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Taking the measure of the profession: Physician associations in the measurement age

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ABSTRACT

Systematic measurement of healthcare services enables evaluation of health professionals' quality of work. Whereas policy makers find measurement a useful mechanism for quality improvement, a public choice perspective implies that physicians would resent such an initiative, which undermines their professional autonomy.

In this article, we compare two healthcare systems of economically developed countries – Israel and the UK. Both systems share common features such as universal coverage, strong state intervention, and enthusiasm for New Public Management. In both countries, quality measurement was introduced in acute care hospitals at around the same time. However, while the UK succeeded in establishing a framework of surgical outcome measures during the 2000s, a similar initiative in Israel failed completely during the 1990s. We also refer to subsequent quality indicator efforts in Israel, in both community and hospital frameworks, that were more successful, but in a way that reinforces our central thesis.

We contend that differences in reform outcomes stem from the medical profession's reaction to government's endeavors. This response, in turn, hinges on the professional organizations' relative institutional position vis-a-vis state authorities. This study constitutes a unique investigation of the medical profession's response to critical quality measurement reforms. Most importantly, it stresses the institutional position of medical associations as the primary factor in explaining cross-case variation in government's success in introducing quality measurement.

1. Background

Many countries invest substantial efforts in improving the performance of their healthcare systems while trying at the same time to curb escalating health expenditures. These efforts are manifested in a variety of professional, organizational and administrative activities regarded as quality improvement initiatives.

One of the most prominent initiatives in this field is quality measurement, which aims to measure central aspects of clinical care. Some critics, however, point to the difficulties and dangers in quality measurement, especially when it is connected to financial incentives or to the comparative publication of results of care providers. Despite the ongoing controversy accompanying quality measurement in medicine, it continues to spread rapidly in health systems worldwide [1–4].

Among these are the Israeli and the United Kingdom (UK) systems that share several common features. Both countries started promoting quality measurement in their acute care hospitals at around the same time. However, while the UK has succeeded in establishing a framework of surgical outcome measures during the 2000s, a similar initiative in Israel failed completely during the 1990s.

In this work, we explain the difference in reform outcome between the two countries. We contend that this difference stems from the reaction of the medical profession to the government's endeavors. This response, in turn, hinges on the professional organizations' relative institutional position vis-a-vis state authorities.

This study constitutes a unique investigation of the medical profession's response to critical quality measurement reforms. It goes beyond the descriptive in theoretically considering possible physician responses based on both the public interest and the public choice heuristics. Most importantly, it stresses the institutional position of medical associations as the primary factor in explaining cross-case variation in government's success in introducing quality measurement.

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2. Contemporary challenges to medical dominance

Attitudes of the medical profession toward quality measurement are best understood against the backdrop of social and epidemiological trends, which have challenged its dominance globally, and shaped its relationship with the state and society as a whole.

Scholars suggest that for several decades there has been considerable erosion in the dominance of the medical profession globally [5–11]. However, this does not mean that the profession has lost its power entirely or has been removed from its place at the top of the therapeutic hierarchy by another profession. The medical profession remains a major factor in the healthcare system and broader society. At the same time, the "self-rule" of doctors, which was almost unshakable during the "golden age" of medicine in the first half of the twentieth century, is constantly under attack [12]. In addition to the state's increasing push to tighten the supervision and regulation of medicine, various groups of therapists have been entering domains that have long been regarded as the exclusive territory of physicians. Routinization and simplification of traditional medical procedures allow other health workers, computers, and even laymen, to perform them themselves. Furthermore, public trust in doctors has been decreasing, and the once traditional hierarchy between therapist and patients is dissipating due to generally rising levels of education and wider access to medical information.[1]

In addition, scholars believe that the dominance of the medical profession is eroded by trends of deprofessionalization and proletarianization – doctors becoming salaried employees, managed and monitored by managers who are not necessarily doctors themselves. This management layer adopts new methods of supervision and evaluation in the spirit of "managed care". In addition to budgetary restraint, efforts to measure the performance of bureaucracy intensified along with the demands of public officials for more accountability, managerial flexibility and transparency [13]. Government's desire to apply business sector norms to their public service in order to improve its performance was given the generic name "New Public Management" (NPM). Naturally, not all NPM reforms are alike. Sometimes they are only loosely connected, although generally attributed to a common economic doctrine or school of thought known as "Neoliberalism". While some types of reforms concentrate on efficiency and cost-containment, others focus on quality measurement and evaluation of performance [14–16]. This paper is about the latter.

