Where Does the Money Come From?
Reflections on Physician Incentives

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You are a 39 year old orthopedist, just about 10 years in practice and starting to look to the future. Your practice is as busy as ever, even busier. Compensation is down, even with the extra volume, and practice overhead expenses are always going up. Nevertheless, you feel good to have a practice that you can still call your own. Two years ago you moved your office closer to the hospital in order to be adjacent to the operating suite which you use most frequently. Last month, the hospital announced that they were moving Orthopedic Surgery cases to another facility which they had recently acquired. The site is not nearly as convenient and you shudder at the thought of moving your office again.

A few moments ago, you were called into your consultation room to take a phone call from a colleague who had made an attractive offer. He asked you to join a select group of orthopedic surgeons in partnership with a private, non-hospital affiliated surgicenter. The venture would be structured to allow each of the admitting physicians to receive some form of stipend or dividend that could amount to $100,000 or more per year.

Leaning back, you speculate on the validity of such an offer as well as the legality of its claims. Somewhere along this line of reasoning comes a passing reference to its ethical propriety. But then, you tell yourself, "This is a business deal, not a medical one." In no way would it compromise your medical care. In fact, by being personally invested in the operating facility you would have greater ability to see that your patients got the very best of care. Given all the discounts you have been forced to take by managed care contracting, it is nice to find a new income stream to pick up the shortfall. After all, what has the hospital done for you lately?

Sure, you recognize the financial incentive to send patients to the new surgicenter, but you have to operate somewhere, why not somewhere that gives you something in return. How can it be that different than using your special VISA card that gives you miles on your next vacation flight. Financial incentives are everywhere, so it is no use trying to avoid them all. The key is to not let them influence your decision making when it comes to taking care of people.

When you started practice the operative financial incentive was the fee-for-service system and the incentive was a predominantly positive one. Providers were rewarded for providing as much medical care as the patient would allow. Your colleagues recognized the nature of this arrangement but insisted that their medical decisions were uninfluenced by it. Their position was supported as the AMA and other professional organizations promoted the physician's ethical responsibility to provide the highest possible medical attention, regardless of its financial implications.

Unfortunately, some physicians were unable to see fee-for-service as anything but a financial opportunity. A while back you read a book by Marc Rodwin called Medicine, Money and Morals. In it, the author documented numerous instances that suggested

positive financial incentives increased utilization. For instance, Medicare patients, in 1987, received 45% more lab tests if their doctor owned their own lab than patients whose doctor did not have their own laboratory. Other examples include a physician found guilty of accepting $400 gratuities from pacemaker companies for inserting their brand, and ophthalmologists receiving kickbacks from intraocular lens companies.

After a solid analysis of the strengths and weaknesses of the fee-for-service system Mr. Rodwin highlighted six other financial incentives that are often associated with fee-for-service practice and might have significant ethical implications.

1) Paying and receiving kickbacks for referrals.

2) Income earned by doctors for referring patients to medical facilities in which they invest (physician self-referral).

3) Income earned by doctors for dispensing drugs, selling medical products, and preforming ancillary medical services.

4) Payments made by hospitals to doctors to purchase physicians' medical practices.

5) Payments made by hospitals to doctors to recruit and bond physicians.

6) Gifts given to doctors by medical suppliers.

Each of these incentives has its own degree of propriety or impropriety depending on the setting and circumstance. It is obvious, however, that the fee-for-service system has plenty room for introducing "distractions" to medical care that may have influences more subtle than we realize. It is tempting to look elsewhere for a system of financial incentives that is clearer and less open to abuse.

Your practice might have begun in the fee-for-service era, but that isn't the main theme now. Unregulated incentives to provide more and more medical care shot the costs of Medicine through the roof. Your clinical years have seen the advent and the dominance of managed care and a whole new set of incentives centered on capitation. Fixed fees based on a diagnosis or, for your friends in primary care, on a head count, have the incentive to make you look for short cuts or cheaper ways to get the job done. You continue to insist to your colleagues, and to yourself, that the negative incentives introduced by managed care do not affect your medical decision making any more than the positive ones of fee-for-service did. But recently you did have a few loose thoughts as you examined a patient with chronic back complaints and multiple failed surgeries who was requesting yet another MRI. It crossed your mind that he was wasting not only your time, but your money! And when you think about it, you certainly see fewer primary care doctors around the hospital since the IPA offered them a hospitalist service to care for their hospitalized patients with no reduction in their monthly capitation payment.

Even the hospital ethics committee that you serve on has seen the nature of their consultations change. Ten years ago most of the cases centered around supporting a patient's competent wish to remove themselves from medical therapy or refuse recommended treatments. Now you rarely hear about the case when a patient wishes to quit medical treatment. Instead, most of the consultations now revolve around the concept of medical futility. In general, patients or their family wish to continue pursuing

aggressive medical options while the caregivers are trying to promote comfort care or less aggressive approaches.

If there are ethical hot spots in fee-for-service medicine like Marc Rodwin pointed out, then perhaps there are similar situations in the negative incentive system of managed care that can be identified. Consider the following:

1) Hospital incentive pools that return money to primary care doctors if allocated hospital days are not used.

2) Specialty pools that return unused specialist referral fees to primary care physicians if the number of specialist referrals is less than expected.

3) Pharmacy shared risk pools.

4) Individual primary care capitation.

5) Specialist capitation.

6) Withholds on payment pending determination of profitability of the physician corporation.

7) For-profit health care corporations that need to return 15 to 20% of their premium as dividend and even more to service the debt on the capital used to buy the company and turn it from a non-profit status to a for-profit one.

"Let's face it," you tell yourself, "financial incentives are everywhere - and unavoidable." You don't even have to buy a pen to write with, if you are willing to use one with some drug logo emblazoned on it. As long as we exist in a money-based economy, it is impractical to expect medical practice to be completely devoid of financial incentives. Instead of recognizing the incentives, physicians and society seem to be playing a game of "Don't ask, don't tell". Wouldn't it be better if we started to explore and discuss these incentives more fully in order to align them with our best understanding of good patient care? Otherwise, our financial incentives will be left to shift with the whims of the market.

You begin to envision a system in which physician's personal financial incentives are minimized as much as possible. Those that remain are structured to align the doctors interests directly with the patient's. It seems reasonable to promote financial incentives based upon good outcomes. You realize the problems inherent in everything from the micro issues of how we measure and quantify data to the macro question of the definition of a "good" outcome. Financial incentives based upon patient satisfaction is another idea that needs to be developed.....

.....Your reverie is interrupted. The receptionist has just announced the arrival of the Pfizer rep. You had promised to meet with her after she arranged to provide pizza to feed and attract house officers to your noon conference last week - on ethics.