

Reforming Physician Payment

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At the heart of the decline in primary care lie dysfunctional payment systems, from the “gatekeeper” schemes of the 1990s to the current volume-driven, fee-for-service approaches. These have proved antithetical to the goals of primary care, leaving patients unhappy, physicians demoralized, a generation of U.S. medical students shunning careers in the field, and access to care increasingly problematic — all contributing to an impending national health care crisis.¹

Several payment reforms have been proposed. One approach would augment fee for service with a “management fee” to pay for coordination of care extending beyond face-to-face encounters. This evolutionary ap-

proach, while recognizing an important need, retains the predominantly piecework payment system that perpetuates our “hamster-wheel” environment. Moreover, it relies on the Relative Value Scale Update Committee (RUC) of the American Medical Association to set values for primary care services, despite the committee’s marked overweighting in favor of procedural specialties and the potential conflicts inherent in a fiscally constrained budgeting environment.

Value-based payment has become popular with some payers and purchasers, leading to “pay-for-performance” programs that are incorporated into fee-for-service systems (often as part of a hybrid approach that also includes a management fee, as outlined by the Patient-Centered Primary Care Collaborative, www.pcpcc.net). Clinicians’ concerns about the emphasis that pay for performance

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Refocusing the System

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Robust evidence shows that patient care delivered with a primary care orientation is associated with more effective, equitable, and efficient health services. Countries more oriented to primary care have residents in better health at lower costs. Health is better in U.S. regions that have more primary care physicians, whereas several aspects of health are worse in areas with the greatest supply of specialists. People report better health when their regular source of care performs primary care functions well. In addition to features promoting effectiveness and efficiency, there are fewer disparities in health across population sub-

groups in primary care-oriented health systems.^{1,2}

Important functions of primary care include serving as the first point of contact for all new health needs and problems; delivering long-term, person-focused care; comprehensively meeting all health needs except



those whose rarity renders it impossible for a generalist to maintain competence in them; and coordinating care that must be received else-

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Lessons from the U.K.

Martin Roland, D.M.

The United Kingdom takes the importance of primary care for granted. The U.K. government is effectively the country’s single payer, and successive administrations have been convinced by mounting evidence that primary care promotes high-quality, cost-effective, and equitable health care.¹ If anything, the U.K. government has become more convinced over the past 15 years that strong primary care needs to be at the heart of the country’s health care system — quite the reverse of the situation in the United States. U.K. primary care physicians now have average earnings of \$220,000 (in U.S. dollars), which is more than many specialists earn. The payment system is a mixture of risk-adjusted capitation and 25% additional pay for performance.

Having a single-payer system helps a great deal in terms of organizing quality-improvement activities. Over the past decade, the U.K. government has been able to introduce myriad nationwide quality-improvement initiatives, ranging from annual performance reviews of all physicians by local peers and national standards for the care of major diseases to coordinated local programs of clinical auditing. These activities have resulted in substantial quality gains² so that the additional introduction of a major pay-for-performance scheme in 2004 resulted in only modest further improvement.³

U.K. primary care physicians increasingly work in multidisciplinary teams, with nurses taking on an increasing proportion of the work. Nurses see patients with minor illnesses and assume responsibility for the routine management of chronic diseases. Physicians generally agree

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where. The appropriateness of primary care–based health systems has been endorsed by the Pan American Health Organization and the World Health Organization.^{3,4}

The United States now ranks 15th to 40th worldwide on various key health measures, such as life expectancy or years of life lost owing to preventable causes. And our rank has been falling steadily, indicating a need to reassess the delivery of services and the balance between primary care and specialty services. Today, more than half of specialist visits are for routine follow-up — a misuse of expensive resources. There are large inter-regional variations in referral rates and use of specialist services that cannot be explained by differences in patients' needs. Primary care services in most industrialized countries are more comprehensive than those in the United States, where patients are often referred to specialists for problems — such as conditions requiring minor surgery or joint aspirations — that are common in the population and should therefore be addressed in primary care.

There are a number of policy options for improving U.S. primary care. The first imperative is to recognize that the health services system is dysfunctional. Most approaches to reform do not distinguish the use of primary care services from that of specialty services, despite the underuse of the former and overuse of the latter.

Second, perverse financing incentives must be eliminated. Federal subsidies for specialists' training programs now greatly exceed those for primary care physicians — a situation that needs redressing. Encouraging the use of primary care physicians for common health needs instead of specialists in diseases, organ systems, or procedures requires increasing earnings of the former to levels commensurate with those of the latter. In many countries, specialists are paid by sal-

ary. In other places, specialist-visit reimbursements are lower when patients are not referred by a primary care physician.

Relatedly, better use of information on the frequency of various illnesses and complications could provide a much-needed basis for understanding when specialist services are warranted. These criteria should focus on the likelihood that patients have uncommon conditions or unusual complications. Primary care management for the vast majority of health problems should be the rule for most diagnosis and care, with specialist intervention when diagnosis requires confirmation with the use of special technology that is impractical to provide in primary care settings. For management dilemmas, primary care physicians can often seek advice from a specialist themselves, obviating the need for direct contact between patient and specialist.

In addition, evidence regarding the benefits of health services interventions in primary care would be more useful if interventions were tested in community-based primary care settings. Primary care practitioners should be the main decision makers about the applicability of clinical-trial results in primary care populations.

Since it will be a long time before U.S. primary care services are equitably distributed, the network of federally funded community health centers should be expanded in areas of shortage. At the same time, we urgently need to standardize insurance benefits to ensure that the benefits of health services are equally available to everyone.

Health challenges are changing. States of increased risk, such as elevated blood sugar level or elevated blood pressure, are now treated as diseases. With conditions being diagnosed earlier and populations aging, the prevalence of various illnesses has increased, their character has changed, and patients with multiple

coexisting conditions are common. Still, much of primary care consists of dealing with problems that are never attributed to a specific diagnosis.⁵ Better patient-level measures, such as physical and emotional signs and symptoms, rather than disease-oriented measures, such as laboratory values, will be necessary to more adequately assess outcomes and the quality of care.

Finally, new approaches to information technology will be needed to facilitate the recording of patients' problems and assessment of their responsiveness to interventions, encourage practice-based learning about interventions' effects, eliminate duplicate and conflicting services through care coordination, and provide for ongoing upgrading of an information base for assessing community health needs and detecting adverse effects, incipient epidemics, and health-compromising exposures.

A stronger primary care infrastructure — with more appropriate, evidence-based specialty care as backup — demands policy consideration if the United States is to improve its international standing in health.

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