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PHYSICIAN PAYMENT MECHANISMS: AN OVERVIEW OF POLICY OPTIONS FOR CANADA

CHSRF SERIES ON COST DRIVERS AND
HEALTH SYSTEM EFFICIENCY: PAPER 3

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KEY MESSAGES

- ▼ Canada's healthcare costs are rising and now constitute an important share of GDP. In response to healthcare growth, governments can act to contain spending and/or improve efficiency within the healthcare system.
- ▼ An often cited source of inefficiency in the Canadian system is its overwhelming reliance on the fee-for-service (FFS) physician payment mechanism. Inefficiencies resulting from FFS payments are especially important since physician expenditure is second only to hospital expenditure as a share of total public-sector spending on healthcare.
- ▼ The FFS payment mechanism creates financial incentives for physicians to encourage over-consumption of care, since physicians are rewarded for a higher volume of services. In other words, physicians get paid more when their patients consume more care. Further, the FFS system does not encourage physicians to consider the cost of the treatments they provide to their patients and their remuneration is not tied to patient health outcomes.
- ▼ Alternative payment mechanisms that aim to reduce health expenditures by curtailing the provision of excessive (i.e. inefficient) care have been proposed and implemented in Canada and abroad. Such mechanisms include capitation, fundholding (a more complete form of capitation), mixed payments, pay-for-performance and profit sharing.
- ▼ Although capitation and fundholding provide straightforward ways to control healthcare costs (namely by tying the physician's income to his or her patients' use of care), these payment mechanisms may lead to issues of stinting (providing less than efficient levels and quality of care) and accessibility.
- ▼ A mixed payment system that includes capitation and FFS components is a promising solution for Canada. Implement with a mixed payment system in combination with physician monitoring will provide physicians with incentives to consider costs and benefits of different treatment options, and thus lead to an efficient level and quality of care.
- ▼ Group-based profit sharing programs may be an interesting option for Canada in the long term. However their applicability in the short to medium term is unlikely. Profit-sharing programs allow hospitals to provide bonuses to physicians based on hospital savings created when physicians coordinate their use of drugs and devices (quantity and market share discounts). That is, the more that a hospital purchases of a particular drug or device from a particular vendor/manufacturer, the more they benefit from quantity and market share discounts.
- ▼ Adding profit sharing programs to the current FFS system may provide a powerful way to align physician incentives with those of the hospital and of policy-makers. However, little is known about the effect of these programs on patient outcomes, and current regulation in Canada does not allow hospitals to pay physicians in such a manner. Actual experiences in U.S. hospitals may be informative in this case.

1 INTRODUCTION

Canada's healthcare costs are rising and now constitute a large share of GDP. Although increased healthcare spending (even in percentage terms) may be a good thing if it reflects a country's increased wealth and ability to pay for valued care, there is a widely held belief that the growth rate in Canada is not sustainable nor is it necessarily improving our health outcomes. Consequently, reducing the growth rate of healthcare spending (i.e. bending the cost curve) is seen by many as an important and urgent policy goal. A corollary to this goal is whether or not it can be achieved without sacrificing other important goals such as free and complete healthcare for all citizens. Those who believe that improving the healthcare system while controlling its costs is possible point to its many inefficiencies.¹ If such inefficiencies can at least be partially reduced, it may be possible to redirect savings to underfunded areas instead of simply looking for new sources of government revenue.

An often cited source of inefficiency in the Canadian system is its overwhelming reliance on the fee-for-service (FFS) payment mechanism.² Although paying physicians a fee for each service they provide is both conceptually simple and easy to implement and manage, it provides no incentive for physicians to consider the costs of treatment nor the benefits associated with them. In fact, the FFS system rewards one thing and one thing alone: volume. As a result, it provides little incentive to consider the costs of treatments and it may actually provide financial incentives for physicians to encourage the over-consumption of care. In response to such inefficiencies, many payment alternatives have been proposed and implemented in Canada and abroad. These alternatives seek to reduce health expenditures by reducing excessive (i.e. inefficient) care by directly targeting the physician. Among potential payment alternatives are capitation, fundholding (a more complete form of capitation), mixed payments, pay-for-performance (P4P) and group-based profit sharing. All of these alternatives attempt to provide incentives to physicians so that they consider the benefits of treatments and their costs. Although some may hold promise for Canada, they have often met with opposition—especially with respect to their expected effect on the level and quality of care provided.

