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Employee Incentives

Physicians Can Help Cut Costs. They Just Need the Right Incentives.

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Summary. Health care organizations have long tried to enlist physicians in their effort to control or reduce costs. One effective means for doing so is to create an incentive system that rewards physicians for their contributions. To design such a system, organizations... **more**

Many of physicians' daily decisions — such as their selection of drugs, devices, and technologies, and the amount of time they utilize resources such as operating rooms and hospital beds —

have a significant financial impact on hospitals. By providing physicians with the appropriate incentives, hospitals and health systems can enlist them in the effort to manage costs while simultaneously maintaining or improving patient outcomes.

The reality, however, is only a small percentage of health systems do so today. To help the others who haven't yet taken this path, we present guiding principles in this article for designing incentives. It is based on our experience over the last decade working and speaking with dozens of health systems to help them improve their financial, clinical and operational performance and the research of one of us (Susanna) on the design of incentive and performance management systems.

1. Broad or Narrow Incentive Structures?

Physicians can help hospitals manage costs in myriad ways. For example, they can contribute by helping to renegotiate prices with vendors, switching to lower cost supplies, improving clinic or operating room flow, reducing patients' length of stay, adjusting the mix of staff performing different tasks, changing post-discharge care, and so on. Physician incentives can be structured narrowly around each of these types of improvements. For instance, hospitals can share with their physicians a percentage of the savings arising from the renegotiation of a contract with a supplier of surgical implants or an initiative to standardize the kind of device used in a particular procedure, thus motivating and rewarding their efforts to obtain better prices. Additionally, shared savings can compensate physicians for the temporary lower productivity they may experience as they learn the new implant system, thus removing some of the barriers to change.

While institutions can successfully design incentives around narrowly targeted cost-saving initiatives, we believe it is better, where possible, to incentivize physicians to contribute to

reducing costs for a particular procedure or treatment course (e.g., a type of spine surgery) or clinical condition (e.g., low back pain). This broader scope empowers physicians to explore opportunities to reduce costs that are not limited to pre-determined initiatives. It increases physicians' sense of autonomy and discretion and leverages their expertise to identify ways in which costs can reasonably be managed without compromising quality. Measuring costs at the procedure or clinical condition level also helps monitor potential undesirable spillover effects, such as a reduction in costs in one dimension of care delivery (e.g., pain management medications) leading to an increase in costs in another one (e.g., patients' length of stay).

Cambridge Health Alliance (CHA), an innovative safety net health system in Greater Boston, and its Department of Orthopedics led by Hans P. Van Lancker have developed a cost-management incentive program based on these principles. (Disclosure: CHA is a client of Derek's company, Avant-garde Health.) The health system and the department set a goal of reducing the total cost per case for each of the most common orthopedic surgeries that the departments' physicians perform. The program began in 2024 and has already led to several improvements. For instance, CHA saved nearly $1,000 per hip replacement patient by reducing the use of an expensive type of acetabular liner (an implant component) that has not been shown to be worth the cost premium in low-risk patients.

2. Individual- or Team-Based Incentives?

In some institutions, incentive programs reward physicians based on their individual contributions to savings, while others do it based on team/collective performance across physicians in a clinical division or department. We recommend incorporating elements of each of these approaches.

A necessary condition for any physician to earn a reward is that the program yields net savings. This ensures the hospital is not paying an incentive if the aggregate costs increase. For instance, if Physician A saves $50,000 while Physician B's costs go up $60,000 then the hospital's costs in total increased by $10,000 and there are no net savings with which to reward Physician A. Team-based goals foster a sense of mutual accountability since each physician's performance impacts everyone's earnings potential.

It is, however, appropriate to reward individual physicians for the portion of net savings that is directly attributable to each of their own actions and independent of the actions of other participants in the program. For instance, individual physicians may have discretion on whether to use a more-expensive or a less-expensive version of a product (e.g., bone cement) when the products are equally clinically effective for a patient.

The following example shows how to attribute net savings across physicians based on each of their contributions. For instance, if Physician A saves $50,000, Physician B's costs go up $60,000 and Physician C generates $100,000 of savings, then the total gross savings from Physicians A and C are $150,000, and the net savings are $90,000. Physician A generated one-third of the gross savings and Physician C generated the remaining two-thirds of the gross savings. These percentages should then be applied to the net savings, which means Physician A is attributed with one-third of the net saving ($30,000) and Physician C is attributed with two-thirds ($60,000). A portion of these attributed net savings would then be shared with Physicians A and C; Physician B would receive nothing.

