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**The Impact of Pay-for-Performance Beyond Quality Markers—A Call for Bioethics Research**

By David Satin, MD

What if your doctor’s salary depended on whether you quit smoking, lost weight, and lowered your cholesterol? It already does. Pay-for-performance (P4P) models of physician reimbursement have been around in some parts of the country for more than 15 years. Medicare and Medicaid are about to adopt the strategy nationwide. Although the particulars of each payment scheme vary by insurer, P4P can be summed up as “the use of incentives to encourage and reinforce the delivery of evidence-based practices and health care system transformations that promote better outcomes as efficiently as possible.” That is, clinicians are paid more if their patients score well on a particular set of health care quality markers.

The past year has yielded an explosion of studies investigating the efficacy of P4P. Yet few have examined its safety or net effect. Evaluating the adverse effects from the perspectives of disciplines such as ethics, psychology, sociology, economics, epidemiology, public health, and clinical medicine is exactly the kind of interdisciplinary research bioethicists ought to be doing. I propose the following research questions necessary to examine the safety and overall impact of P4P programs.

**Research Question #1:** How does P4P affect access to health care?

All forms of physician reimbursement can impact access to health care. For example, under capitation (fixed annual payment per patient), “both physicians and hospitals have been found to attempt to select healthier patients . . . to maximize net revenues.” Under our current fee-for-service model, “maximizing net revenues” increasingly involves

**David Satin, MD – Faculty Profile**

Dr. Satin currently holds the positions of Post-Doctoral Fellow at the University of Minnesota’s Center for Bioethics and Assistant Professor in the University’s Department of Family Medicine and Community Health. He practices family medicine at Smiley’s Family Medicine Clinic serving the inner-city Minneapolis community and its homeless. He completed his Family Medicine residency at the University of Minnesota, following a medical degree from the University of Western Ontario (Canada), a Robert Jones Scholarship in philosophy at the University of St. Andrews (Scotland), a philosophy degree from the University of Western Ontario and a health sciences degree from Mariposa College in his home town of Montreal, Canada.

Dr. Satin has been the recipient of multiple clinical, teaching, and research awards including most recently: The Minnesota Academy of Family Practice Resident of the Year Award, The Society of Teachers of Family Medicine’s Resident Teacher Award, The American Academy of Family Practice Award for Excellence in Postgraduate Medical Education, and The University of Western Ontario’s first prize in Bioethics. As a medical student, Dr. Satin co-authored an ethics text in Obstetrics and Gynecology. During his medical residency, Dr. Satin was the primary investigator of an NIH grant investigating

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excluding patients with medical assistance insurance. Although a healthy infusion of P4P dollars into medical assistance programs may reverse this trend, some data already suggest that sicker patients have a harder time accessing care when clinicians are rewarded for healthier patients under P4P.\textsuperscript{2} But can one predict who will be a sicker patient? In some cases, we can. Rural, minority, and low socioeconomic status patients are all, on average, worse health outcomes.\textsuperscript{4} Unlike Britain and New Zealand, American P4P programs do not adjust for these factors, putting clinics that disproportionately care for such patients at a disadvantage.\textsuperscript{5} These clinics are often smaller, less profitable inner city or rural practices that may find the upfront investments required to meet P4P goals difficult if not impossible. The need to invest in an electronic medical record, re-train staff, and create tracking systems may render small or poorly financed clinics unable to compete. The financial pressures mount as many insurance companies do not offer true P4P bonuses, but rather withhold a proportion of the fee-for-service reimbursement and redistribute the withheld dollars to the clinics meeting the P4P goals. This “reverse Robin Hood” strategy may result in the loss of smaller, less profitable clinics and could leave poor inner city and rural patients with even less access to health care.\textsuperscript{6} When the Centers for Medicare and Medicaid release their nation wide P4P program, will these patients appear financially more or less attractive to clinics? What sorts of practice and use patterns are emerging as a result of P4P? Can the scope and impact be quantified? What safeguards might reduce the risk of adverse effects on access to health care?

