unhappy about that. So, paradoxically in some ways access improved in some areas, but got worse in others. The other issue, which you could have predicted from my earlier slide, is there's been probably some gaming around exception reporting. The evidence, the data I've got here is based on a limited sample, but what we see first of all is a high level of exception reporting up to a third of patients for some massive indicators. Five out of the sixty-four samples in this practice were very clear statistical outliers in terms of the number of patients that they were exception reporting. And most importantly, we see a strong correlation

between the level of exception reporting along the horizontal access here and the level of achievement along the vertical access here. A one interpretation of that is that perhaps we are achieving high scores in this framework by exempting more patients. In summary, what are the strengths of the GP Incentive Scheme? First of all, the Scheme is undoubtedly focused practices on key policy areas in exactly the way it was designed to do. Secondly, I think what we see and we've heard something about that this morning is a very high level of professional and practice engagement in this scheme. They really are interested. They're seeing something that is being done to help professional—it's being done with them and by them. And we also see that the practice is stimulated a lot of innovation at a practice level because essentially the system is an exercise in micro-management. What this scheme says is, "Here's a lump of money. This is basically what we expect you to deliver, but deliver how you like." And practices are being very innovative in how they are delivering it. There are some weaknesses, of course. A complete absence of patient and public involvement. I don't think that the public even knows that this is happening. And I think that the British public knew that their doctors were being paid a significant amount of money for doing things to them, they might have become very suspicious about that because that isn't our culture in the UK. And the other

problem we have is the lack of systematic data about gaming, which I've mentioned already. And, I think particularly interestingly we have a lot of trouble linking the performance data, the routine performance data to any population demographic characteristics, so we've got no idea what impact this kind of scheme has on inequities. How about the uncertainties, the—I think what Donald Rumsfelt would call the "unknown unknowns" or was it the "known unknowns unknown"? I can't remember. There are all the things that we don't know about this scheme. For example, here's the high level of performance, the apparent high level of performance represent really improved quality of care. Or is it just improved reporting, we don't know that. What is the impact on the unmeasured aspects of care? And I'm not referring here so much to the clinical accommodations that are being set in device, for I am referring to the other key aspects of primary care like coordination and continuity of care. Is such a large investment a cost effective use of the nation's resources? Two billion pounds went into providing this scheme. If policy makers had 2 billion pounds sterling in their hands now, with a usable scheme like this or would they use it in some other way. Are financial incentives a cause of the problem? Some of the data here, the preliminary data like presented here suggests that maybe they're not. But there other aspects to this new contract like improving the

morale of the profession. Like providing a more systematic approach to care delivery, which might well be the effective components to this scheme. Rather than the money that's linked to those activities. Would incentives work in the future? David Blumenthal's [mispelled?] has done some lovely work. This is just that doctors have a fixed sense of financial worth, a target income in you like. And when they achieve that targeted income, they are no longer motivated for incentives. And I argue at the moment, that earning a hundred-twenty thousand pounds is probably pretty close to that target income. So, we'll tweaking the incentives in the future will actually make any difference. We don't know the answer to that. And finally, I think it is an important issue and an issue that in many ways John Berwick stole my thunder yesterday. What is the impact of using external motivators, like financial incentives on internal professional motivation? I think that this is a key issue and perhaps an interesting issue for discussion. I was very interested to hear Mark McClellan yesterday at lunch time, describing how rather than providing financial incentives he is now in the process of reducing physician's pay by four percent. Even more worryingly reducing patient's benefits for four percent. I wonder what kind of message that gives to the quality improvement world. So, in summary, what are the lessons that we have learned from this scheme? I think

these are probably the key ones. If you want an incentive scheme to be effective, it's more likely to be so if you use evidence-based indicators or consensus based indicators. Indicators around which people believe really are important. It's more likely if you involve the people who are being incentivized in the process and developing the scheme and this confab was very much in negotiated process from a professional representative on one-side and government representatives on the others with academic input. We need to consider the scale of this scheme. I've said around about twenty percent of income is linked to incentive in this scheme. I know in Ceinmask [mispelled?]they're talking about five percent. I suspect that's too little to get attention. I suspect 50 percent is too much and it rights its energies in too much gaming. What is the right percentage? We don't really know. I think schemes are going to be more likely to be more effective if they are introduced in a high trust environment. It's very tense to introduce bureaucratic and regulated mechanisms to check that all this is being done correctly. I think that would be a big mistake. I think it's important to plan for an unintended consequence because they're almost always predictable. I think it's much more likely to be effective if you start off with new money. Now I recognize there are many countries that can't do that. We are in a very fortunate position in the UK in introducing