The following questions are addressed in this report:

- ▶ Can we influence the level of public spending and/or the efficiency of the system by moving from a FFS system to an alternative payment mechanism?
- ▶ What are the most promising payment mechanisms for Canada and what policy or regulatory elements are required or desirable for their implementation?

In order to answer these questions, the concept of efficient provision and consumption of care, and the difficulties in achieving it, are discussed. Next, the current FFS system, including some of the criticisms that it faces, is introduced. The main body of the text presents a series of potential options for Canada, highlighting their respective advantages and disadvantages. In the final sections, pay-for-performance and profit-sharing programs, which can be viewed as complements to any existing system (including FFS) and which may provide additional incentives for cost-containment and quality provision, are discussed. Throughout, policy relevant recommendations are provided in hopes of increasing the efficiency of Canada's healthcare system.

1 A very rich literature on the size and scope inefficiencies in healthcare systems has developed over the last decade and has been led by a group at Dartmouth University. Their research finds (at least in the U.S.) wide variations in spending across geographical regions (across and within states) without corresponding variations in outcomes (controlling for population characteristics and prices). That is, some regions use a lot of expensive care which appears to have very little benefit to the health of its citizens (Skinner, Chandra, Goodman and Fisher, 2009).

2 According to data from the National Physician Survey of 2007, over 80 per cent of physicians are (at least in part) paid by FFS (where the average percentage of income coming from FFS among this group is above 75 per cent).

2 THE EFFICIENT PROVISION OF CARE AND THE FEE-FOR-SERVICE SYSTEM

Before discussing some of the potential drawbacks of the current FFS system and potential benefits of moving to an alternative payment form, it is important to define what is an efficient provision/consumption of healthcare and why achieving such an outcome is difficult in practice. Economists generally define an efficient consumption of care as the type and quality of care that a fully informed uninsured individual would chose. More specifically, it is the quantity and type of care that a patient would choose if: (i) he or she could perfectly observe their illness, the value of all potential treatment options and their respective prices, and (ii) he or she paid for all treatments out-of-pocket. Although easy to define, there are many reasons why the level of care currently consumed is not efficient. First, individuals often lack information about their illness or the treatment options. Furthermore, even in the presence of complete information, patients often do not pay for their care (because of insurance) and are therefore unlikely to consider prices when making healthcare decisions. Finally, treatment decisions are most often made by the physician, not the patient, and are unlikely to satisfy the above criteria, particularly if physician payment is not tied to the cost or quality of care.

Although insurance can encourage the over-consumption of medical care (a phenomenon known as ex post moral hazard), many health economists believe that insurance reform (such as introducing co-payments or user fees) will have limited effect on healthcare consumption and costs.^{3, 4, 5} This is because physicians (especially in an emergency or hospital setting) often dictate the type and level of care and thus, directly influence healthcare costs. Also, evidence suggests that individuals who ration care due to cost sharing do so in an inefficient way. That is, they may cut back on both effective and ineffective care (Newhouse, 1993).

