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Disparity in Patient Care and a Physician Pay-For-Performance Compensation Model as a Possible Solution

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Disparity is prevalent in the American healthcare system and creates unequal care for the poor as well as racial and ethnic minorities. Although this problem is recognized, and some efforts have been made to improve the situation, disparities continue to worsen. The poor and other minorities have seen their quality of care and access to care decrease over the last decade. A proposed solution to this difficulty is to encourage physicians to provide care for these individuals. One way in which physicians may be encouraged is by either increasing or decreasing pay based upon a compensation model. Although various compensation models exist in the United States, the pay-for-performance model, if properly executed, would substantially improve the access to and quality of healthcare for the poor and minorities in the United States.

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I. DISPARITY IN HEALTHCARE

Healthcare disparities in the United States is defined as the difference in care provided to one population group as compared to another, specifically being measured by access to healthcare and the quality of healthcare received.[1] According to the National Healthcare Quality Report, Americans often do not receive necessary care or they receive care that causes harm.[2] All Americans deserve an opportunity to experience positive health outcomes by receiving timely and appropriate healthcare.[3]

Looking first towards the quality of care received, the report found that between 2000 and 2006, healthcare disparities based on socioeconomic status stayed the same or worsened in over 60% of the studied measures.[4] This trend was also true for Blacks, Asians, American Indians, Hispanics, and the poor.[5] Moreover, each of these groups received a quality of healthcare which was lower than Whites in the United States over the same time period.[6]

These statistics demonstrate that racial minorities and the poor receive inferior healthcare compared to White Americans of good financial standing. Additionally, there is not a significant trend of improvement in healthcare for these populations, as less than 40% of the study's quality measures improved

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[1] AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, NATIONAL HEALTHCARE DISPARITIES REPORT 2008 1-2 (2008).
[2] *Id.* at 1.
[3] *Id.* at 2.
[4] *Id.*
[5] *Id.*
[6] *Id.*

across these groups as a whole.[7] Even more concerning is that by 2006, the quality of care received by Blacks, Asians, and the poor actually worsened rather than improved.[8] This means that an individual belonging to one of these populations who received some type of healthcare in 2006 was more likely to receive worse care than they would have received in 2000.

In regards to access to healthcare, a similar study from 2000 to 2006 demonstrates that these same racial, ethnic, and socioeconomic disparities produced similar trends in healthcare access.[9] Access, in healthcare, refers to a person's right and ability to receive the care necessary to maintain a healthy life. When looking at core healthcare access measures, Blacks, Asians, Hispanics, and poor Americans had 40% of conditions worsen.[10] Only one group, American Indians, avoided this trend, and experienced no conditions worsening and saw improvement in 75% of the core access measures.[11] Nevertheless, the remaining groups saw no such improvement.

A number of barriers exist that may lead to difficulty in accessing healthcare, such as a lack of health insurance or a lack of healthcare providers in a geographical region.[12] Blacks, Asians, Hispanics, and the poor all experienced an equal or greater difficulty accessing appropriate healthcare in 2006 as compared

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[7] *Id.*
[8] *Id.*
[9] *Id.* at 3.
[10] *Id.*
[11] *Id.*
[12] *Id.*

to 2000.[13] As this suggests, improvements in healthcare access are being negated by an equal or greater number of barriers to access.[14]

Together, these statistics suggest that poor Americans, and those from racial minorities, are facing great difficulties obtaining appropriate healthcare, as measured by two key components—access and quality. Some scholars and economists suggest that looking to improved physician compensation methods will encourage physicians to provide better access to and a higher quality of healthcare.[15]

II. PHYSICIAN COMPENSATION MODELS – PAY FOR PERFORMANCE

Across the United States, there are numerous models and pilot programs that are used by healthcare providers to pay physicians, aimed at improving the quality of care and increasing efficiency.[16] We can look to these models to see which, if any, can or may reduce the disparity in American healthcare as highlighted above, such as state-based capitation and pay-for-performance.[17] Each of these models utilizes unique forms of physician compensation.

