Physician Consortium for Performance Improvement Position Statement*

The Linkage of Quality of Care Assessment to Cost of Care Assessment

The tradition of physician professionalism is grounded in the obligations to society and individual patients to achieve optimal health outcomes and to responsibly use health care assets. The profession and society are confronted by the related challenges of escalating health care costs; increasingly complex and expensive medical innovations; pervasive consumer demand for interventions; an increasing problem with access to care and concerns about the quality, safety, and appropriateness of medical care delivery. As a result, new performance measurement initiatives have arisen from outside of the profession that significantly affect the relationship between patients and their physicians. Medical societies and accrediting boards are exerting increasing leadership in the determination of the criteria and processes that evaluate and communicate the quality and effectiveness of care delivery, and have reinforced the profession's commitment to incorporating performance data into the process of life-long professional development.

Some of the problems that arise are the result of confusion relating to the terms "quality of care", "cost of care", "efficiency of care" and "value of care". It is useful to define these terms as has been done by the Ambulatory Care Quality Alliance (AQA). The following definitions are taken directly from the AQA web site:

"Quality of care", is a measure of performance on the six IOM-specified health care aims (safety, timeliness, effectiveness, equity, efficiency and patient centeredness).

"Cost of care" is a measure of the total health care spending, including total resource use and unit price(s), by payer or consumer, for a health care service or group of health care services, associated with a specified patient population, time period, and unit(s) of clinical accountability.

"Efficiency of care" is a measure of cost of care associated with a specified level of quality of care. "Efficiency of care" is a measure of the relationship of the cost of care associated with a specific level of performance measured with respect to the other five IOM aims of quality.

"Value of care" is a measure of specified stakeholder's (such as an individual patient's, consumer organization's, payer's, provider's, government's, or society's) preference-weighted assessment of a particular combination of quality and cost of care performance.

The data, analytic tools, methodologies and processes for performance evaluation are developing at a rapid pace. So also have the range and consequences of initiatives that employ the results of performance assessment. Of particular interest and concern to many physicians, and other stakeholders with an interest in enhancing the quality of delivered health care, are recent efforts that seek to evaluate and publicize the cost of care delivery separate from any measurement of the quality of that care. This is of concern for the following reasons:

1. The greater social goal of performance assessment is to optimize health care outcomes at a cost that our nation can afford. A mature and complete assessment strategy requires evaluation of all domains of quality. Initiatives that look only at cost of care delivery are inherently insufficient.

2. Evaluating cost, separate from quality and appropriateness, is misleading. As an example, unnecessary and inappropriate clinical interventions that are delivered "inexpensively" serve no useful social goal. Rewarding or recognizing such care in isolation could serve to exacerbate, not resolve, the challenges before us.

3. Examination of total costs of care within a practice provides little insight for the physician to make improvements. For cost-of-care measurement to be most useful in changing behavior, the focus of the cost of care measures needs to be as narrow as possible, ideally linked to care of a specific condition or procedures. Also, component costs need to be explicitly defined.

4. For any cost of care measurement to be useful it will require transparency of the measure. Some, if not many of the current methods being used are based on products developed without substantive clinical insight. Ultimately, physician acceptance, and leadership in this field must occur and is essential to success.

5. Given the above, we take this opportunity to urge our colleagues to continue to advance our profession's collective leadership in assessing clinical quality efficiency and to incorporate these assessments into the process of continuous professional development. We encourage them to lead the search for and use of true measures of efficiency that help to make care less costly without compromising quality. We strongly disagree with interpreting cost related information independent from quality related data.

*Approved by Consortium Membership on March 9, 2007