As discussed briefly above, Canadian physicians have traditionally been paid by FFS. The FFS system is known as a retrospective payment system as it covers essentially all costs borne by the physician plus a margin for each service they provide. By covering all expenses associated with treatment and rewarding physicians exclusively on volume, this system provides little incentive for physicians to consider costs when treating their patients. This tendency towards volume is confirmed in part by empirical evidence that shows that FFS physicians provide more consultations and more diagnostic testing than their non-FFS counterparts.⁶ Furthermore, by rewarding volume instead of appropriate treatments and/or desired outcomes, the FFS system may in fact punish efficient use of preventive care and specialty/hospital care as well as effective chronic-disease management.⁷

Because the FFS system rewards volume, some have suggested that physicians may actually exploit their informational advantage to encourage their patients to consume too much care (by exaggerating the patient's illness and/or the need for additional treatments/visits) (Evans, 1974). This concept, known as supplier-induced demand (SID), has been a feature of the health economics literature for decades,

3 The presence of insurance is (net of the moral hazard problem) is nonetheless likely to be welfare increasing. That is, risk averse individuals would prefer to pay a fixed premium in return for care in the case of illness (even if the premium reflects the expected consumption increase due to moral hazard). It can also be argued as collectively welfare improving on equity grounds.

4 Although excessive consumption due to insurance could be reduced through the use of co-payments and deductibles, such demand-side cost sharing would reduce the benefits of insurance.

5 How demand for medical services responds to prices is an important empirical question. The empirical literature suggests that individuals respond to prices when deciding whether or not to seek medical care but that prices have little effect on quantities consumed once the patient has sought medical care (Manning, Newhouse, Duan, Keeler and Leibowitz, 1987).

6 See Gosden, Kristiansen, Sutton, Lesse, Giuffrida, Sergison and Pederson, 2004 for a more complete review.

7 Take for example, a physician who is paid by FFS and who provides good preventive care and chronic-disease management, such as smoking cessation programs or weight control programs. By doing so, the physician's patients are likely to be healthier and require less care in the future, thus jeopardizing some of the physician's future income.

but has only recently been credibly tested empirically. Although it is still unknown how important this phenomenon actually is in practice, evidence of SID has been found in the fields of obstetrics (Gruber and Owens, 1996) and thoracic surgery (Yip, 1998).^{8,9} It is important to note, however, that even in a perfect environment setting (i.e. where patients have all of the necessary information to make the “right” decisions), physicians may be able to “force” patients to consume unwanted visits/treatments if the physician faces less than perfect competition (McGuire, 2000). By simply making a “take-it-or-leave-it” offer of treatment to the patient (i.e. the patient must accept the treatment recommendation or seek care elsewhere), the patient may be forced into accepting too much care even if he or she does not value such units simply because seeking care elsewhere may be too costly or even impossible.^{10,11}

In short, the FFS puts little weight on cost control, and does not provide specific rewards or incentives for the delivery of high-quality care (through effective use of resources, whether preventive or therapeutic) or the achievement of desired outcomes.¹²

3 THE CAPITATION PAYMENT SYSTEM

In light of the undesired behaviours the FFS system seems to encourage, alternative payment schemes have been developed and implemented in Canada and abroad. One of these alternatives is the capitation payment system that first took flight in the U.S. in the managed-care setting of the 1980s and 1990s. In a capitation system (a prospective form of payment), physicians are paid an up-front fixed amount (possibly risk-adjusted) for each patient they enlist into their practice.¹³ In return for this fixed amount, the physician is contractually obligated to provide primary care to the enlisted patient for a given period of time without any additional reimbursements.

Because physicians in a capitation system must provide care without any additional payments, more volume does not translate into more income. In fact, each additional visit or treatment is actually costly to the physician – at least in time and effort – so there is an incentive to keep the cost per patient low. As a result, the most obvious advantage of the capitation payment system (compared to the FFS system) is how it fully eliminates the incentive to encourage additional care. Also, by tying the physician’s net income to his or her patients’ future use of care, it may provide financial incentives to physicians (under relatively long-term patient-doctor relationships) to maintain their patients’ health, which is particularly

8 By using changes in the FFS schedules and income caps in Quebec, Nassiri and Rochaix (2006) find that physicians respond to financial incentives by modifying the volume and technical content of their care

9 Another important issue related to FFS (as with any non-market price setting) is getting the actual fees “right”. If fees do not accurately reflect costs, physicians will concentrate on the more lucrative treatments and forgo the less lucrative ones. Traditionally, lucrative fees at the specialist level have come at the cost of primary care. How this happens is quite simple. First, fees are often set when new treatments are introduced. As time goes by, physicians learn about the procedure and become more efficient in its supply. However, because fees are not re-calibrated on a regular basis, these procedures become particularly lucrative. Given that the introduction of new procedures is more common in specialty medicine than general, this issue is much more common in the former than the latter. Furthermore, even if the fees are re-calibrated, specialists can introduce new procedures and the problem starts over again.