Capitation is a model that involves prepaying physicians for healthcare services.[18] These payments are made per month based upon the number of

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[13] *Id.*
[14] *Id.*
[15] Rodney G. Hood, *Pay-for-Performance---Financial Health Disparities and the Impact on Healthcare Disparities*, 99 J. NAT'L MED. ASS'N 1, 1 (2007).
[16] Meredith B. Rosenthal, *Beyond Pay for Performance—Emerging Models of Provider-Payment Reform*, 359 NEW ENG. J. MED. 1197, 1198-1199 (2008).
[17] *Id.* at 1198.
[18] PETER R. KONGSTVEDT, ESSENTIALS OF MANAGED HEALTH CARE 106 (4th ed., 2001).

members enrolled in the program.[19] This type of model is often used by Health Management Organizations.[20] The rates can vary based on the member's age, gender, health, and geography; however, the rates do not change based on volume of services provided.[21] Benefits to this model include incentives for physicians to reduce expenses and streamline care.[22] Nevertheless, this is a performance-based compensation model where a physician is paid for the services provided.[23]

Although pay-per-performance structures often vary, many are organized the same way.[24] Under this model, organizations will pay physicians bonuses for improvements that are made to the quality measures of the organization, which do not include a change to the health plan.[25]

Organizations will also pay physicians if their performances improve. Similarly, individual health plans, Medicaid or Medicare will pay individual physicians for improved performance.[26] A drawback to this model is that physicians are only rewarded for the improvements related to the number of patients that may have a particular medical condition, thereby creating a possibility for minimal monetary incentives for the physicians who treat few patients with the condition.[27] Depending on how the particular program is structured, physicians may not be rewarded for all improvements or in their

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[19] *Id.*
[20] *Id.* at 105.
[21] *Id.* at 106, 108.
[22] *Id.* at 109-10.
[23] *Id.* at 109.
[24] Thomas Bodenheimer et al., *Can Money Buy Quality? Physician Response to Pay for Performance*, 3 IND. HEALTH L. REV. 445, 446-47 (2006).
[25] *Id.*
[26] *Id.*
[27] *Id.*

largest treatment area. Some private health plans, however, along with Medicare, pay the physician's organization rather than the physician.[28] This allows the organization to pool funds and create greater rewards for physicians through bonuses or quality enhancements.

III. USING COMPENSATION MODELS TO REDUCE DISPARITY

Although the capitation system is a good system overall to improve the quality of care and control costs, the capitation system does not provide the compensation-based incentives necessary to significantly decrease the healthcare disparity.[29] Capitation models allow for indirect discrimination through rate changes based on age, sex, and genders, as well as other factors, depending on the type of plan that is used.[30] This type of model has been popular in the United States for over twenty years, however, as new models are introduced, HMOs and other providers are switching to alternative models.[31]

The pay-for-performance model likely provides the best method of decreasing the disparity that exists in the American healthcare system. Many models can be tweaked or designed to significantly incorporate the goals of disparity reduction, but pay-for-performance is best adapted. Moreover, pay-for-performance is becoming increasing popular among physicians' organizations.

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[28] *Id.*

[29] KONGSTVEDT, *supra* note 18, at 109.

[30] *Id.* at 108, 153.

[31] Meredith B. Rosenthal et al., *Pay for Performance in Commercial HMOs*, 355 NEW ENG. J. MED. 1895, 1897 (2006).

By improving an existing popular model, we will have a greater success in reaching our goals.

According to a recent study by The New England Journal of Medicine surveying 252 HMOs across forty-one metropolitan areas, more than 50% of HMOs use a pay-for-performance model.[32] Based upon the sizes of those HMOs, 80% of members enrolled in an HMO utilize a pay-for-performance structure.[33] Of the 126 plans that use pay-for-performance, 90% had programs for physicians and 38% had programs for hospitals.[34] Therefore, it is evident that pay-for-performance programs are becoming an increasingly popular model for the country's most popular healthcare structures.

