Family Practice Forum

Payment for Family Physician Services

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The past ten years have been busy, eventful ones for family physicians and others concerned with the return to a more rational, cost effective, and accessible medical care. Much has been done to establish a new specialty, create residency programs, and stimulate interest among medical students. Progress has been impressive, and the impact is now being seen in communities throughout the country.

Thus far the major emphasis has been on various aspects of the training of family physicians: identifying the content of family medicine, establishing model clinics, constructing curricula, identifying faculty, and training faculty members in teaching techniques and psychosocial concepts. More recently there has been a growing emphasis on promoting sound research in the family practice setting, and answering some of the important questions arising in primary care practice, such as cost effectiveness of diagnostic tests and effectiveness of therapy.

These are important activities, and all who have been a part of these efforts have reason to be proud of their accomplishments. However, equally important problems remain. Foremost among these is the matter of achieving a more equitable distribution of payment for primary care, relative to other segments of medical care. This problem is of urgent importance, not only to family medicine, but to primary care internal medicine and pediatrics as well.

Family physicians and other primary care physicians who enter practice soon learn that they must expect a considerably smaller income than their colleagues in other specialties, and that they must work longer hours to achieve this income. The family physician often finds that he/she is paid less than the obstetrician for a normal delivery, and less than the orthopedist for treating a simple fracture, though these services do not require skills of a secondary level specialist.

Most residency program directors find that patient care income can cover no more than half of the cost of operation of the model clinic, and that federal or other grant subsidies are necessary in order to keep the residency alive. Even hospitals with a strong commitment to provision of a broad spectrum of services to their community find difficulty in justifying the fiscal losses associated with primary and ambulatory care services. One can predict that the phase-out of federal training grants, which must occur in the future, will be accompanied by the closure of residencies, because hospitals are unwilling or unable to pick up the load.

Both the practitioner and the teacher of family medicine find their futures threatened by a payment system which rewards them less than their counterparts in other fields. Both have a large stake in correcting this problem. The problem is

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one of the total cost of medical care and the *balance* between funds flowing into the primary care segment and those flowing into the secondary and tertiary segments of medical care (consultations, special procedures and tests, and hospitalization).

At this time, the cost of special procedures, surgery, and hospitalization has aroused a hornet's nest of public opinion against medical care costs, and providers of primary care are suffering stings, along with those who provoked the problem. How did we get into this predicament, and how can we extract ourselves?

The roots of the problem go back many years. Hospitalization insurance was established in the Great Depression of the early 1930s, as a means of protecting against rarely encountered, but very expensive medical events which could not be reasonably met from savings. At first, most such insurance covered only the cost of the hospital bed and later the surgeon's fee. As time passed, and this method of payment proved an advantage for both patient and provider, more and more situations were covered under the insurance umbrella.

Primary care was and has remained a problem under most insurance plans. Such plans must have a clearly definable, well circumscribed event as a unit for payment. A cholecystectomy, an upper GI series, and a day of hospital stay are examples of clearly defined units of care, and are roughly the same from place to place.

Primary care defies such definition. An office visit may mean two minutes or two hours of physician time. Even if the time involved is specified, the nature and meaning of the interchange between physician and patient is of more significance than the time spent. As a result of this ambiguity, primary care has either remained outside the insurance umbrella, or has been paid for at an extremely low level, creating an impression that it has little intrinsic value.

In addition to this problem, there is another which arose from the days following World War II, when prices and wages were under tight federal control. The coal miners chose this time to strike for higher wages. A settlement was desperately needed to keep the economy in motion, yet a weakening of the price and wage controls would have made a shambles of the whole control system.

An ingenious compromise was devised: coal miners were provided a health care package, rather than an increase in salary, as a "fringe benefit." Thus was established a precedent that health care benefits provided by a company are nontaxable.

This system was soon copied by others, and thus a simple, expedient decision made at a bargaining table between employers and union negotiators with government sanction established a precedent that health care is a "free" benefit provided to employees. The presence of such a benefit invited everyone, patient and physician alike, to use it liberally. This has created a steady flow of funds into the health care system, and fueled the escalation of health care costs. There are, of course, other causes of rising costs, but most experts agree that the voluntary insurance system (which is really not voluntary at all, but is a compulsory benefit of employment for most employees) is a major culprit.

At the present time we find ourselves in a situation in which everyone, the public, government, and many within medicine, feel that health care costs are rising far too fast and must be controlled. There are two general strategies for accomplishing this. The first is governmental regulation. The second is that of allowing the operation of a free market.

The regulation strategy has many disadvantages. It is based on the premise that all physicians, insurance carriers, hospitals, or other agents are potential abusers of the system. For this reason, it must depend on an extremely complex regulatory system, which is expensive to set up and maintain. The ultimate form of regulation is to nationalize the system completely, in which case all health care professionals and workers become subject to close control by a government bureaucracy operated on behalf of the public.

