## Reforming Physician Payment

Allan H. Goroll, M.D.

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 approach, 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

*Continued on page 2090*

## Refocusing the System

Barbara Starfield, M.D., M.P.H.

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 subgroups 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-

*Continued on page 2091*

## 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 gains[2] 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

*Continued on page 2092*



Downloaded from www.nejm.org on November 27, 2009 . For personal use only. No other uses without permission.
Copyright © 2008 Massachusetts Medical Society. All rights reserved.

**ROLAND CONTINUED**

that it makes sense to hire nurses to provide protocol-driven care for chronic diseases. This model has now become universal for primary care in Britain, although there is some concern that the increasing use of nurses in specialized roles may result in physicians' becoming "deskilled."[4]

Having a single-payer system also means that U.K. primary care physicians hold each patient's lifelong record, which includes a letter regarding every visit to a specialist. Virtually all primary care physicians use electronic medical records, and laboratories now generally download lab results directly into family practitioners' computer systems. Again, the government took advantage of having a single-payer system to define common standards to which all suppliers of electronic medical records must adhere.

Some U.K. primary care physicians are concerned that they are losing the personal contact they used to have with patients. Many recognize that the very personal care long associated with the "family doctor" is becoming less common. To some extent this is because primary care physicians have increasingly focused on clinical quality indicators for major chronic diseases and work in larger teams with other physicians and nurses in an effort to perform well on those measures.[4] If such a team becomes too large and the physician becomes too remote from the patient, however, other aspects of care may suffer. To redress this balance, the U.K. government is now starting to survey patients, and it plans to use the results to report publicly on continuity of care and the interpersonal qualities of physicians in all 8500 primary care practices in England.

U.K. primary care physicians gave up contractual responsibility for providing 24-hour care in 2004. Although this move was very popular with physicians, it may turn out to have done long-term harm to both physicians and patients. Most physicians were already organized into large groups for the provision of off-hours care, so the actual additional workload was small. Since the change, off-hours care has become much more fragmented. Patients sometimes receive poor service, and they have lost the sense they once had that their primary care physician was "always there for them" (even if, in reality, he or she rarely was).

It is hard to discuss U.K. medical care without mentioning universal coverage. Although it may not be politically achievable in the United States, universal access to care is probably the key factor behind findings that U.K. citizens have better health outcomes than their U.S. counterparts despite having health care costs that are a fraction of those in the United States.[5]

Although some features of U.K. health care would be hard to transplant to the United States, some that seem to work well in Britain have been advocated by U.S. experts on primary care — for example, registration with a primary care physician, payment involving a mix of risk-adjusted capitation and pay for performance, electronic medical records, and the use of extended teams to improve quality. Are these approaches beyond the realm of political possibility for U.S. health care?

No potential conflict of interest relevant to this article was reported.

Dr. Roland is a professor of general practice and director of the National Primary Care Research and Development Centre, University of Manchester, Manchester, United Kingdom.

1. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005;83:457-502.
2. Campbell SM, Roland MO, Middleton E, Reeves D. Improvements in the quality of clinical care in English general practice 1998-2003: longitudinal observational study. BMJ 2005;331:1121-3.
3. Campbell S, Reeves D, Kontopantelis E, Middleton E, Sibbald B, Roland M. Quality of primary care in England with the introduction of pay for performance. N Engl J Med 2007;357:181-90.
4. Campbell SM, McDonald R, Lester H. The experience of pay for performance in English family practice: a qualitative study. Ann Fam Med 2008;6:228-34.
5. Banks J, Marmot M, Oldfield Z, Smith JP. Disease and disadvantage in the United States and in England. JAMA 2006;295:2037-45.

*Copyright © 2008 Massachusetts Medical Society.*



Downloaded from www.nejm.org on November 27, 2009 . For personal use only. No other uses without permission.
Copyright © 2008 Massachusetts Medical Society. All rights reserved.