When initially designed, the pay-for-performance model did not consider the effects on disparity.[35] Policymakers argue about the true effects of the model, but there are no conclusive studies that suggest that the pay-for-performance model, as currently aligned, significantly improves or worsens the disparity that exists.[36] One study shows that physicians, who are highly ranked through a combination of quality and efficiency variables, are no more likely to care for the poor or racial and ethnic minorities than physicians that are ranked poorly.[37] In contrast, another study shows that hospitals that care for a disproportionate number of poor and ethnic and racial minorities may be less able to earn the

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[32] *Id.* at 1895.
[33] *Id.*
[34] *Id.*
[35] Alyna T. Chien & Marshall H. Chin, *Incorporating Disparity Reduction into Pay for Performance*, 24 J. GEN. INTERNAL MED. 135, 135 (2008).
[36] *Id.*
[37] *Id.*

bonus payments under Medicare's pay-for-performance program.[38] By looking to the future of pay-for-performance, some improvements can be made on the current system, which will help to eliminate healthcare disparity.

To improve the care of minority patients, it is important to analyze what is causing the disparity. There are two primary possibilities: (1) healthcare providers are providing inferior treatment for different members within the same group or (2) minority patients are often cared for by lower quality providers.[39] If it is determined that disparity exists because providers treat minority patients differently from White patients, then physician payments can be correlated to high quality and racially equitable healthcare.[40] If it is determined that disparity exists because minorities are more often cared for by lower quality providers, then pay-for-performance programs can be designed to encourage high quality providers to care for the poor and ethnic and racial minorities.[41] Alternatively, providers could be enticed with additional incentives to pursue equality improvement efforts. Providers that disproportionately serve poor and minority patients are sometimes overwhelmed with the demand, are under-resourced, or lack access to specialty referrals.[42] Improving any of these conditions would help eliminate the healthcare disparity.

Once the source of the healthcare disparity is known, pay-for-performance models should employ measures that reduce this disparity. One way this can be

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[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*

done is by targeting specific medical conditions known to have large disparities and rewarding physicians that demonstrate an equal ability to diagnose and treat the condition.[43] For example, there is a significant gap between the number of White and Black women that are treated for breast cancer in its early stages.[44] Even though diagnostic rates are similar, they are not treated at an equally proportional rate.[45] An improved pay-for-performance model would reward physicians that are able to treat a proportionate number of White and Black breast cancer patients.[46] Another way to improve the existing disparity is to reward physicians that incorporate the medical traditions of different cultures into the treatment process.[47] For example, many minority populations value group decision-making processes, especially when the decisions relates to health conditions.[48] Additionally, the pay-for-performance model can simply reward any direct improvements in the disparity of the healthcare provided.[49] A physician would be rewarded for reducing disparity in the treatment of a specific disease, for increasing his patient diversity, or any other number of disparity measures.

Finally, pay-for-performance models could reward improvements and achievement made by the physician's organization.[50] After making the choice of what type of disparity improvements should be rewarded, as noted above, it will

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[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] *Id.* at 136.

be important to also determine the degree of performance required.[51] Policymakers have noted that pay-for-performance models that set high benchmarks as the sole incentive often yield more negative consequences than positive ones with respect to disparity.[52] If gradual increases are rewarded, however, such as increasing minority screening rates for a certain disease by 50%, then physicians are more likely to reach the target and more patients will receive the care.[53] It is essential that the model recognizes both absolute achievements and gradual improvements along the way.[54]

IV. CONCLUSION

Healthcare disparity is a significant issue in the United States because the poor, as well as ethnic and racial minorities, are not able to access the same quality of healthcare as well-situated white Americans. By utilizing a popular physician compensation model and making minor revisions to its compensation processes, it may be possible to entice physicians to care for more diverse groups of patients and to improve that quality of care.

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[51] *Id.*
[52] *Id.*
[53] *Id.* at 135.
[54] *Id.*