this scheme at a time of massive investment in the National Health Service. I think it's much more likely to effectively use financial incentives along side other ways of improving quality. The classic triad of improving quality, professionally led educational approaches is one important way. Markets are another important way and performance management, things like incentives and targets are another important way. It's getting the balance between those three things, which I think is most likely to deliver quality improvement. There are many ways of improving quality and this is one of them. I'm not necessarily suggesting that we should give Prozac to all our health professionals in order to improve their performance. But equally I'm not suggesting that using financial incentives is the only way to improving performance as well. And what I would argue for is a much more balance approach to quality improvement than the advocates and evangelical enthusiasts of financial incentives, perhaps it's a direct showing at the moment. Thanks very much for listening.

[Applause]

ED HOWARD: Thank you so much, Martin, an excellent presentation. It gives us a lot to chew on and here are a couple of very skilled chewers: Cybele Bjorklundis is the Democratic staff director for the House Ways and Means Health Subcommittee. She works for Representative Pete Stark, who

is ranking Democrat on that subcommittee; she's also spent some time here on the Senate side working for Senator Ted Kennedy on the health staff of the help committee here. She's also spent some time in some key positions as what is now the "Center for Medicare and Medicaid Services." Following Cybele we will hear from Ashely Thompson who is the health policy advisor to the chairman of the Senate Finance Committee, Chuck Grassley of Iowa. Ashley works primarily on Medicare. She's got broad experience particularly in the hospital area. She's spent time as a high policy analyst at the American Hospital Association dealing with hospital problems there and has some ground level experience in hospitals in the Chicago area as well. We're really pleased to have both of you here. Cybele, would you like to start us off?

CYBELE BJORKLUNDIS: Sure. Thank you, Ed, and the Commonwealth Fund for inviting me to be here today. As House Democrat we're sort of the lowest on the food chain here and we're always happy when we're let out and come talk to folks and especially when it means folks from overseas. I should add quickly, although I don't see any of the usual suspects here, I know press were invited and my comments need to be not for attribution if there is a reporter here and you want to take down something, lets' talk afterwards about how to

contribute it. Our members would prefer not to have our names in the paper over there, you might understand that.

ED HOWARD: You might try the formulation former Hill staffer.

CYBELE BJORKLUNDIS: [Laughter] That would be the formulation, potentially.

[Laughter]

He's still teasing me about the actuary stuff. I will say that with 120 towns, I'm thinking I should go back to medical school and move to England. I always wanted to live there and I'm a big supporter of primary care and here with all due respect to probably many GP's in the audience, it's a pretty tough existence. It sounds pretty good over there right now.

And what I would also say is that we, really on a more serious note, certainly both and I work for Mr. Rangel as well. Charles Rangel who's the ranking Democrat on the Complete Ways and Means Committee and he's from New York, also a very progressive fellow. I think he and Mr. Stark both are very disappointed in the American health system. And certainly when you look at us compared to other countries and Commonwealth Fund has done a great job giving us lots of international comparisons, including some out this week obviously in coordination with the conference. He notes consistently showing how poorly we perform compared with

other industrialized, frankly even some not-industrialized nations on health care we send the most and we basically get the least amount for it in terms of outcomes and indicators. So we welcome the opportunity to participate in these kinds of events and learn from the experience of other folks. Certainly, one of the key points that I make when I have an opportunity to talk to visiting delegations is don't do what we do! We've had some Parliament members and some other folks from different euro countries come over at times to look at our private insurance system. We try to send them home with a firm admonishment to not follow out lead. So, the latest fad this year certainly in Congress and primarily with respect to Medicare is the "P for P, P for Q, or VBP." You can pick your alphabet acronym. But, "Pay for performance, pay for quality, valued-based purchasing" is sort of like a Rorschach test. It means different things to different people depending on where you sit and what you do. My personal view is that there is some promise in this concept and there is certainly much more that we need to do in Medicare to leverage our power to exact better care. But I think we're a long way from practical implementation beyond anything but a check the box kind of measurement. And it seems to me that much of the focus this year is the proverbial tail wagging the dog with physicians. For example, people are talking about affecting a very small