10 Using an instrumental variable approach which attempts to control for the self-selection of physicians and patients into different payment options, Devlin and Sarma find that FFS physicians see more patients than their non-FFS counterparts.

11 The FFS system also provides little incentive for cost-reducing innovation as costs are generally reimbursed (McGuire, 2000).

12 I do not consider salary as a potential source of cost control and increased efficiency in the healthcare system. Although a physician who is paid by salary has no incentive to induce demand, he also has no incentive to control costs. Furthermore, because the salary is independent of patient outcomes, the salaried physician is provided little incentive to consider the quality of care or the cost-effectiveness of different types of preventive, specialty and hospital care.

13 Capitation payments which only cover primary care are often referred to as primary capitation in order to differentiate them from more broadly based prospective (capitation) payment systems such as the aforementioned fundholding.

important in primary and chronic care settings.¹⁴ Furthermore, the capitation payment system may encourage physicians to supply services such as phone or e-mail consultations, which are not traditionally reimbursed within the FFS system (as they are difficult to observe by third parties and thus difficult to remunerate on a per-unit basis).

Although there is debate relating to the cost-effectiveness of preventive care in general, there are a series of preventive measures with little or no cost to patients and physicians. They could also reduce costs and improve health outcomes in the long run. By not providing any additional reimbursements for care, the physician in the capitation system wins when their patient is healthier and requires less care (at least in the short run). Unlike the FFS physician who is rewarded for volume, the physician in the capitation system may find it financially advantageous to provide care that: a) helps prevent illness (e.g. offering smoking cessation information, or encouraging regular mammograms for women); and/or b) reduces the likelihood of further complications. Either or both of these can reduce the patient's use of primary care in the future (and thus increase the physician's net future income under capitation).¹⁵

Even though the capitation system may encourage physicians to care about costs (both present and future), it has several negative aspects. First, the capitation system creates the incentive for physicians to select individuals who require little care in the future (making it difficult for expensive/sick individuals to find care, leading to issues of equitable access to care). Further, the capitation system may lead to excessive use of specialty and hospital care. This is because capitation payments generally do not cover specialty or hospital care. By sending patients to a specialist (or to a hospital), the physician does not need to provide care yet retains the capitation fee (Blomqvist and Léger, 2005; Allard, Jelovac and Léger, 2010). Finally, the capitation system may actually lead to inefficiently low levels of care (Newhouse, 1993, 2004; Huskamp, 1999). In fact, physicians may end up under-reporting a patient's illness to them or may not disclose all possible treatments (in essence, inducing a smaller demand for care) (Ellis and McGuire, 1986, 1990).^{16, 17}

The risk of under-provision of care by physicians in a capitation system (or any payment system that has a capitation component) is a particular concern in Canada because physicians face little competition. In such an environment, patients who are not satisfied with their care may find it difficult or nearly impossible to seek care elsewhere. As a result, physicians are unlikely to face competitive pressures to provide high quality care (Allard, Léger and Rochaix, 2009). In the absence of competition, effective physician monitoring (either internally or through a government agency) and sanctioning (internally or through the courts) may be necessary to ensure appropriate levels of care (Danzon, 1990; Léger, 2000).

In summary, the capitation payment system is one that encourages cost control by tying the physician's income to the use of care. Although the use of this payment mechanism may help "bend the cost curve" in the primary-care sector, it may also come with unwanted consequences on the quality of care provided by primary physicians and excessive use of both specialty and hospital care (which tend to be very expensive). Unfortunately, empirical evidence on the effects of capitation on healthcare costs and quality remains limited.

