

## 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.<sup>1</sup>

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](http://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.<sup>1,2</sup>

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.<sup>1</sup> 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<sup>2</sup> so that the additional introduction of a major pay-for-performance scheme in 2004 resulted in only modest further improvement.<sup>3</sup>

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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puts on the processes of care (few outcome goals) and about the clinical wisdom of formulaically performing recommended actions raise questions about the advisability of this approach<sup>2</sup>; initial outcomes in controlled trials have been disappointing.<sup>3</sup> A more comprehensive approach to payment for “doing the right thing” is the Prometheus system ([www.prometheuspayout.org](http://www.prometheuspayout.org)), which emphasizes comprehensive payment by episode of illness for the application of evidence-based practices and sharing of the savings achieved by preventing avoidable complications. Current incompleteness, prolonged development time, expensive preparatory work, and complexity of implementation (e.g., when there are concurrent illnesses) limit the present application of an otherwise promising system.

Some large integrated care systems and multispecialty practices offer better-than-average salaries to their primary care physicians, as long as certain “productivity standards” and related performance goals are met. The enhanced salaries depend on the sharing of revenues generated by highly reimbursed procedural specialists. Such revenues are not available to most primary care physicians, who tend to work in solo or small-group practices.

Viewing the current fee-for-service system, its institutional mechanisms, and proposed modifications as structurally flawed, clinically questionable, and inadequate for the delivery of robust primary care, my colleagues and I have proposed fundamental reform of payment for primary care, replacing volume-based payment with risk-adjusted comprehensive payment for the delivery of comprehensive primary care.<sup>4</sup> Such payment would consist of a risk-adjusted “base payment” supplemented by a risk-adjusted “bonus” for achieving desired outcomes in the areas of cost, quality, and patient satisfaction.

The base payment would exceed the currently inadequate payments for primary care evaluation and management services. It would provide the additional dollars practices need to establish multilevel teams and implement health information technology — measures deemed essential to giving physicians more time with patients, enhancing access, improving coordination, and ensuring evidence-based care. It would cover all primary care evaluation, management, and coordination services (while tests, procedures, specialty care, hospital expenses, and medications would continue under fee-for-service arrangements, pending complementary payment reforms). The bonus payment (up to 25% of the base amount) would provide the opportunity for a substantial increase in income for physicians (and, if desired, for other team members) but would be commensurate with the value created. Strong risk adjustment of the base and bonus payments would ensure a level playing field and remuneration commensurate with the burden of care assumed.

This proposal may sound like “capitation” revisited, supplemented by a bonus system, and indeed it does borrow the logic of comprehensive payment for comprehensive care. But unlike previous iterations of capitation, it seeks to avoid the pitfalls of inadequate payment, excessive financial risk, shunning of complex patients, withholding of care, and cost reduction as the only rewarded outcome.

Back-of-the-envelope estimation indicates that our reform could increase payment to primary care practices by as much as 40%, but total personal health care expenditures by only 3%. This amount approximates the net investment needed to implement and sustain high-performing primary care practices, which, according to analyses by Starfield and colleagues, have the potential to significantly reduce costs, improve health status, and minimize disparities in care.<sup>5</sup> The

dollars needed to pay for the net investment will come from reducing currently wasteful expenditures (estimated at nearly 30% of total spending) through enhanced application of evidence-based, coordinated care.

For payment reform to achieve its objectives, it must be accompanied by complementary practice reform. Willingness to reorganize and commit to a high standard of primary care delivery (for example, to meet the criteria for a “patient-centered medical home” outlined by the National Committee for Quality Assurance; [www.ncqa.org](http://www.ncqa.org)) might be a prerequisite for practices to qualify for payment under our model. If we are to realize the promise of primary care and avert an impending health care crisis, we need to proceed vigorously to fundamental reform of both practice and payment of primary care.

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