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Ethical Physician Incentives — From Carrots and Sticks to Shared Purpose

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As health care reform’s focus turns to change in U.S. health care delivery, concerns about the use of incentives for physicians are intensifying. One fear is that incentives will undermine physicians’ professional ethos, leading them astray from the primacy of their duty to patients. Another fear is that incentives will be ineffective and merely cause confusion and irritation among patients and clinicians alike, without actually improving outcomes or efficiency. These fears characterize the perspectives of the ethicist and the manager, respectively; we believe that a synthesis of these perspectives is not just possible, but strategically valuable for implementing health care reform.

It seems clear to us that incentives are omnipresent and unavoidable in health care delivery. In any context, decisions are influenced by whatever decision makers stand to gain or lose — not just in economic terms but also in psychological and social terms. Accordingly, the debate over incentives should focus not only on the effect of individual elements (e.g., pay-for-performance bonuses) but also on the full array of financial and nonfinancial incentives used by a health care delivery system. The challenge for the leaders of health care organizations is to shape and align this web of incentives in ways that promote the institution’s goals while avoiding unintended harmful consequences, such as over- or underprovision of services.

The importance of this process is increasing as financial risk begins to be shifted to provider organizations along with responsibility for patient outcomes, as is currently occurring in accountable care organizations (ACOs). For ACOs to be successful, they must improve the efficiency of care. But they must also maintain or increase their market share, which means that they need to fulfill patients’ expectations regarding experience and outcomes. At the same time, to attract and retain excellent clinicians, ACOs must be places where top-quality professionals want to work. Incentives, like targets and performance measures for quality and efficiency, are management tools for steering toward these goals.

How can incentives be developed that are both effective and ethical? Given the complex realities of health care and human behavior, we believe that a simple carrot-and-stick model won’t do. The economist and sociologist Max Weber offered a typology of motives for social action that might be useful in the design of a more appropriate incentive scheme (see table).

As Weber stressed, these categories — which a widely used adaptation has labeled “traditional,” “self-interest,” “affective,” and “shared purpose” — are ideal types, and real-life actions will frequently result from mixed motives. But we believe this typology provides a useful framework for health care organizations to apply in considering their incentive strategies.

Incentive mechanisms that are based on these four types of motives vary in their development as well as their ethical implications. For example, some provider organizations were formed explicitly to deliver most or all care for a well-defined patient population. Such organizations may invoke a culture emphasizing stewardship of resources to motivate clinicians to practice efficiently. The incentive for clinicians in this context consists in being part of the group and its tradition.

Financial incentives typically employ the instrumentally rational mode of self-interest, in which individuals and groups judge actions by their likely consequences. Examples include financial rewards for achieving quality- or efficiency-related targets. These incentives must be used with great care, since any such incentive, carried to an extreme, has potentially perverse consequences. Financial incentives in particular can introduce conflicts of interest that threaten a trusting patient–physician relationship; they also provide ready targets for external and internal critics who are unhappy with pressures for change.

Affective motives are frequently used in nonfinancial incentive schemes, such as performance rankings that are openly discussed in group settings, potentially leading to peer pressure. These techniques can be highly effective and can result in colleagues’ learning from one another — for example, when data on variation in outcome or utilization of resources causes physi-
Ethical Physician Incentives

Ethical Physician Incentives

However, peer pressure is a powerful double-edged tool that carries some risk of manipulating behavior against individuals’ moral judgments. It also requires that physicians consider themselves part of a community of colleagues whose opinions actually matter to them.

The shared-purpose orientation focuses attention on goals that are broadly accepted within a health care organization. To gain such acceptance, these goals must resonate with the personnel’s sense of purpose. Thus, an organization’s commitment to the triple aim of improved patient outcomes, better population health, and reduced costs cannot conflict with, and should indeed be shown to align with, the core principles of the medical profession, as expressed in the Physician Charter on Medical Professionalism (www.abimfoundation.org), including the primacy of patient welfare, patient autonomy, and social justice. Once a shared-purpose orientation is accepted by clinicians within an organization, it can be translated into a performance framework through incentive interventions, such as performance report cards for value-based care.

Using incentives both effectively and ethically requires a shift away from a simple, one-lever model that relies on tradition, self-interest, or emotional responses to reward participants for a desired action (or punish them with financial loss or shame for an undesired one). Such an approach risks alienating physicians and other personnel. Rather, the challenge is to cultivate consensus on an organization’s shared purpose and put that orientation into action through per-
The Oregon ACO Experiment — Bold Design, Challenging Execution

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The Affordable Care Act (ACA) and the Center for Medicare and Medicaid Innovation emphasize accountable care organizations (ACOs) as mechanisms for achieving cost savings while ensuring high-quality care. ACOs are expected to contain costs through improvements in health care delivery and realignment of financial incentives, but their effectiveness remains unproved, and there are reasons for concern that they may fail.1 Oregon has embarked on an ambitious...