Not all savings, however, can be directly attributed to the actions of one individual. Some improvements require collaboration and alignment. For example, in 2017 the Neurological Institute at the Cleveland Clinic revamped its OR scheduling process to better

utilize the available capacity. This process entailed a pervasive transformation, which involved all the surgeons in the institute (as they all had to participate in the new process), the scheduling staff, and the OR staff. The initiative replaced the common industry practice of "templating" (i.e., reserving regular blocks of OR time *ex-ante* for each surgeon over a long time, regardless of whether they had scheduled surgeries to utilize those time blocks) with a more flexible scheduling system, whereby OR utilization would be prospectively analyzed on a weekly basis for the next two weeks, and OR time would be allocated accordingly. This initiative improved capacity utilization. Collectively-achieved savings should be split following an equitable criterion among all who contributed to the savings — for instance, by giving the same amount to each physician or staff member involved or awarding each an equal percentage of their individual compensation).

3. What's the Right Timeframe for Compensation?

We frequently hear of tensions between administrators and physicians over how long cost-saving incentives should last. Administrators may want to share savings only in the year when the work to achieve the savings occurs (e.g., the year a process redesign was implemented or a product price renegotiated), while physicians may want to receive a share of any savings resulting from that work in subsequent years too.

We recommend providing an incentive for achieving reductions over time. The amount paid each year should reflect that it gets harder to achieve further savings as costs progressively decrease. So, institutions could, for example, share an incrementally larger percentage of incremental savings.

We also recommend providing a relatively smaller incentive for maintaining a given cost level. Maintaining cost savings should still be rewarded to prevent future increases in costs (e.g., people returning to older, less-efficient practices). The amount of the

ongoing incentive should depend on how much work it is for physicians to maintain that level of spend. For example, if physicians need to spend extra time with every patient to prepare them to start on dialysis correctly, those physicians should receive a larger ongoing incentive payment for maintaining costs at a certain level than if they had made a one-time change to use a lower cost product.

We suggest basing the incentive structure on the hospital's cost levels relative to a benchmark (e.g., a national or peer group average). For instance, if a hospital's costs are significantly above average, the incentive structure should first reward the physicians for reducing costs from their current level down to the benchmark over a reasonable period (e.g., two or three years). If performance reaches benchmark levels, there should be an annual payment for maintaining that level of performance and a larger incentive for continuing to further reduce costs.

Here is an example of how to structure a cost-savings incentive program for physicians. In the first year, the physicians receive 30% of the savings achieved by driving costs below the starting level. In the second year, the threshold for sharing savings is reduced to halfway between the starting cost per case and the national average cost for the procedure. Starting in the third year, physicians receive an incentive (e.g., $100 per case) for keeping costs at or below the national average benchmark, and they also earn a higher share (50%) of any savings — reflecting that it is harder to reduce costs below the national average than it was at the outset of the program. From the fourth year onward, the physicians continue to earn 50% of any savings they achieve relative to the prior year, and they also continue to receive an incentive for maintaining savings they have achieved in prior years. This structure provides a meaningful incentive to achieve further savings each year and rewards physicians for sustaining savings they have achieved in prior years.

4. How Much to Compensate?

We think the appropriate amount of shared savings depends on the individual physician's compensation level as well as any incremental costs they might incur to implement the changes that will lead to cost savings (e.g., temporary reductions in surgical productivity due to the learning curve associated with a new implant system). An appropriate range is about 5–15% of the physicians' compensation — enough to motivate physicians but not so large that it leads to undesirable cost cutting that may reduce the quality and safety of patient care.

5. Financial or Alternative Forms of Incentives?

Monetary rewards are not the only way to promote and recognize physicians' efforts in controlling costs. Alternative mechanisms include sharing the savings with the physician's department so they can fund initiatives and programs that matter to the physicians. Additionally, leaders should account for the variation in individuals' preferences. It is important to structure the incentive systems to offer a choice or mix of rewards in addition to cash compensation, such as funding for a project the physician wants to develop, training opportunities, protected time for research, or more time to spend with their family. If the physicians are in private practice as opposed to employed, then there may be fewer types of rewards that the hospital can offer, but it is still possible to offer options such as preferential OR scheduling or additional staff support.

Appropriately structured incentives can be effective in helping bend the cost curve in health care. They can empower physicians to propose solutions informed by their expertise, foster collaboration and mutual accountability, and reward performance improvement by sharing the benefits generated by these initiatives. The principles we have offered can help create an incentive design that all parties believe is fair.

It is important that these incentives go through a legal review and are supported by accurate and timely cost accounting that is visible to all stakeholders, as well as robust measurement of care quality and outcomes to ensure these are not being adversely impacted. The good news is that many of the same actions that help lower costs, such as delivering care more consistently, lead to both lower costs and better outcomes.

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