Primary Care Value Proposition

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Value, Problems, Propositions

- Value
  - Health, Costs, Equity
- Problems
  - Undervalued, underinvested, underpaid
- Propositions
  - Patient-centered Medical Home
  - Change Medicare
  - New Social Contract with Primary Care

Problems

"Primary Care in the United States is on death row"

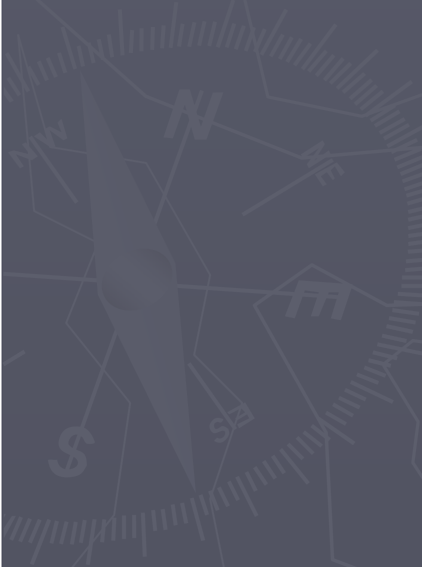
--David Reuben, MD

American Journal of Medicine January, 2007

"Unless there are changes in the broader health care system and within the specialty, the position of family medicine in the United States may be untenable in a 10-20 year time frame"

--Future of Family Medicine Project, 2002

Value

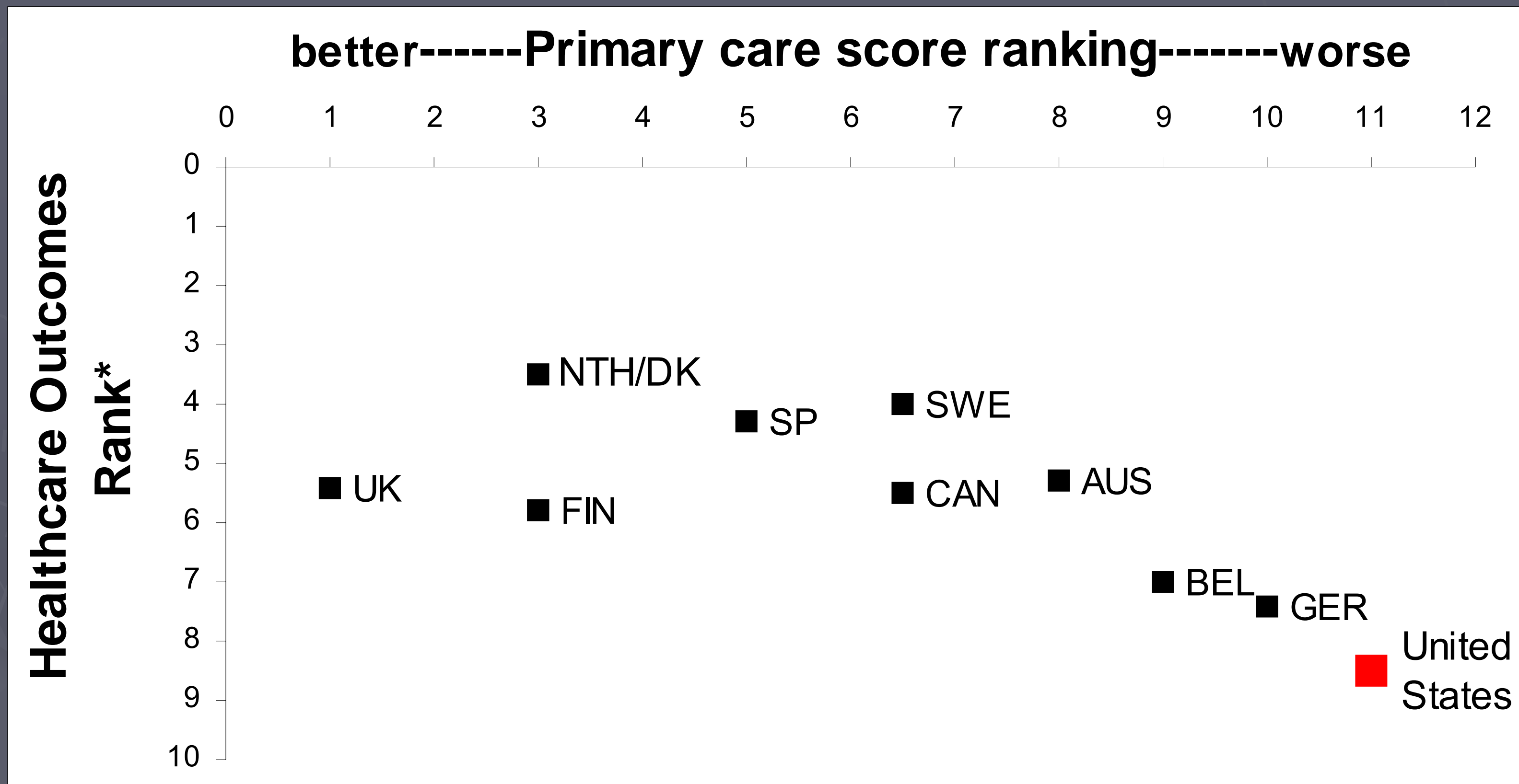


Value

- Evidence for Effectiveness:
  - People live longer and fewer die due to heart and lung disease
  - Less ER and hospital use
  - Better preventive care
  - Reduced health disparities

Macinko J. Starfield B. Shi L. HSR. 2003;38(3):831-65.