amount of the payment while ignoring the bigger systemic problems getting to the update issue that Dr. McClellan apparently mentioned yesterday and other fundamental issues with the core of our Medicare program. And furthermore I'd say it seems to me that Dr. Marshall's report on the initial UK experience with the new program is nowhere beyond it on a number of fronts and for a variety of reasons I'd argue the program he describes is probably not generalizable to the proposals under consideration here for an incredible variety of reasons. Not the least of which is we don't have a coordinated health system but even with respect to Medicare, which is loosely our best attempt to have a coordinated health system. We're just not prepared and the two most important aspects for funding with the UK initiative putting significantly higher dollars on a proportional basis in play. If I understood it correctly and I think you echoed it in your slides that the outcome is to potentially increase one's practice income by twenty percent. Most of the proposals here are one to two percent, actually, in terms of the fees. I'm not sure how it would calculate it out for overall income because it would vary because doctors have different proportions of Medicare patients in their base. But, it's also in the UK, it was obviously new money and not redistributed and we don't have that kind of new money around here. I gather from Dr. Marshall's summary paper that the

funding came about in part because England has decided to increase its health spending to bring it in line with other Euro countries. I think it safe to say we don't have a problem with under spending here in the U.S. That said I'm very interested in the results. The participation and the achievement levels are impressive although caveated by the lack of a previous baseline and the other changes happening in each of the systems at the time obviously make it tough to draw direct comparisons and presumably from this point forward it will be possible now that you've established a baseline to see, but I still don't know whether you have the confounding factors and I also appreciate you've acknowledged the difficulties in tying the investments in actual improvements and outcome. If you know they are subsequently able to track and report that accordingly, that's obviously the ultimate goal for any of these systems is to see if you're investments are making a change in the outcome for folks.

I'm concerned but not surprised that preliminary evidence shows that the advancement of some undesirable behaviors including higher administrative costs which may not be all bad. I mean I know that some of the complaints people have had with NHS might result from lack of additional administrative staff or some of the other niceties that might come with higher spending there. The selection issues in

particular, it's these unintended consequences that can come about are serious and that's a lot of our concern when we look at the development of a "P for P system" around here. So, as always I think there's much we can learn from England's system and the thoughtful approach taken toward paying for parties is no exception but there's obviously a lot of additional work that needs to be done there.

Moving back here, I'd say that right out of the box we fail on several of Dr. Marshall's lessons for designing an effective system. We are not talking about investing significant new money. We do not have a trust-based relationship right now, I'd say with our providers. There are scaling issues and everything else. We could probably accommodate some of the lessons as well, but I hate to be such a naysayer. I don't think we are ready.

Some of the concerns that Mr. Stark and others have actually said, seem to be validated by Dr. Marshall's evaluation. Depending on how these systems are created, we are worried about the perverse incentives that could happen to select or deselect, if the case may be, certain patients. I don't have blind faith in the immediate creation of accurate risk adjusters. Some of the legislation that we look at waves a wand and says, "We'll be able to take of that; if you have a disproportionately sick population because we'll adjust it accordingly." I mean, maybe more

likely you end up with an exceptions process and that's open to its own demons as you've already seen right away in England.

We are also concerned that Congress not get in the business of practicing medicine, per se. Difference obviously needs to be shown to the professional societies but not so much that we lose sight of our ability to govern appropriate spending of taxpayer dollars and equally important to ensure proper care is delivered. I'm not sure that we actually do either of those well now but I'm worried about how we proceed. It's a very tough balancing act. So I guess the upshot is that on a personal level, and I get mixed messages from my members, we're not opposed to the concept. But we've yet to see a proposal whose execution doesn't raise alarm bells. It's hard for Pete Stark in particular, to imagine paying more for basic services. For example, one thing under discussion here is the "AQA Starter Set" and I think any layperson can look at that set and say, "I didn't go to medical school, and I think those things should be a part of your current practice." I don't think we pay a car mechanic more for fixing the car. You pay him the bill because he fixed the car. To pay more to do what you're supposed to already do raises a lot of concerns. On the other hand if they're not doing this desirable behavior, financial incentives are obviously one part of the equation