14 The capitation system also eliminates the distortions associated with imperfect fee schedules as discussed in footnote 8.

15 The capitation system may also help reduce excessive provision of care by the physician due to his or her altruism – something which may be particularly important in settings like Canada where patients are fully insured.

16 Professional norms may limit the physician's desire or ability to manipulate information in such a manner.

17 The capitation system may also encourage physician gaming in the form of a "DRG (Diagnostic Related Group) creep". This problem has been particularly important for hospital-based capitation payments (i.e., payments that are made to the hospital based on the patient's illness which must cover all costs) where physicians may wish to "up-code" their patient's illness (i.e., exaggerate at the margin the patient's medical problem) in order to receive a bigger up-front payment (Dafny, 2005).

4 THE FUNDHOLDING SYSTEM

The fundholding system (as it was coined in the U.K.) is a more inclusive or broad-based prospective payment system. Like physicians under capitation, physicians in a fundholding system must provide care to the patient for a given period of time without any marginal reimbursement. Where it differs is that physicians in a fundholding system are responsible for (almost) all of his or her patients' medical consumption, including prescription medications, specialty care and hospitalizations. Thus, these physicians must manage all types of care and must consider the costs and benefits of each. This is particularly important for the specialty-care/hospitalization component as physicians under capitation may send their patients to specialty care too often (Blomqvist and Léger, 2005; Allard, Jelovac and Léger, 2010). The fundholding system also provides the right incentives regarding prevention and chronic disease management (even more than the capitation payment system). This is because keeping one's patients healthy leads to less future care and expenses and thus, greater net revenue. Thus, the fundholding system can be seen as a high-powered form of the capitation payment system: it provides the cost-control incentives of the capitation system without unintentionally encouraging specialty care for which the cost has not been considered.¹⁸

Although fundholding systems are generally targeted to teams rather than individual physicians, it can nonetheless be financially risky. More specifically, physician groups may face large future expenses (and thus small net payments) not because they poorly manage their patients' care, but because their patients' health worsened for outside or purely random reasons. Thus, physician groups paid by fundholding may face important income variations outside of their control or sphere of influence. Making sure that physician groups who happen to have such costly patients aren't unjustly punished may require additional elements including risk corridors, reinsurance and outlier provisions. Otherwise, selection of low-risk patients is likely to be even more problematic in the fundholding system than it is the capitation system as the financial risks associated with "expensive" patients are even greater. As in capitation, this could lead to important inequities in access to care.

5 THE MIXED PAYMENT SYSTEM

As highlighted earlier, the FFS system may encourage over-provision of care while the capitation system may encourage under-provision. Another important disadvantage in each system is their inability to achieve the right balance between the provision of observable types of care (i.e. care that is observable to the insurance provider such as diagnosis tests and treatments and thus can form the basis of a per-unit remuneration) and non-observable types of care (i.e. care that is unobservable to the insurance provider such as physician time and effort that cannot form the basis of a per-unit remuneration but is nonetheless important determinants of quality). More specifically, because FFS physicians are remunerated for each observable treatment they provide, they have an incentive to focus on such treatment and minimize their provision of unobservable care such as effort. Capitated physicians, on the other hand, will tend to over-provide the non-observable types of care while minimizing costly observable types of care.¹⁹

One potential solution to this issue is the use of a mixed payment system. Such a system would include a prospective component (i.e. an up-front part like a capitation payment) and a retrospective component

¹⁸ Corxon, Propper and Perkins (2001) find that physicians did respond to financial incentives by inflating their costs the period prior to becoming fundholding physicians.

¹⁹ This is the well known multi-tasking problem (e.g. where a subset of relevant tasks is rewarded, non-rewarded tasks suffer relative neglect) (Holmstrom and Milgrom, 1990).

(i.e. a marginal reimbursement like a fee-for-service payment) that are either *equal to or less than* the marginal cost of treatment. The combination of these two components may provide the right incentives for several reasons.