**Research Question #2:**

**How does P4P affect patient-centered care?**

When a version of P4P was introduced into elementary school systems, many educators soon began “teaching to the test.”\textsuperscript{6} Medical P4P programs not only tell clinicians the subjects in which they will be tested, but tells them the questions that will be on the test. For example, Minnesota Governor Tim Pawlenty’s “QCare” initiative for primary care in Minnesota will soon announce the measures upon which physicians will be judged. Many clinicians expect that it will include items like how many of their diabetic patients are non-smokers, have LDL cholesterol under 100, have blood pressures under 130/80, have A1C blood sugar measurements under 7, and take an aspirin a day.\textsuperscript{7} Under these P4P criteria, clinicians would have a financial disincentive for investigating a diabetic patient’s back pain, as it would take time and effort away from collecting the P4P quality markers. In this way, P4P has the potential to create incentives that undermine patient-centered care. The clinician must choose between addressing the patient’s issues and addressing the criteria by which reimbursement will be determined.

Given that P4P quality markers represent a small sampling of overall quality, clinicians who “treat to the test” will not fully serve the needs of their patients. It will be important to understand to what extent clinicians are striving for this year’s P4P quality markers to the exclusion of others not rewarded. Can P4P programs safeguard against “treating to the test,” and what ought to be the relationship between P4P and patient-centered care?

**Research Question #3:**

**Will sicker patients get worse care under P4P?**

The vast majority of current P4P programs focus on the percentage of a clinic’s patients achieving the highest quality standards. For example, within diabetics, most P4P programs provide bonuses for achieving a certain percentage of patients with excellent blood sugar control as measured by an A1C blood test of less than 7. Such programs provide little incentive to improve a diabetic patient’s A1C that is hopelessly far from goal (e.g. A1C greater than 12). As a result, some clinics participating in P4P have special programs to lower the blood sugar of diabetics who are close to the goal (e.g. A1C between 7 and 8), despite the knowledge that risks of diabetic complications are exponentially greater for the patient with the A1C greater than 12.\textsuperscript{10,11} A recent ethics article in the journal *Medical Economics* asks whether non-compliant diabetic patients ought to be “discharged” in order to preserve the doctor’s P4P bonus.\textsuperscript{12} The
Bioethics at the Fair–2006

By Jeffrey Kahn, PhD, MPH

This summer, Center faculty and staff spent the first Sunday of the Minnesota State Fair working at the Academic Health Center’s booth. We’ve come to appreciate our ability to literally reach out to the public at the fair, and this year was no different. Since it was a beautiful summer day and the first weekend of the fair, we enjoyed an unprecedented number of visitors to the booth (nearly 1,000). We assume that they were attracted by our large signs suggesting “CHEW ON THIS,” but it may have been the free packs of gum (sugar-free) and University logo gifts. In return for their choice of prize, visitors to the booth were asked to answer one of the three “Chew on This” questions:

1. SHOULD PEOPLE PAY HIGHER HEALTH INSURANCE PREMIUMS IF THEY HAVE UNHEALTHY BEHAVIOR?
   - Yes-84%; No-16%
2. WOULD YOU BE WILLING TO WAIT LONGER FOR A TOTAL KNEE REPLACEMENT SO THAT MORE PEOPLE COULD HAVE ACCESS TO HEALTH CARE?
   - Yes-84%; No-15%; Unsure-1%, the majority who said yes indicated that they’d be willing to wait for up to six months.
3. SHOULD THE GOVERNMENT IMPOSE MANDATORY QUARANTINE (LOCKING PEOPLE IN THEIR HOUSES OR IN THE HOSPITALS) IN THE EVENT OF A BIRD-FLU OUTBREAK?
   - Yes-64%; No-30%; Unsure-6%

The answers that people wrote on index cards weren’t so surprising for the way the majority “voted,” but they were interesting for the overwhelming proportion that shared the same viewpoint. The individual comments showed insights, sophisticated comments, and the sort of public engagement that we can usually only dream about. It’s heartening to know that the work we do touches a chord with so many, and makes it clear why outreach continues to be an important part of our mission. The Minnesota State Fair brings out millions of our fellow citizens every summer, and it’s great to know that so many are willing to exercise their minds in addition to their pocketbooks and waistlines. See you there next year!