to move us there. I would say that the score of the Senate proposal and Ashley can speak to this in greater detail, obviously leads me to believe that maybe they're not performing so well, if we're finding 4 billion savings from implement "pay for performance." It doesn't sound like we'll be paying for very high performance but we're open to working on these issues and looking at these issues and I guess only time is going to tell where we're headed from here. There's a lot of interest and a lot of proposals, but a lot of uncertainty. Thank you.

ED HOWARD: Ashley?

ASHLEY THOMPSON: Sure. Thank you. I think we're probably a little more optimistic on the Senate side from both of the other panelists but I do appreciate all of the words of caution. And I think one of the reasons why we are optimistic is just late last night the Senate actually passed a bill that has "pay for performance" measures in there. I think Cybele did a great job of telling you of where we're at. Medicare is the government payment system for the elderly and the disabled. It covers about 40 million individuals and we don't do a good job there. Right now, most people would say that payment system is broken. Whether we're talking about payments to hospitals or payments to physicians because what it does, it's the typical "P for Service" side for physicians and rewards kind of more. More

of what you do and on the hospital side, while there are some ability because it's a bundled service that you're paying for; we do pay more for complications and co-morbidities. So the incentives seem to be warped right now. The worse you are, perhaps the higher payment you get, and that's not necessarily something that we want to reward. So, in the bill that passed last night, it would be the first time that we actually shifted a portion of payment to ask providers to do something. And it really is, its baby steps compared to what I think the capability is out there. But it starts with a "paid for" reporting scheme for a number of providers who would be physicians, who would be hospitals, skilled nursing facilities, home healthcare organizations, even managed care plans, reno-dialysis, etcetera. So it is very, very broad. It's very ambitious as well. And we would pay hospitals more if they reported certain measures of quality care. This happened to take place in the Medicare Modernization Act that was passed in Congress in 2003. There was a link between very small portion payments to hospitals per reporting ten measures of quality care. It is amazing that in the United States at least, the ability to get that extra point four percent upgrade resulted in over 98 percent of hospitals choosing to voluntarily report that data. And it's interesting because I think that we've been able to capture a little bit of baseline data as we move forward to not just

pay for reporting but actually pay for the outcomes. So just to give you a sense of what's going on now, hospitals get a higher payment if they give an aspirin to a cardiac patient upon admission if it's not contra-indicated. And all they do is they get paid more if they report whether or not they did it. They don't get paid more if they do it. And so there's a sense that we really have to move forward there and link it to better outcomes. And these really are baby steps. I so appreciate and oh, I'm so sorry. I meant to immediately to thank the Commonwealth because we do rely on your data and the Alliance for putting together this symposium because I think I learn more when I stand up here, then I do in my everyday experience. So, this is wonderful. What I've learned from your lessons learned, is that we're getting there, but we definitely need to re-examine some of the stuff and I just wanted to go through and give other people a sense of kind of what the Senate is approaching in the "pay for performance" spectrum.

You talk about your lessons learned to use evidence and consensus based indicators, the language that was passed night has a very lengthy consensus development process involving everyone and the kitchen sink. How all of the multiple entities from providers and quality improvement organizations, payors, employers, everyone at the table including the Centers for Medicare and Medicaid Services are

going to agree on indicators as probably the bigger picture story. We do as Congress pass this bill, there's language to make sure that the indicators are evidenced based valid and reliable. That they are risk adjusted. Whether or not we have the capability to do all this again is unclear but that's what our grand goal is.