Suppose that patients value both observable (i.e. tests and treatments) and unobservable (i.e. physician time and effort) types of care. Because each patient enlisted makes an up-front payment, physicians will be encouraged to attract them. To do so, the physician must build a reputation, based in part on their provision of time and effort (unobservable care) to each patient. However, once a patient has been attracted, the physician must then consider the costs of treatment (because the fee-for-service component is less than the marginal cost of its provision). Thus, the mixed-payment system will simultaneously provide an incentive for quality and for cost control.

Another advantage of a mixed-payment system is that it may reward (or at least compensate) valued services that are not traditionally covered by FFS payments (e.g. research, administrative duties, teaching) by providing an up-front payment to the physician independent of the number of patients they see. This is what the Quebec government introduced for some surgical groups. As Dumond, Fortin, Jacquemet and Shearer (2008) show, mixed payments in Quebec lead to reductions in the number of billable services, increases in time spent per patient, and increases in time for administrative work and teaching.²⁰

One of the main issues with mixed-payment systems is their reliance on competition to fully exploit their strengths (even though, in its absence, they provide better incentives than either fully prospective or retrospective payment systems). As is shown by Allard, Léger and Rochaix (2009), in the presence of mixed payments, competition between providers (which can be measured in part by the ease in which a patient can seek care elsewhere) can lead physicians to provide the appropriate amount of both observable and unobservable types of care.²¹ However, as the level of competition decreases, physicians may decrease their provision of unobservable types of care.

In light of these findings, the mixed-payment system may provide Canada with an interesting option that could be used more broadly (not just for small groups of specialists, as is the case in Quebec) by providing the “right” incentives with respect to types and quantity of care. Even though mixed payment is preferred to FFS and capitation in the absence of competition, additional measures (e.g. physician monitoring or pay for performance) may be required to achieve desired levels of quality of care.

20 Unfortunately, the authors were unable to examine the effect that such a payment option had on patient outcomes.

21 This result is also shown to hold under uncertainty about: (i) illness severity, (ii) the efficacy of treatment, and (iii) the type of physician (measured by his or her level of medical ethics or altruism) the patient would get if he left his current physician for another.

6 PAY FOR PERFORMANCE (P4P)

As discussed throughout this report, payments to physicians generally reflect either the quality of services provided under retrospective systems, or reflect the patient's future need for care (often proxied by the patient's characteristics or illness) under prospective systems. None, however, directly rewards the actual desired outcome – which is what patients and policy-makers ultimately value. It is therefore not surprising that issues of quality have plagued the healthcare system (even in the presence of increased spending). In fact, poor quality of care (measured by the inappropriate level of preventive, acute or chronic care) in many specialties as well as in many geographic areas has led governments in the U.S. to specifically examine the quality issue and provide recommendations (Institute of Medicine, 2001, 2007).

In response to these quality issues, many have either proposed or implemented a particular form of additional remuneration known as Pay-for-Performance (P4P). P4P seeks to reward appropriate and high-quality care and can be paired with any existing payment mechanism. In order to implement P4P, physicians can be rewarded for their processes (how things are done) or their patients' outcomes (how effective their treatments prove to be). Although paying physicians for good performance should provide incentives for physicians to care about their patients' health, implementing such a system will likely meet with several significant challenges (Rosenthal, 2004).

Tying a physician's remuneration to processes (preventive tests, immunization rates and treatment therapies) is administratively straightforward to implement (these processes are generally easily observable and coded). However, this strategy can create unwanted incentives. Among them, physicians may want to “teach-to-the-test”, or in the medical context, concentrate on the processes that are targeted while ignoring or skimping on the processes that are not. Another potential issue with P4P programs is the incentives created for physicians to select patients who will adhere to the tests and procedures recommended by the physician while avoiding those who will affect the physician's “numbers” (i.e. the physician's scores and thus income).