The alternative form of control is to modify the operation of the existing free market. There are two ways in which it might operate. The first is at the level of the patient, and the second is at the level of the primary care physician. The patient level presents difficulties since the patient is often a poorly informed consumer of medical care and often unable to make wise choices in the marketplace. However, there is another, and probably more important problem with this level of free market operation.

Under such a free market system, it would be necessary to allow each individual a completely

free choice as to whether he spends the health care dollars allocated by his employer for health care or for some other service or commodity. Each individual could choose whether to purchase health care, or some other item in the marketplace. Under such a free choice system, fewer dollars could be expected to flow into health care, and health care costs could be predicted to decline.

However, for proper operation, it would also be required that each individual, or each family, suffer the consequences (bad or good) of this choice. If an individual elected to buy a television set instead of providing health care insurance for a given year, and had the misfortune to require expensive health care, then society must be willing to permit that individual to experience the repercussions of this choice. In all probability, our society would not permit this to occur, but would step in and relieve the unfortunate individual of the responsibility created by the poor choice. The system would pay for the services anyway, negating the effect of the free market mechanism.

The second form of free market operation operates at the level of the primary care physician. Each patient would choose a personal physician, and that physician would be at risk for the cost of health care which he provides to that patient.

Under this system, each primary care physician would have a certain sum of money to spend for each patient. If, by judicious and parsimonious use of health care resources, money is left in the system at the year's end, he would share in the distribution of the extra funds. On the other hand, if the amount of money allotted for the care of patients is overspent, then the physician would suffer some financial penalty.

Under this system, each doctor would become a wise shopper for the patient, in a marketplace with other doctors. Having only a limited number of dollars to spend per year for the patient, physicians would make sure that each patient received full value for each health care expenditure, and would eliminate those expenditures which were not necessary. The primary care physician could be protected from the impact of very expensive "catastrophic" events affecting one or two patients by a superimposed reinsurance plan.

An example of this second form of free market operation, in which the physician is the focus of action of the free market, can be seen in the Northwest Health Care Plan, operated by the Safeco Insurance Company in the Pacific Northwest. Under this system, each patient chooses a personal physician, who agrees to provide primary care services and serve as a medical manager on behalf of the patient. The patient agrees that the insurance policy will pay for all services ordered by the designated primary care physician, but will not pay any bills for services which are *not* authorized by the primary care physician. Each primary care physician controls two sums of money, maintained by the insurance company on behalf of the patient. The first sum is designated for the physician's own primary care services during the contract period. This sum is usually distributed to the primary care physician in equal monthly payments. No billing or filing of claims forms with the insurance company is necessary.

The physician is also fiduciary for a second sum of money, which is allocated for specialty consultations and procedures, and for hospitalizations. The amount of funds necessary for each account is predicted on information regarding the needs of an average patient of that age and sex, for these services. The primary care physician is the "gatekeeper" for the second account and must authorize all payments for a consultation. Without such authorization, the insurance company will not pay for services, leaving the patient liable for all costs.

The primary care physician's referral and hospitalization accounts are reviewed at the end of the year. If funds remain, the physician receives a check for half of the remainder, up to a limit of one tenth of the primary care income. If these funds are overspent, the physician receives a bill for half of the overexpenditure. To protect against one or two severe or catastrophic events, the plan provides reinsurance for amounts over a certain level paid in behalf of a single patient.

The Northwest Health Plan has proved acceptable to physician and patient alike, and has shown remarkable savings in consultations, days of patient care, etc. These savings are the same as, or slightly greater than those produced in closed panel HMOs such as the Kaiser Permanente Plan.

The features of the Northwest Health Plan especially attractive to the family physician are:

1. It places greater control in the hands of the primary care physician for selecting the care needed for the patient.

2. It promotes a close working partnership be-

tween physician and patient, placing the physician in the role of manager and advocate for the patient.

3. It saves money, and promotes cost consciousness among physicians and patients alike.

4. Outpatient and preventive care services are covered under the plan, while paperwork and accounting procedures are minimized.

5. Privacy of the patient-physician interactions are improved, since the insurance company need not keep extensive files on individuals in order to process claims.

In my opinion, family physicians should become much more active in promoting alternative financing systems for medical care which will give them greater influence in designating how funds are spent. The Northwest Health Plan is but one such plan, but it does illustrate principles which would be to the great advantage of the family physician and his patients.

Alternative payment systems which can lead to a more equitable and rational redistribution of the funds now available for health care, while still preserving the private sector and the freedom of choice features of our current medical system deserve active pursuit. Money saved through prudent use of consultations, special procedures, and hospitalizations would be available for expanded primary care services to the benefit of the patient. This would enhance the survival both of family practice and of family medicine residencies, and, thus, consolidate and extend the gains which have been made over the past decade.

The family physician could promote such plans by actively working with interested insurance carriers, or by forming independent corporations for designing and directly marketing such services to employers in the area. The creation of rational, cost effective, and accessible medical care is not enough. We must work for a rational, cost effective, and accessible payment system to accompany such care!