You talk about involving the professions, which I think that we've done. You spent some time talking about the scale of the scheme. And Cybele talked about this too. Boy, do we wish had new money to put behind such an initiative, but I think that the sentiment is very much with Cybele. You're also going to see something that we all agree on. You know why more for getting things right? And I don't think we're asking a lot for what we're actually going to begin tracking. What I've heard from provider groups however, is we're planning on setting aside one percent of payment and growing that to two percent over five years. And that's too much money for the hospitals. They are very much opposed to that much money coming out of their bottom line to be redistributed based on whether or not they're a high quality facilities as to whether or not they meet certain measures. The physicians however, the concern even though we are—that the physicians are probably the least excited about this initiative. They feel that one percent is too much. As you probably jump in here because I know that Dr. McClellan

yesterday, talked about the negative four point four percent update to physicians. The bill that was passed last night actually has a one percent update, so overall they kind of got a 5.3 percent palm [misspelled?] if we can get something through the House that's similar and then in conference and something in the law. But it does link a payment update for physicians to hopefully provide them with background and incentives to then conduct this payment for reporting moving to pay for performance. Looking at some of your other stuff, the plan for unintended consequences, I absolutely agree with you. And we don't know how to solve that right now. In the hospital setting, at least the ten measures of quality of care are all on three conditions. Heart attack, heart failure, and pneumonia. And my concern from all my time in a hospital setting is that hospitals if they have one percent Medicare bottom line, which can be millions of dollars contributed to outcomes for those patients. Because they will pull every single staff person and put them to make sure that the aspirin is given to that patient upon arrival and upon discharge or beta-blocker. They're going to pull them from the OB Suite, where the complication rate or infection rate might be 20 percent. And we absolutely don't want to reward that behavior and I think that is why we really are trying to take my boss, Senator Grassley, really wants to take an aggressive push to move forward to more and more

measures. And I think that Dr. McClelland felt the same way or he sounds likes CMS is moving in the same direction. That they want to move not just on process measures, which not is in the hospital setting or outcome measures for really patient experience of care, which will touch all conditions. And it's interesting to see that you do all of that in Europe.

If we talk about some of the areas that we have lessons to learn, it's a lot. I think that what we've learned so far though is that payment for reporting of data has hopefully led to better quality care. And I know that that is a purpose of your discussion. Is there any evidence to suggest that incentives work? I think that, I don't know whether it's the incentive, the carrot, or the stick? I think the stick is what we're implying is working a little bit. We found that when you make data publicly available that providers compare themselves to others. I mean especially physicians. We know how competitive they are and how they have probably excelled and were all of the A+ students in school. And they want to do the best. I think that reporting that data and making it publicly available has risen the level of quality of care in the States or at least again on the reporting. Oh, I just lost my train of thought. There was something else I was going to mention. Moving forward – it's also a way that patients can have more

information and make choices about their healthcare and make informed decisions about where they go, so hopefully that will weed out some poor providers over time. They just won't have the flow of patients directed to them. I see that I have used up my time, but I would be more than happy to answer any questions on any of these topics. I have to thank you for giving me a lot more to chew on as we move forward with this bill and move it through hopefully conference around the corner. Thank you.

ED HOWARD: Terrific, thank you very much Ashley. Now we have a chance to follow up on some of these points with your questions in mind. Yes sir, why don't you go ahead?

BOB CRANE: I'm Bob Crane with Kaiser Permanente. Martin, I'm interested in the lay of the land is with respect to evolving the quality measurement scheme that you have that's heated the waste between the three categories or other categories. Liam had talked about the lack of patient safety kind of orientation, where are things likely to move?

DR. MARTIN MARSHALL. M.D.: The plan is certainly to evolve the scheme. Unlike previously the contracts that have existed virtually unchanged for between fifteen and thirty years. This one is being revamped probably every two years with minor changes being made to it. And again all the

evidence says that you have to evolve the scheme in order to make it effective.

What we're planning to do is to add some new disease areas, a limited number. Obesity is probably going to be one of them one. Depression is probably going to be one of them. I'm not sure about patient safety. Planning to remove the indicators where practices are achieving 100 percent or close to 100 percent and shifting them out of the indicator scheme. Perhaps as most importantly in policy terms, the plan is to increase the proportionate points going to patient experience. Because if there is a weakness to general practice in the UK, then probably patient experiences from one policy that needs to be focused on. It will be interesting to see how that's done because I'm not convinced that the patient experience indicators are necessarily strong enough in comparison with say, clinical indicators in order to be able to do that. But that certainly is the direction of policy movement. Other questions? Yes, Karen.

