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Why pay-for-performance makes little sense in healthcare management

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EDITORIAL

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Introduction

Pay-for-performance, where healthcare remuneration is linked to prescribed key performance indicators (KPIs) rather than units of service delivery, is currently popular with healthcare administrators in many Organisation for Economic Co-operation and Development (OECD) countries as a tool for managing the complex balance of healthcare costs, quality, and outcomes.

Where is the evidence?

There is, at best, equivocal evidence that pay-for-performance is an effective way to improve service efficiency and quality. A 2013 article in the *Harvard Business Review* stated:

> *Overall, evidence of the effectiveness of pay-for-performance in improving health care quality is mixed, without conclusive proof that these programs either succeed or fail. Some evaluations of pay-for-performance programs have found that they can modestly improve adherence to evidence-based practice.*
>
> *There is little evidence, however, that these programs improve patient outcomes, suggesting that to the extent that health care providers have responded to pay-for-performance programs, that response has been narrowly focused on improving the measures for which they are rewarded . . .*[1]

So, why do healthcare administrators persist with pay-for-performance?

Pursuit of productivity

In the late 2000s, concern was raised at the 50-year trend for healthcare expenditure to grow more quickly than GDP, compounded by the predicted increase in the numbers of elderly people in OECD countries. A 2008 *McKinsey Quarterly* article projected this trend forward to 2080 and dramatically asked:

> *What will have to change to prevent health care from devouring half of a national economy?*[2]

By 2010, growth in healthcare expenditure as a proportion of GDP had actually begun to fall and in 2013 was still at about the 2009 level.[3]

Nevertheless, healthcare administrators have remained concerned to improve healthcare productivity, which is traditionally seen as being low. Their goal is to achieve better health outcomes for the money spent on healthcare. This is a laudable mission in principle but there are real problems in satisfactorily defining productivity in healthcare, not to mention defining health outcomes, which raise questions about the real usefulness of this economics-based approach to the management of healthcare.

Costs, quality, outcomes, and productivity are all parameters of healthcare services, not the services themselves. Patients benefit from services that are composed of clinician behaviour. Costs and quality then are a product of clinician behaviour, while outcomes are a product of both clinician and patient behaviour.

Pay-for-performance is a means of influencing clinician behaviour, and healthcare administrators have tried a variety of other approaches to exert this influence, such as capitation, managed care, and fee-for-service. All these remuneration systems have been shown to have

problems with effectiveness and unintended consequences.[4]

The validity problem

Pay-for-performance also faces some serious implementation challenges. To begin with, how performance is measured and monitored; valid KPIs and measures of those KPIs can be difficult to establish. This difficulty is compounded when measures are repeated, extended over time or goals are set relative to a baseline, adding measurement sensitivity and reliability to the methodological challenges.

Then there is the problem of multifactorial causation, requiring valid KPIs to be complex systems of compounded metrics based on a good understanding of the underlying causal processes—models that are rare in healthcare, especially at a high level of outcome monitoring.

Homo economicus, homo clinicus, and unintended consequences

The focus on remuneration systems as a means of influencing behaviour tells us something about the theory and view of clinicians held by healthcare administrators. That is the theory of classical economics, predicated on the behaviour of the rational consumer operating in a free market—the so-called *Homo economicus*. The behaviour of *Homo economicus* can be likened to the behaviour of objects responding to gravity in a vacuum, where the feather and the lead ball fall at the same rate: true only under conditions that do not naturally exist in the real world.

It is perhaps remarkable that this highly abstracted set of behavioural precepts is still used for practical, real-world decision-making about the economic behaviour of individuals. An alternative paradigm, behavioural economics, has been around since the 1950s, has been a dominant force in economic research and practice since the 1980s, fits better with theory in psychology and sociology, and is a better predictor of the actual behaviour of consumers. It specifically allows for "irrational" decision-making and individual variability in economic behaviour.

It is even more remarkable that the spectre of *Homo economicus* haunts healthcare, which is highly subject to irrational forces and perhaps nowhere could be described as a free market.

Further, there is good reason to believe that *Homo economicus* is a poor representation of clinicians, who actually may not be seeking to maximise personal gain, at least in terms understood by finance (a strategy deemed "irrational" by classical economics).

For example, the Australian Fair Work Commission's *Australian Workplace Relations Study* found that pay was only in fourth place of importance in determining overall job satisfaction, with work-life balance and "the work itself" in first and second place. This effect was particularly strong for females, with 37 per cent of women putting work-life balance first against the 12 per cent who put pay first.[5] This finding is typical of many studies of job satisfaction, including in healthcare.

Healthcare services are particularly likely to be staffed by people who have a sense of vocation and whose basic needs are reliably met. They probably see their job not so much as the best way for them to make money, but as the best way for them to fulfil personal desires such as for technical challenge and achievement, "making a difference", earning recognition, working with and helping people, career progression, collegiality, etc.[6]

Not only is remuneration unlikely to be supreme on the list of motivators for clinicians, it can erode the so-called "intrinsic" motivations, such as the desires for autonomy, competence and relatedness.[7]

KPI measures that poorly reflect the true state of the cost, quality, and outcomes that are sought result in seemingly arbitrary and capricious consequences for clinicians, militating against the successful influence of their behaviour.

KPIs are closely allied to the management principle of "what gets measured gets done", which has a dark corollary: "what doesn't get measured doesn't get done". KPIs can disproportionately divert clinicians' attention from treating the patients to treating the KPIs (for example, spending precious consultation time filling in a KPI reporting form that in itself adds nothing to clinical care instead of listening to the patient's comorbid mood disorder).

Widespread low rates of patient adherence to treatment recommendations are clear evidence that the linkage between healthcare services and patient outcomes is far from robust. It is easy to hold healthcare professionals accountable for behaviour that although under their influence, is beyond their control. Being held to account for outcomes that are beyond one's control is archetypically stressful, a real-world instance of learned helplessness.[8]

If the KPI measures are methodologically weak and experienced by the clinicians as capricious and arbitrary, a response of apathy or resentful resistance rather than cooperation is probable.

KPIs can also motivate people to "game" the system.[9] Gaming is particularly a risk if workers believe that they have more control over the means of "cheating" than they have control over the intended means of influencing the KPIs.

The clinician's focus on the individual patient's well-being of and the administrator's focus on system and population wellbeing is already fertile ground for organisational tension. Provoking passive or even active resistance by clinical staff through implementing pay-for-performance systems that they perceive as unfair and stressful is likely to be counterproductive.

Seen from this motivational perspective, pay-for-performance looks like a weak strategy for influencing clinicians to change their behaviour.

Seeking concordance

Patients are the only true creators of value in healthcare—it is their capacity to heal that delivers outcomes for every other component of the healthcare value chain. Low treatment adherence and concordance levels have alerted clinicians to the power that patients have to influence clinical outcomes and the importance of developing cooperative relationships with patients to enable these outcomes to be achieved. The clinician who understands what is important to the patient and tailors the treatment to reflect the patient's preferences and priorities is much more likely to achieve the results they are looking for.

Similarly, healthcare administrators need to understand the preferences and priorities of clinicians if they are to build cooperative relationships that will harness the power that clinicians have to achieve improvements in costs, quality, and outcomes. Pay-for-performance is a poor way of doing that.

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PEER REVIEW

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CONFLICTS OF INTEREST

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