

Comment on the Publication: Lazarevik V, Kasapinov B. Medical Doctors' Attitudes towards Pay-For-Reporting in Macedonia: A Web-Based Cross-Sectional Survey. *Maced J Med Sci.* 2012;5(4):437-443.

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Abstract

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We are truly glad for the interest in scientific approach towards the model for Payment-for-Activity (PPU), recently introduced in the Republic of Macedonia, taking in consideration that for the very first time a system is introduced capable of providing exact information on medical interventions or procedures performed in public healthcare facilities, and to use such information for evaluation of physicians' activity. In this context, we welcome the publication of Lazarevik et al. Medical Doctors' Attitudes towards Pay-for-Reporting in Macedonia: A Web-Based Cross-Sectional Survey. However, in order to further contribute towards the scientific discussion arising around the issue of payment for physicians' activity; we herewith present the following comments.

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Pay-for-Reporting in Macedonia: A Web-Based Cross-Sectional Survey [1]. However, in order to further contribute towards the scientific discussion arising around the issue of payment for physicians' activity; we herewith present the following comments.

Despite the fact that the area of Pay-for-Performance (P4P) is still new and evolving very quickly, yet with the title the author demonstrates non-adherence to the generally accepted standard definitions and terms. Namely, the term Pay-for-Reporting (P4R) refers to

programs where payment is made when providers (doctors or hospitals) report quality-related data [2].

These programs usually intend to develop into Pay-for-Quality once providers become more comfortable with the validity and reliability of the quality measures and data collection procedures [2]. Example of P4R in the United States (US) is paying hospitals if they publicly report on the rates of intra-hospital infections; meaning that through financial incentives or disincentives, hospitals in the US are encouraged to publicly report on intra-hospital infections' rates aimed at informing patients on such rates among different hospitals [3].

Therefore, it is quite obvious that P4R, as defined above, could not be identified with the PPU system, since the financial incentives or disincentives in our system are not related to whether the physicians are reporting on their interventions. Reporting of performed interventions/procedures is binding for physicians through data entry into the PPU system, unless the public healthcare institution owns an information system directly generating the requested information. Rewarding of doctors through PPU system is based on the work accomplished, and not on reporting of interventions, as the latter is mandatory.

Additionally, the author, in his attempts to analyze the PPU system, demonstrates essential disagreement with the established standards in this area, comparing our PPU system with the P4P programs in the US. For this purpose, it is necessary to clarify that the term P4P is used for programs providing incentives or disincentives for physicians and healthcare facilities to achieve better performance by increasing the quality of care through quality indicators, or by reducing the costs; however, these programs are applicable for far less doctors/hospitals compared to the predominant model for measurement of physicians' productivity in the US based on RVU (Relative Value Units), similar to coefficients of difficulty in our PPU system [2, 4].

The predominantly used model in the US is a quantitative one where the total value depends on the quantity (volume) of the interventions performed. Thus, the similarity of our PPU with the US model is the use of total amount of different interventions/procedures, as depicted in the different coefficients of difficulty (PPU) or RVUs (US), whereas the difference between the two models is that the quantity of services with various difficulty is used for relative assessment of the workload in predefined groups, resulting in salary within the range of +/- 20% of the base salary in PPU, compared to the

quantity being directly related to the total value in the US [4].

It is evident that there has been a huge difference in the way the healthcare workload has been evaluated in our country and in the US, used as a model in the mentioned publication [1], as there has never been a situation in the US when physicians were rewarded equally independent on the job accomplished, and any job-related irregularities (e.g. absences during working hours, irregular data entry of completed medical interventions, etc) in the US are sanctioned with most severe penalties, including financial penalties, prison sentences and withdrawal of medical license [5, 6].

It is worth noting that P4P programs in the US serve as a tool for cost reduction and creation of higher healthcare value; certainly not as a way for even distribution of workload, being the main goal of the PPU system introduced in Macedonian healthcare. In our assessment, it is necessary to use the PPU system for certain time period, before moving to more complex programs involving quality indicators or patients' satisfaction, such as P4P. In fact, it is the exact way these programs have also evolved in the US. Further addressing the complexity of P4P, it should be recognized that there has been no universal P4P program, but many various P4P programs instead - up to our knowledge, there are currently more than 258 P4P programs in the US (at least 130 at a primary health care level, 72 at a specialist level, 56 at a hospital level), being financially linked to the healthcare value in a completely different manner [2].

The publication itself [1] is based on physicians' responses to a simple survey about a system not applicable to most of respondents, i.e. most of respondents have never had the opportunity to work with the PPU system, and certainly have no sufficient information on the methodology behind it. Lazarevik and Kasapinov, 2012 [1] stated that out of 295 respondents, only 118 work in public healthcare institutions, meaning a maximum of 40% of respondents are likely to have had any experience with the system. It should be noted that PPU system is still not applicable for considerable number of specialists in public healthcare institutions (e.g. Healthcare Centers across the country). Very small number of relevant respondents compared to the total number of specialists using the PPU system, additionally to the major methodological limitations recognized by the author himself, make the conclusions stated in the discussion highly questionable [1].

Most of those who responded to the survey are working in the primary health care ($n = 123$) where this system is not in use. Total number of respondents from public sector is 118, and this number is not equal to the sum of respondents from specialized clinics ($n = 48$), general hospitals ($n = 71$) and university clinics ($n = 61$) ($48 + 71 + 61 = 180$), meaning that PPU system is not applicable for a significant number of those who responded from the secondary and tertiary health care [$n = 62$ ($180 - 118$)] [1]. Hence, the results and discussion of the author could be questioned even further [1].

Additionally, the author himself demonstrates insufficient understanding of the PPU system, stating that the system does not include the complexity of interventions - not referring to the different coefficients of difficulty associated with various interventions; that the teamwork is not included in the PPU system - not referring to interventions such as e.g. first surgery assistant, that the outcome measures for hospitals are not included – omitting the fact it is subject of another system (Balanced Score Card), that PPU system has not been communicated before introduction - despite the number of pilot public healthcare institutions, and several months of trial period for all users before full implementation.

It is easy to conclude that considerable number of questions in the survey, as well as the author's own comments, can be more easily categorized as political, and hardly as medical and scientific. Taking into account the conceptual errors when comparing the systems, we find this publication to be more a reflection of some current political moments than to be based on scientifically sound methods.

Having in mind that the author is a former

Deputy Minister of the Ministry of Health of the Republic of Macedonia (2006-2008) when the Government was led by the same political structure as today, current member of the Committee for Improvement of Healthcare Sector within the Ministry of Health, actively involved in the creation of healthcare policies, we strongly believe that he had to demonstrate more comprehensive and scientifically sound coverage of the systems he intended to analyze, including our PPU system. On the other hand, we are fully aware that introduction of such system in Macedonian healthcare for the very first time necessitates its continuous review and improvement.

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