Physician Productivity Breakout Session

The definition of productivity in medicine is less than clear. The ultimate goal of any health care system is the improvement in the health of patients and the population. However, no health care system measures health systematically either in terms of mortality or health related quality of life. Indeed, work in this area has exposed its complexities, e.g. the work of Dranove et al in Pennsylvania and New York showed that publication of adjusted mortality rate data at the practitioner level led to doctors changing admission criteria to avoid being outliers in the distribution. The work of the UK insurer, BUPA, has illustrated that it is possible to use a generic health related quality of life measure (SF36), but problems remain in severity adjustments and sensitivity.

Problems with measuring outcomes have led to a focus on process, i.e. measuring variations in activity between practitioners in particular specialties (e.g. Bloor & Maynard, 2002). Such data can also be used to measure the impact of guidelines on medical practice (e.g. Bloor et al, 2003) and whether contractual status has an impact on public sector activity (e.g. Bloor et al, 2004).

Providing explicit financial incentives for productivity, measured as outcomes or process, is increasingly evident in the USA (Robinson, 2001, 2002) and the UK (DoH, 2003). These countries are selecting mixed or blended payment systems. The efficient roles of competing remuneration systems need careful specification of policy goals and explicit ranking trade-offs inherent in payment choices.

The Breakout Session with address two main themes:

1. Measurement of productivity
2. Providing incentives for productivity

There will be two brief presentations from the UK and comments from country contributors, followed by general discussion.

References

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