P4P payments tied to patients' outcomes may seem like an obvious thing to do. However, doing so may not be as easy as it seems. The first challenge is how to measure outcomes and how many to measure. Again, it could create issues of “teaching-to-the-test”, where physicians would concentrate on outcomes that are easily measured and minimize those that are not. Furthermore, patients' underlying physiology and adherence to treatments and medication may affect their outcomes. Thus, physicians may be unjustly punished (or conversely, rewarded) because they happen to have patients who do not respond well to treatments or do not follow their physician's advice. If there is no way to isolate the physician's contribution to the patient's outcome then physicians may be put at unjust risk and may also select patients who are likely to respond well to recommendations and treatments.²²

Although P4P may provide policy-makers and hospital administrators a tool to encourage high-quality and appropriate care, it is unlikely that it can be sufficiently powerful to encourage an efficient level and quality of care without challenges.

²² For example, a physician may want to select educated individuals or generally fit individuals (or those with fewer co-morbidities) who are more likely to follow their physician's recommendations and/or respond well to treatments.

7 GROUP-BASED PROFIT SHARING

In the current healthcare system, physicians often make decisions regarding the use of drugs and devices that in turn affect the costs borne by the hospital and system. This is because physicians are generally independent contractors (not hospital employees) and making direct payments to them is often prohibited. As a result, physicians have no incentive to consider the costs of the drugs and devices they use for their patients. If the hospital or system could influence the choice of drugs and devices the following would be encouraged: (i) substitution toward cheaper drugs and devices, and (ii) standardization on drugs and devices among physicians. Standardization on drugs and devices is an important cost saver as hospitals and systems can benefit from quantity and market-share discounts. That is, the more that a system or hospital purchases of a particular drug or device from a particular vendor/manufacturer, the lower the per-unit costs. Furthermore, through standardization, hospitals/systems may be able to bargain for better prices (through increased market power).

In order to address this issue, certain hospitals (or certain groups within the hospital) in the U.S. have been permitted to implement some group-based profit-sharing programs, also known as gainsharing. In these programs (targeting cardiologists and orthopaedic surgeons), physician groups split bonuses based on savings (relative to a historical baseline) on different drugs and devices.²³ By tying a part of their income to group-level expenditures on drugs and devices, physicians are encouraged to consider the costs of drugs and devices while also coordinating such decisions with their colleagues in order to benefit from the aforementioned quantity and market share discounts. Preliminary results from Ketcham, Léger and Lucarelli (2010) suggest that these group-based profit-sharing programs can help reduce drug and device costs and that a significant proportion of the savings come from lower per-unit prices (which occur through both better bargaining power and quantity and market-share discounts).

Although group-based profit-sharing programs such as those described above may be an interesting option for Canada in the long term, they are less likely to be so in the short to medium term. First, regulatory barriers exist that prevent such programs from being implemented in any meaningful way (hospitals are prohibited from providing direct payments to physicians). Furthermore, little is known about the effect that such profit-sharing programs have on patient outcomes. Nonetheless, under the right regulatory framework, profit sharing combined with physician monitoring may provide a powerful way to align physician incentives with those of the hospital and policy-maker.

8 REMARKS AND CONCLUSIONS

Several payment options for Canada, and their effect on physician behaviour, the type and quality of care received by patients, and healthcare costs, have been discussed in this paper. Although the capitation and fundholding payment systems are seen by many as straightforward ways to “bend the cost curve”, they may come at the cost of quality and may encourage risk-selection. By combining both prospective and retrospective components of care within a mixed payment system, physicians are encouraged to consider both costs and benefits of different treatment options. Furthermore, mixed-payment systems are likely to achieve a desired mix of observable (such as tests and treatments) and unobservable (such as time and effort) types of care. In addition, these payment schemes can be designed so as to reward non-clinical work such as research and teaching, which can be costly to physicians in the current FFS system. Finally, policy-makers may want to consider add-ons to the current FFS system (or to future ones) such as group-based profit-sharing programs or P4P programs, which can provide additional incentives for cost control and quality, respectively – depending on their relative importance and the institutional/legal environment.

²³ Like P4P, group-based profit sharing can be implemented in combination with any other type of payment mechanism including the current FFS system.

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