University of Minnesota, the Mayo Clinic and Mayo College of Medicine awarded a Ruebhausen Visiting Professorship in Fall 2007

The University of Minnesota Center for Bioethics and Consortium on Law and Values in Health, Environment & the Life Sciences; and the Mayo Clinic and Mayo College of Medicine Biomedical Ethics Program Research Project were awarded a $25,000 grant from the Greenwall Foundation for the Ruebhausen Visiting Professorship. The three programs submitted a joint application to maximize the reach and impact of the Ruebhausen Professor’s visit, as well as create additional opportunities for further collaboration between the University of Minnesota and Mayo.

Zach W. Hall, PhD, President, The California Institute for Regenerative Medicine (CIRM) has been appointed to this professorship, and will visit in October 2007. Dr. Hall is the former Director of UCSF’s Zilkha Neurogenetic Institute; Senior Associate Dean for Academic Development in the Keck School of Medicine of USC; Chancellor at UC San Francisco; and Director, National Institute of Neurological Disorders and Stroke (NINDS), National Institutes of Health.

Dr. Hall’s perspective will be important and interesting to faculty, researchers, students, staff, and members of the administration on our campuses, and to members of the public from our communities and across our region. His visit will be a new and important way to collaborate for the University of Minnesota and the Mayo Clinic and Mayo College of Medicine, and will create a platform for ongoing discussion of issues between the two institutions.

Look for details in upcoming issues of the Bioethics Examiner as well as on our website at www.bioethics.umn.edu.

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42. United Kingdom Prospective Diabetes Study. (UKPDS) http://www.dtu.ox.ac.uk/index.html?maindoc=/ukpds/.
From several viewpoints Professor Marshall’s reflections on the act of killing in extreme circumstances is interesting and in some ways even moving. Nevertheless, as I see it, some important considerations are missing. Besides the fact that American ethicists still like to refer to Nazi conditions they never met, there is more than just a difference in this Katrina case. One of the most important focuses for an ethicist should be in inquiring about responsibilities. The acts of killing Professor Marshall’s mentions are basically different from each other if considered on the dimensions of responsibility. Her article is a clear illustration of the inescapable individual intertwining of responsibilities with the context of the actions. Under the Nazi regime power-dependency was the one and only (political, ideological) condition. Killings taking place like those in the case of Sophie’s Choice were based only on intention: the whole system was set up to kill (certain groups) and nothing else. The Katrina ordeal in New Orleans, what an inspiring place it was, was completely different. The chaos implicitly was the result of governmental incompetence, passivity, denial and may be even more. In the acts of killing, personal acts are never independent from their context. It is clear that in both cases, the Nazi case as well as the Katrina case, responsibilities can be clarified and indicated. The essential difference is in the inapproachable power depending dictatorship during the German (Nazi) occupation in Europe and the open democratic system in the USA which at least suggests the approachability of institutions to openly discuss circumstances.

The Katrina case, consequently, is a complicated situation: a complex picture of responsibilities and co-responsibilities. Those who try to claim euthanasia in New Orleans too easily ignore the important fact of shared responsibility. Those who were inactive, incompetent or too passive on the level of governmental responsibility are as responsible on this point as those healthcare workers who had no care or mercy-option left than to free those patients from suffering. The positive aspect of this experience is the illustration of the difference between a dictatorship and a democracy, which we enjoy together with our American colleagues.

The missing but essential issue in Professor Marshall’s contribution is the political context when it comes to evaluation of issues like mercy-killing. Medical ethics, certainly not only or especially if it wants to focus on extreme cases like these, should be much more alert to political/ideological contexts. Responsibility is in the personal act, but in the context of that act as well. This has nothing to do with the relativity of values. It has important meaning for thinking about the intertwining of responsibilities in situations where medical actions have to be evaluated, like in our hospitals. If this issue is overshadowed by referring to the Nazi, it has no meaning at all. The Nazi system was primarily a political-ideological system, inapproachable regarding their values. In case of comparisons and evaluations the ethicist should broaden her own focus into the direction of acts and circumstances, deeds and contexts, and clarify and name the responsibilities where they are really located. Don’t be afraid Professor Marshall, give the issues the real names they deserve.

Response to article by Marshall M. Oh, the water . . . it stoned me to my soul. Bioethics Examiner 2006;10(4):1-3.