One of NPMs main objectives is the search for a consistent and systematic measurement of workers' performance or the system's efficiency as a whole. All this undermines medical dominance while increasing state intervention in areas formerly controlled exclusively by the doctors. The use of tools of supervision, evaluation, monitoring and measurement, ultimately diminishes doctors' professional autonomy. According to Willis, professional autonomy is a core element of medical dominance [7,17]. Freidson argued that professional power stems from professional monopoly over knowledge [18]. In turn, this autonomy enables self-regulation and control over resources. Therefore, based on the public choice perspective, which assumes that public actors are guided by utilitarian self-interested considerations, it could be argued that physicians would tend to resist quality measurement initiatives [19]. This perspective coincides with a critical view of the medical profession expressed in the neo-Weberian research approach. According to this approach, professionalization is intended to promote professional practitioners' own occupational self-interests in terms of their salary, status and power as well as the monopoly protection of an occupational jurisdiction [6,20].

It should be acknowledged that utility maximization is not the only motivation guiding medical professionals. Public sector professions, let alone physicians who are committed to the ethos of medical professionalism as expressed in the Physician's Oath, could be both intrinsically and extrinsically motivated [21,22]. Nevertheless, without disavowing voluntarism and social involvement as important features of professional activity, it seems that in the political arena, especially while facing an eminent threat to its autonomy, the actions of the profession as an organized entity are appropriately understood through the lens of a rational interest seeking perspective.

Professional autonomy itself depends on the inability of the layman to properly evaluate, assess or appreciate the esoteric work of the expert, making medical professionals the only authority able to judge the quality of their own work. The potential threat to medical dominance stems from quality measurement on the one hand, and the growing ambition of the regulatory state to apply rigid measurement mechanisms to healthcare services on the other hand. This threat raises the following question: *How would the medical profession respond to quality measurement initiatives in healthcare?*

The question of how physicians, as the most prominent healthcare professionals, view, experience and react to the continuous governmental effort to measure system efficiency – and more specifically – physicians' performance, is crucial to the understanding of the delicate political aspects of healthcare measurement processes. The fact that information based on measurement offers managers and the public the ability to judge medical performance, holds the potential of undermining medical authority, especially against the rise of the regulatory state motivated by a set of neoliberal ideas and attitudes. Therefore, we argue that medical associations would generally reject measurement. Nevertheless, their decision whether or not to clash with the government over this issue very much depends on the profession's cost-benefit calculus, as performed by its representative organizations. Basically, organizations can cooperate or oppose reform with a wide range of in-between options. As we shall further demonstrate based on the Israeli and British cases, the choice of action could vary considerably. A major factor in shaping the profession's response is the nature of the medical profession's relationship with the state. As will be further discussed, patterns of state-medical profession relationships could vary widely between countries due to particular political norms, cultures and traditions.

3. Patterns of state – medical profession relationship

Immergut's work, which centers on medical organizations' resistance to public healthcare reforms, constitutes an important example of different patterns of state–medical profession relationship. Doctors' resistance tended to be more successful in political system that offered them multiple venues to block reform [23]. In another prominent work, Tuohy accounted for change in three healthcare systems by analyzing dynamics between stakeholders against the backdrop of different institutional structures, political cultures and policy legacies. Tuohy identified in Canada and the UK "*'implicit bargains' between the state and the profession, under which the profession retained clinical autonomy to allocate resources within budgetary parameters established by the state*" [24]. In addition, Tuohy noted that the role of the medical profession varies considerably across nations. In Scandinavia, elements of organized medicine were integrated within the state system. In Spain, quite

[1] Although common, the view of medical power decline is not shared by all. Freidson, for example, contended that changing reality forces the medical profession to re-organize, but not necessarily erodes its dominance. That is, an internal stratification is created in the shape of an emerging professional elite which forms standards that the "rank and file doctor" must follow [[10]].