



Notes from the Guest Editor

IMAGINE FOR A MOMENT that you are invited to meet privately with the Minister of Health. You are ushered into the Minister's presence, and after the usual exchange of pleasantries the Minister begins reflecting on her past several years in office. The Minister discusses the circumstances when she was appointed to her Cabinet post. She describes her inherited portfolio as one plagued by the interconnected challenges of unsustainable cost increases, public impatience about access to service and growing concerns over the quality of patient care and safety. The Minister tells you that her Cabinet colleagues are concerned, on the one hand, about increases to the health budget crowding out other important government policy objectives and, on the other, about complaints from their constituents about the length of time voter-taxpayers are waiting for access to service. She tells you that, while access is one important performance feature, solutions extend far beyond adding additional capacity to the putative system and include considerations of appropriateness, quality and efficient use of existing resources. The Minister is concerned that system components are not behaving in synchronicity, and that resources are wasted because providers do not pay attention to fundamental approaches by which systems can be improved. And, at the end of the day, she continues to be concerned that while there is a reasonable sense of how much service is being provided there is no real evidence of the level of system or service quality.

She says she has been considering a number of options to improve the

healthcare system, and that she is thinking about instituting pay-for-performance, whereby there would be incentives for providers to achieve predetermined performance expectations. She is very serious about making pay-for-performance her signature policy to improve access to and the quality of health services. She then turns to you and asks for advice.

This vignette is not that farfetched. It speaks to many of the shortcomings of our health system. Problems of information, measurement, alignment (or misalignment) of incentives, the motivations of people and their ability to influence organizations and their colleagues to do the right thing are all intertwined in the dilemma posed by the Minister. The fundamentals of this problem are rooted in the challenge associated with identifying what stimulates change for the better.

Luckily you have just read this issue of *Healthcare Papers* and feel somewhat equipped to offer advice. What would you say? "Yes Minister, this is the only solution to the problems you face, full speed ahead?" "Yes Minister, but this would be a very "courageous" decision (in other words, don't do it unless your idea of career progression is warming on the backbench)?" "Yes Minister, but take measured steps subject to careful consideration by a committee of experts and implement them slowly (likely long after you have left this portfolio)?"

The lead article by Pink et al., "Pay-for-Performance in Publicly Financed Healthcare: Some International Experience and Considerations for Canada," is a thorough review of the

evolving experience, evaluation and potential of pay-for-performance in our health system. The authors and respondents have provided us with a wonderful basis for debate of the various perspectives on paying healthcare providers in response to their performance. This is not a new conversation. It stretches back to the early days of medicine and the inherent conflicts of doing the right thing on the one hand and the temptations of misaligned incentives on the other.

As you consider your response to the Minister, you reflect on the premise of Pink and his colleagues that the absence of rewards for high quality stands in the way of improving the delivery of healthcare. While you have reasonable confidence in the ability of systems to measure and report (albeit not in a very timely fashion) on the amount of service provided as well as the opinions of patients of their experiences in receiving services, you are less sure of the ability of systems to measure and report on the “technical” quality of service provided. You agree with the authors that one of the most important enablers to pay-for-performance is information. The experiences of the United States, the United Kingdom and Australia, summarized by Pink et al., is a helpful outline of international attempts at rewards; however, the outcomes associated with pay-for-performance schemes are less clear. The authors rightly advocate for the need to design pay-for-performance frameworks in which performance is within the scope of providers, incentives are applied for good performance rather than disincentives for bad performance and the rewards are timely and sufficient and applied fairly.

You also reflect on the varying perspectives of the article’s respondents on the utility of pay-for-performance as a mecha-

nism to improve the health service system. The challenge of defining expectations and measuring experience is raised by Culyer and Greengarten and Hundert. The need to clearly define what elements will improve our health system measuring results and providing rewards is, like most things, easier to discuss than to fill.

Most respondents discuss directly or indirectly the notion of providers “doing the right thing.” Golden provides, through comparison with for-profit enterprise, important cautions about the poor track record of pay-for-performance. He attributes the failures to poor goal-setting, inadequate measurement, fraud, inadequate governance and misaligned incentives. While everyone involved in healthcare would maintain that they or their organization “do the right thing,” you agree with Hudson on the insufficiency of this commitment on its own to achieve any significant improvement.

Support for the concept of linking performance rewards to uptake in “best practice” is shared by Halparin and Davis, who reflect on the promise of incentives now in place through some primary care models for preventive screening. Feasby and Gerdes suggest that financial bonuses be paid to organizations that adopt quality improvement processes.

The mixed international picture of results in pay-for-performance, as Vertesi points out, should not come as a surprise, because incentives are being discussed across a range of management levels within systems with significant variations in structure. You add this mixed picture to Culyer’s perspective that while monetary levers may be the most effective ones, there are others, and we do not as yet understand the relative responsiveness of various combinations of incentives. Halparin and Davis point to

regulation, organizational and clinician-directed strategies as other levers.

Policy decisions are as much about deciding what problems you prefer to manage as about determining what solutions fit best in a given circumstance. Vertesi points out that pay-for-performance is an option and not a panacea. Hudson explores the success of tying rewards to increases in patient service volumes in selected areas but also raises concern that volume-based incentives do not address problems of quality, safety and appropriateness. Feasby and Gerdes, on the basis of what is thought to be growing evidence that those who do more perform better, suggest that steering businesses to high-volume providers will improve quality.

Landon articulates the weakness in fee-for-service-based systems consisting in the fact that the same amount is paid to providers regardless of the level of quality and they are incented to provide more care at the margin regardless of need. He raises important concerns about the unintended consequences of pay-for-performance and the quality implications for services that are not measured, and refers to the need for explicit incentives to deliver higher quality. But again you ponder Culyer's and Golden's concerns about the ability to select those elements that are within provider control, can be measured and are directly linked to quality improvement. You recall Culyer's and Halparin and Davis' recommendations for a cautious, go-slow approach coupled with low expectations.

Given the length of time that you have taken to consider these various perspectives, the Minister repeats her question: Given the challenges inherent in the healthcare system, what is your advice about implementing pay-for-performance? Would you advise that the Minister take

the same leap taken by the United States, United Kingdom and Australia? Would you advise a bold implementation, a measured one or a wait-and-see approach?

Pink and colleagues, and the thoughtful respondents, deserve our appreciation as they do provide a useful exploration of the topic of pay-for-performance in a Canadian context. There is no real debate about what in our healthcare system needs improvement but rather about what solutions might work best. My take is that no one involved in this issue is arguing that pay-for-performance is the magic bullet. The question is: Should it be extended beyond those few system features that are now subject to pay-for-performance?

The experience of publicly reporting through various versions of report cards has, I believe, encouraged organizations to find ways to improve their performance. No one wants to be part of an organization known to be sub-par. Gathering data and reporting results does cause organizations to pay attention to their performance and to institute change to improve, but it probably doesn't go far enough. Those at the helm of health systems must consider pay-for-performance as a reasonable option to improve provider performance, and they must, given all that has been argued, have the courage to take this leap in areas that are reasonably well defined, measurable and likely to make a positive difference – with the understanding that it will not be perfect and will need constant analysis and adjustment.

– Mark Rochon
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