New government pay-for-performance policies punish doctors who care for obese patients

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Pay-for-performance reimbursement of surgeons, intended to reward doctors and hospitals for good patient outcomes, may instead be creating financial incentives for discriminating against obese patients, who are much more likely to suffer expensive complications after even the most routine surgeries, according to new Johns Hopkins research.

Medicare and Medicaid, for example, are increasingly using pay-for-performance formulas to cut doctor's pay when their patients develop infections after surgery. But the Johns Hopkins researchers say there could be negative unintended consequences, because obese patients, who make up about one-third of the population, are at significantly greater risk of complications — notably surgical site infections — following appendectomy and gallbladder removal surgery than non-obese patients. They also cost thousands more dollars to treat than the non-obese.

The new research is scheduled to be presented at Digestive Disease Week, the nation's largest gastrointestinal medical conference, which runs from May 1 to May 5 in New Orleans. "This is a government policy that promotes patient selection and discrimination," says Martin A. Makary, M.D., M.P.H., an associate professor of surgery and health policy at the Johns Hopkins University School of Medicine, and the study's leader. "The policy incentivizes doctors to pass on, stall or delay treatment of obese patients, many of whom are minorities."

Makary suggests that the potential discrimination will disproportionately affect African-Americans whose rates of obesity are higher than in the white population. An estimated 65 percent of African-American women are overweight in the United States compared to 20 percent of white men. In this way, Makary says, flawed pay-for-performance policies hurt minority populations — and the doctors who treat them — the most.

Makary says hospitals and doctors should be held responsible for preventing surgical complications. But, he says, any pay-for-performance system needs to look beyond complication rates and take into account the increased risks and costs known to be associated with obesity.

"Rewarding providers based on outcomes is good when the outcomes are adjusted for case complexity or co-moribidities," Makary says. "But it can be discriminatory and create perverse incentives when metrics aren't adjusted. And what is the most prevalent and leading co-morbidity in America that skews outcome? Hands down, it's obesity."

Makary and his colleagues examined insurance claims for 35,096 patients who underwent gallbladder removal and 6,854 patients who underwent appendectomy from 2002 to 2008. They compared 30-day complications as well as total direct medical costs following surgery for obese and non-obese patients.

They found that obese patients were 27 percent more likely than non-obese patients to have complications following gallbladder surgery and 11 percent more likely to have complications following an appendectomy. These complications mean obese patients end up costing more to treat, with median total inpatient costs for basic gallbladder removal $2,978 higher for obese patients, and $1,621 higher for obese patients who had appendectomy.

Obese patients undergoing appendectomy had longer hospital stays and higher rates of reoperation, infection and hemorrhage than non-obese patients, the researchers found. Obese patients who had their gallbladders removed saw higher rates of blood clots, reoperation and infection. Surgery is particularly difficult on obese patients, the authors note, especially procedures performed in the abdominal region where fat is disproportionately located. Operations in the obese often take longer and require larger wounds. Obese patients may also present at later stages of disease, making surgery and subsequent care more complex.

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