

How family physicians are funded in the United States

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Underperformance of the healthcare system at great expense is the situation in the United States. The results are great inequity, problems with access, missed opportunities for prevention, fragmented rather than integrated care, relatively poor chronic disease care, and high expenses without commensurate improvements in health as compared with what would be expected from a well-functioning primary care system.¹ Indeed, "... the need to manage escalating health care costs while maintaining reasonable access to care is becoming the salient challenge in US health care policy".²

The diversity of healthcare arrangements in the US precludes a single, reliable answer as to how family physicians are paid. However, using national reports,³ including surveys done by the American Academy of Family Physicians,⁴ a generally accurate idea of "how it works" in the United States can be derived (Box). It is stunning how much is spent to accomplish occasionally spectacular results for some, but overall so little, for so few.

Family physicians are not satisfied with the results of current payment arrangements in the US, as they undervalue family medicine and primary care in general; too often family physicians are unable to provide the care they think their patients need.⁵ Through research and deliberations by their national organisations, family physicians have concluded that, without significant changes in both the way they practise and the way family medicine is financed, family medicine in the US will probably become untenable in 10–20 years.⁶ In aggregate, the current payment systems are believed to contribute to a deterioration of primary care, with market forces rewarding commodity production and use of technology, while punishing sustaining relationships, listening to people, and sorting out and responding to troubles that may or may not be amenable to technological medical care.

The solutions

Fee-for-service payments alone are not sufficient, as this approach rewards doing more, not necessarily doing best. Capitation is no panacea, because it is subject to rewarding underservicing and may deter care for the sickest patients unless payments are adjusted for greater need. Paying for performance (outcomes) is intuitively attractive, but subject to factors well beyond the control

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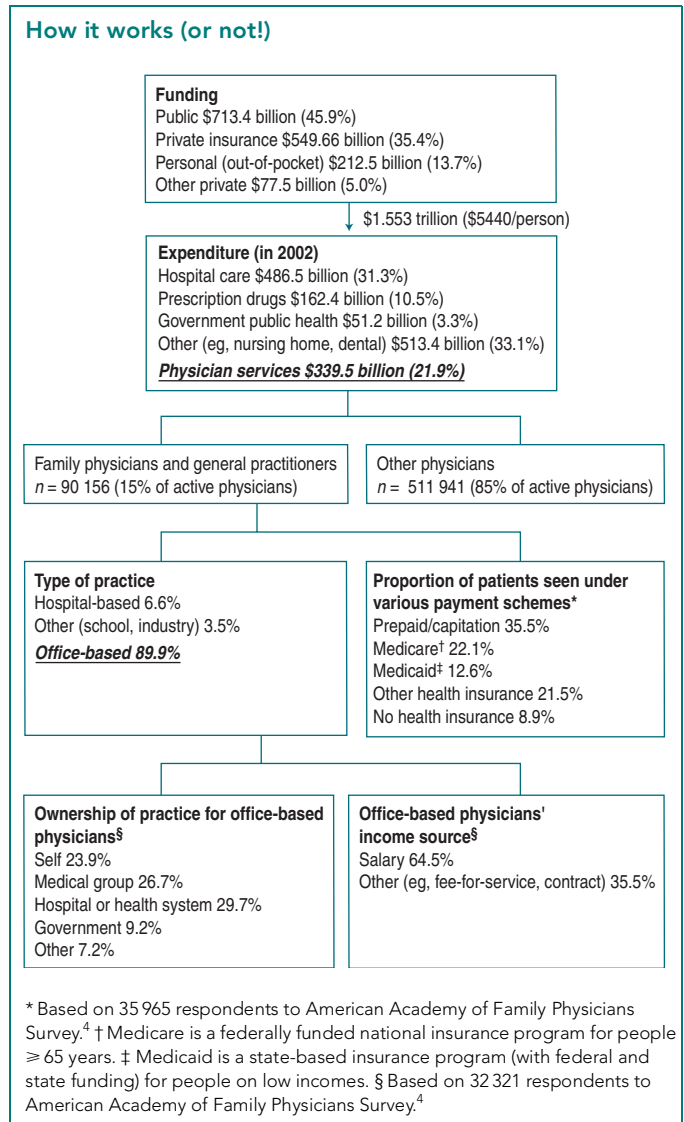
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of individual clinicians, or even, in many instances, an entire practice. A system of payment that blends these different approaches to capture their respective strengths while minimising their weaknesses is conceptually attractive, but difficult to define and implement. Such a blended system would presumably be based on capitation adjusted for population characteristics, additional premium payments based on services provided, and incentives based on achieving particular policy objectives.⁶

Currently, in the US, calls for a new model of family medicine, with a robust "basket" of services and the intelligence and performance attainable through information technology, have created an urgent sense that payment reform is necessary. A classic "chicken-and-egg" problem exists — the new model is not feasible until there is payment reform, and payment reform is not realistic without demonstrated improvements inherent in the fully imple-



mented new model. Fortunately, both public and private payers recognise that steps need to be taken to assure entry to timely healthcare, health promotion, disease prevention, and care of chronic conditions.⁷⁻¹³ As a spokesperson for the US Medicare program (which provides health insurance for people aged 65 and older) noted at a recent policy forum in Washington, DC: “With very little friction, we will probably approve expenditures in the billions of dollars for biventricular pacing, yet we still don’t know how to pay for someone to have their own doctor.”¹⁴

A task force chartered by the Future of Family Medicine collaborative project is now at work, estimating the full cost of the proposed new model of family medicine and the amount and sources of revenues necessary to cover its cost and leave a margin sufficient to pay family physicians fairly and competitively. As concluded at the Keystone III Conference in 2000, family medicine in the US needs to spend less time justifying itself and more time acquiring the practical means to achieve its objectives.¹⁵ Indeed, another time to revise family medicine in the US is at hand — this begs for reform in how family physicians are paid.

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