Editorial

Family Practice and the Gatekeeper Role

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Although the gatekeeper function has begun to receive some attention in family practice and other primary care circles, the role remains controversial. Many primary care physicians view the development of health maintenance organizations (HMOs) and other prepaid medical practice plans with caution, usually on the basis of concerns over risk-sharing, interference with customary practice patterns, and related reasons. Some even view the task of regulating health care services as "objectionable."[1]

It is becoming increasingly obvious, however, that various forms of prepaid medical practice are here to stay, and that the prognosis for traditional fee-for-service medicine, without significant change, is guarded at best. The escalating cost of health care remains uncontrolled, as evidenced by doubling of the costs of health care from 5.3 percent of the gross national product in 1960 to 10.3 percent today.[2] The trust fund for hospital insurance for the Medicare program is threatened with bankruptcy by 1988, and its cumulative deficit is projected to reach $300 billion by 1995.[3] Over the past 12 years since enactment of HMO legislation through both Republican and Democratic administrations, the federal government has encouraged the development of various forms of prepaid medical practice. In recent years, larger organizations have entered the field, including Blue Cross and Blue Shield, which now regard HMOs as their major area of growth in many parts of the United States. Currently the Health Care Financing Administration is pressing ahead toward a future system whereby services provided to Medicare and Medicaid beneficiaries would be financed on a capitation basis as an alternative to fee for service.[4] Medicaid contracts are already being negotiated in California with selected hospitals on a prepayment capitation basis.[5]

In this context, it is useful to consider the early experience of some primary care physicians vis-a-vis their gatekeeping role in various prepaid capitation plans. In this issue of the *Journal,* Catlin and her colleagues[6] examine the primary care gatekeeping role in more than 100 HMOs in the United States. They point out that the gatekeeper role can have an impact on the cost of health care in two potential ways—by the physician's own style of practice, and by control over utilization of other services. Their findings shed light on the operations of HMOs, but are inconclusive in terms of potential cost savings because of the limited experience of most HMOs to date.

Stephen Moore and colleagues have described the natural history of one HMO, which carries many important lessons for family practice and the other primary care disciplines with regard to HMOs (personal communication, August 1983). Although this

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plan ultimately failed, the reasons for its failure should help other HMOs and their participants avoid serious pitfalls. This HMO, created in 1974 by the SAFECO Insurance Company, was operated until 1982 in northern California, Washington, and Utah. Under this plan, fee-for-service reimbursement was preserved, and the risk sharing for cumulative costs was limited to 10 percent of primary care fees. Initially, there was an open-door policy for participating physicians in both primary care and the other specialties, no disruption of referral patterns, and no mechanism for utilization review of office and hospital practices. By 1980, enrollment had grown to 41,000 patients and 905 participating primary care physicians, but the plan was in financial difficulty. At that point, several major changes were instituted including reduction of the physician panel in primary care as well as consulting specialties; institution of protocols for length of stay, requirements for outpatient surgery, and maximum fee schedules; preauthorization of hospital admission; increase in risk sharing to 20 percent for primary care physicians; and reduction of the benefit package with introduction of cost-sharing copayments by enrollees. These changes were too late, however, and the plan was terminated in 1982 with sizable financial losses.

It is premature to draw any definitive conclusions about the role of the primary care physician in prepaid capitation practice settings. The next few years will inevitably see experimentation and evaluation of many different types of prepaid capitation practice. Some may be viable, others will fail, all will change the practice of medicine in one way or another. At this stage, however, several observations appear warranted:

1. It seems certain that various forms of prepaid medical practice will expand steadily across the country, forcing new relationships between patients, physicians, hospitals, and third-party payers.

2. Primary care physicians will necessarily play a pivotal role in these new plans; they will need to limit total expenditures for their patients' care and yet assure acceptable outcomes of care through their primary care and gatekeeper roles.

3. New areas of knowledge and skills will be required to effectively serve the gatekeeper role. Teaching and nonteaching family practice groups can play an important role in this regard by participating in demonstration projects and collaborative research efforts and developing educational experiences for family practice residents in this area.

4. The gatekeeping role, to be effective, must be supported by needed system changes (eg, copayment provisions for patients, utilization controls, defined practice style expectations for consultants, protocols for ambulatory and hospital care).

5. Prepaid medical practice will ultimately require renegotiation and reallocation of limited funds for the primary vs tertiary care sections; it will be essential to preserve solid funding for primary care services by preventing a small number of tertiary care services to expend a disproportionate share of total health care dollars without reasonable limits. At present, for example, patients with end-stage renal disease (less than 0.25 percent of all Medicare part B beneficiaries) account for more than 9 percent of total Medicare part B expenditures.[7]

As family practice and other clinical specialties address these issues, Iglehart's recent observation is well worth noting:[4]

> The message to organized medicine, it seems to me, is not that the government's efforts will obliterate the fee-for-service mode, but that they will test it in many different ways. The challenge for American medicine is to face up to these tests rather than steadfastly cling to the status quo, and to develop new variations on the traditional theme that more efficiently reconcile the intensifying conflict between infinite demand and limited resources.

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