KAREN DAVIS: Thank you. As you drop your indicators off, given you get to your hundred percent, how are you going to monitor whether they stay at a hundred percent, as you should your percent to other indicators?

DR. MARTIN MASHALL, M.D.: As a research organization, we certainly will be. Whether the data will still be collected in a national level externally, I'm not

sure about that. But I think it is a fundamentally important thing to do because the expectation might be that quality might drop off. Having said that, I'm not sure it is going to happen. I think there's something about the systemization of care that the contract is produced in general practice which I think will probably will be sustainable.

RICHARD CRAWL[spelling?]: Richard Crawl from the Netherlands. Martin, thank you very much for the presentation. I wonder about if there is an optimal present of income that you can use for "pay for performance." We do an experiment ourselves in the Netherlands where we have 10 percent of the income for "pay for performance" but the rest is on basis of capitation and fee for service. So, would 20 percent rather than 10 percent in terms of [inaudible]? Can you say anything about that?

DR. MARTIN MARSHALL, M.D.: I can't say anything about it. There is no evidence to guide us there it all. In some ways, maybe it's the wrong question to ask because what we ought to be trying to do with incentives is be much more sophisticated. We all know from our personal experiences that some people are very motivated by money and some people much less motivated by money. So I think the challenge and this is a major challenge and it's probably more of a challenge to the recess community than practice at the moment, is to try to target quality improvement initiatives

in a way that makes sense to organizations or to individuals. So the analogy that I use is like applied genetics or pharmacode genetics. Pharmacode genetics is allowing us to target drugs as an individual to work in a specific way. In a much more efficient way than we've used pharmacology in the past. The quality improvement challenge is to do the same with individuals or with organizations. This organization is much more responsive to professional education. That's what we'll use there. This organization is much more responsive to financial incentives, that much we should use there. A bit of a challenge, that one.

MALE SPEAKER: Ashley, can I ask you how you got in the Finance Committee in the Senate to the numbers of one and two percent range that you arrived at, at the past [misspelled?]?

ASHLEY THOMPSON: Sure. Luckily for us we have what's called the Medicare Payment Advisory Commission. It's a commission of seventeen individuals who make recommendations to Congress on Medicare payment policy. And they did a look at quality of "pay per performance" incentive scheme and that is what they actually recommended is to start small and move forward. But I did participate in the discussions and I must say, among those 17 members, there were those who said, "No, you have to start at 20 percent, especially for physicians. It's not going to change anyone's

behavior if you have only a dollar on the table. That's going to be nothing!" But then again, when you talk to the hospital administrators in the room, they say, "One percent of our bottom line is way too much." Systematically I think that hospitals can make a number of changes to improve patient care but they also say that it's the provider, the physician who actually makes the decision so they shouldn't be held accountable at such a high level. So, we were able to blame it on them. Say it was their recommendation and see how it goes. But, that is a lot of money. It's a lot money.

ED WILSON: Yes?

DAVID LEIN: David Lein [misspelled?] from Canada. Martin, very interested in the slide you showed up about the changes in practice staff. Very much looking at how to get GP's to better use multidisciplinary teams in the work they're doing. What is some of the more specific incentives that were used for the specific issue?

DR. MARTIN MARSHALL, M.D.: No specific incentive was used for that specific issue. This is entirely an issue I said before that this is in many ways a form of macromanagement. You give the money to the practice and the practice can decide to how they want to respond to that incentive. So there are some practices that have not changed their staffing structure at all. Where the GP's have decided that they want to work a lot harder and earn a lot more

money. There are other practices that have changed their staffing structure that have employed a lot of extra staff and the GP's are taking home less as a result. So, that's what I like about this scheme. It allows innovation and flexibility on a local level.

DAVID LEIN: The question that I then asked if I could have a supplementary is do you have enough GP's. Are you in the shortage of GPs? Was it considered to be a shortage of GPs or were you have certainly enough GPs to cover the needs of the population?

DR. MARTIN MARSHALL, M.D.: It depends entirely upon who you talk to. The VMA will tell us they don't have enough GPs of course. I don't know. I don't know where skill mix is going to take us. I suspect that we need more GPs and I'm not just saying that as a former professional protectionism for myself as a GP. I think our range should be to have much longer consultations and I think we need more GPs to be able to do that. I think the 10-minute consultation in British general practice is a crying shame and shouldn't be allowed. Having said that, I think that there are some things GPs do that could be done by other health professionals. I agree with you entirely the gist of your question, which the multidisciplinary primary healthcare team has to be the way to deliver good primary healthcare.

ED WILSON: We have time for just one more question and I think the lady in the back was the quickest with her hand.

FEMALE SPEAKER: Thank you very much. I'm a current Harkness Fellow. I was wanting to really ask, we seem to be implementing these systems in paying for absolute performance. The article that you referred to that recently has been published here in the US was obviously raising the issue of whether we should be paying for performance improvement. That range that you showed in the UK suggested that, again, we're probably paying some of this new money to practices to who is already performing at quite a high level. So that was sort of the first issue, should we be thinking already about paying for performance improvement rather than just for performance. And the second is more of an equity concern. Sort of hidden in some of that data that Martin presented there. What about these people who are being excluded? If we are only paying for the people who are utilizing this service, what about a quality service that is actually reaching out to some of those asthmatics that were being excluded because they didn't show. We actually want to be incentivizing these providers to actually have outreach services to be getting the more vulnerable and difficult to reach patients in. So how can we design financial incentives that actually reward performance not just for the easy

patients who are coming in to the provider services but incentivizng to provide high quality care for everybody?

CYBELE BJORKLUNDIS: I hate to chicken out of this, but the difficult thing again that I think we face here is a lack of a coordinated health system. So in terms of providing incentives that a national or federal level in the United States to help everybody's care, when (not to politicize things on the panel) but when republicans took over Congress here in 1995, one of the first things that they did was dis-mantle our office of [inaudible] Assessment, which was a wonderful resource. Then they proceeded to nearly de-fund what's now called ARK. The agency you know that John Eisenberg used to run, Karen Clancy runs now. And because they have the gall to put out a guideline on back pain that did not recommend surgery. And the spine surgeons came after their friends here and nearly de-funded. So right now, we don't even have—ARK is building back up. I think a good reservoir of health services research but still very skittish on guidelines. We don't have a lot of good unbiased information from which clinicians can make a lot of informed decisions but furthermore without having the structure of a system here in place to insure coverage for everybody. You otherwise have an enormous amount of gaming and practice differentials depending on the payor sources in your practice. I don't think we have a lot of opportunity here

under our current system. That are baby steps that can be taken under Medicare and elsewhere, but again there are ramifications for each other piece of the puzzle. Martin probably has a more thoughtful—

DR. MARTIN MARSHALL, M.D.: Well, I think your second question is a really key one, around equity and impact of incentives on equity. And I don't think there's any doubt that we need to look very closely at exception reporting to make sure that those patients that are being exception reported are being excepted reported for good reasons. Because there are some good reasons for accepting them from the figures. Because they are difficult to reach populations is not a good reason. So we need to be clear whether that's happening. There actually is some evidence here that the use of financial incentives actually is, may be the only effective way of reducing disparities. This is evidence that we've produced looking at survivor screening rates and immunization rates, which say that if you pay financial incentives initially the disparities do not socio-economic classes increases because its easier to do those procedures on the higher social classes that turn up in your practice. For over a period of between four or five years, the disparities reduce because the upper social classes reach a ceiling and practice then put more effort into the lower social classes. So, it's the actually evidence based

intervention that I've heard of that can reduce inequality. So, I think we should stick with it.

CYBELE BJORKLUNDIS: And again in a fully contained system, I think that that's more possible, putting aside the broader issues that I was getting at with the clinical effectiveness research and such rating everything on disparities in particular in the United States. We're abysmal and it gets worse. But one of the primary causes, if you will, of the disparities here, I think is the lack of universal coverage. But even when you are covered in Medicare and in other populations that are well covered, we still see enormous disparities. But I think the first and most important step we could take here is to get everybody covered.

ED WILSON: Ashley, want a final word?

ASHLEY THOMPSON: A final word?

ED WILSON: Well, let me use the final word. Lunch! But before that please join me in thanking these folks for an incredibly good discussion.

[Applause]

[END RECORDING]