Primary-care score vs health outcomes



*Rank based on patient satisfaction, expenditures per person, 14 health indicators, and medications per person in Australia, Belgium, Canada, Denmark, Finland, Germany, Netherlands, Spain, Sweden, United Kingdom, United States

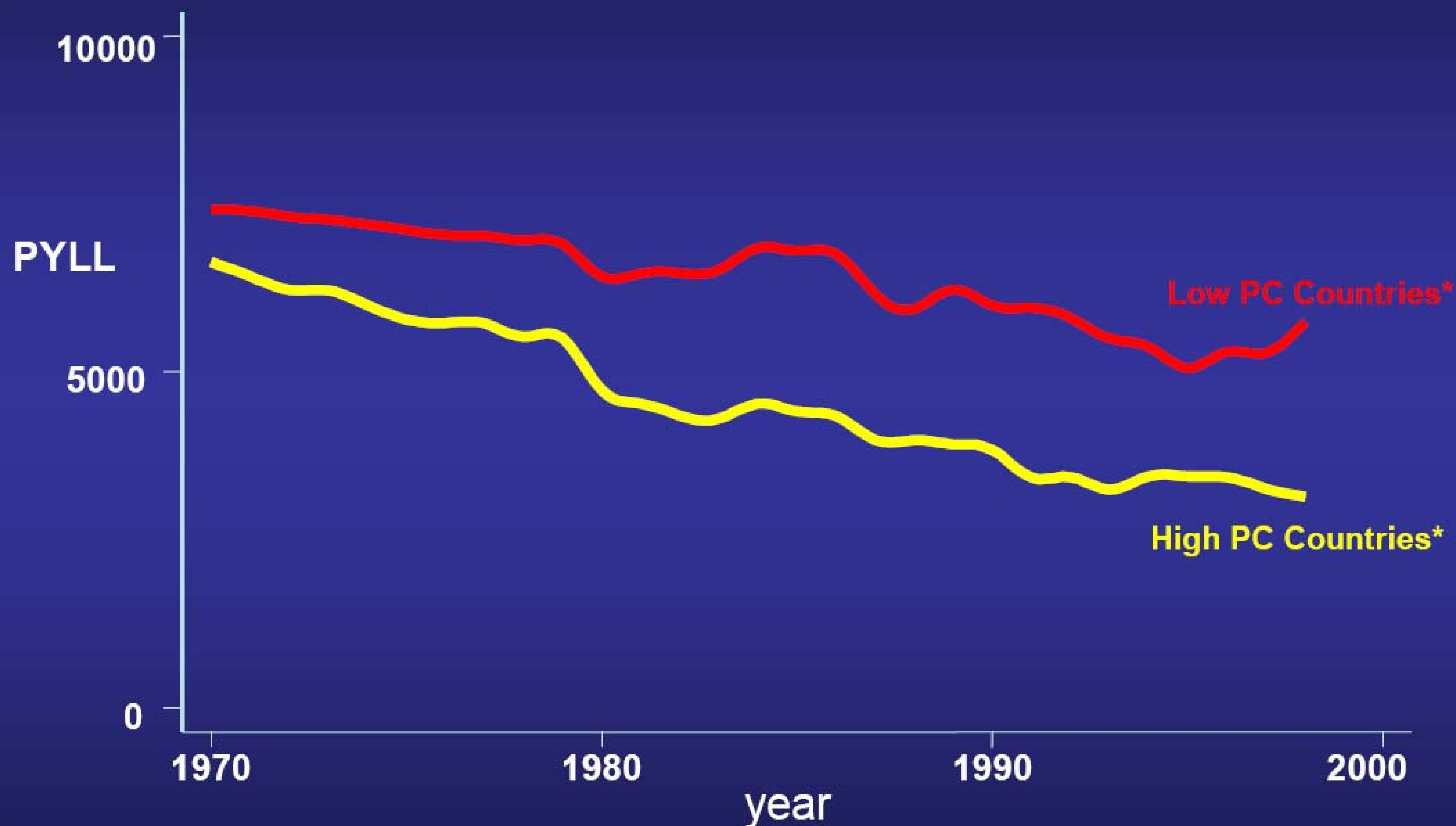
The greater the supply of primary care physicians, the lower the total mortality, heart disease mortality, and stroke mortality at the US county level.

In 35 analyses dealing with differences between types of areas (7) and 5 rates of mortality (total, heart, cancer, stroke, infant), the greater the primary care physician supply, the lower the mortality for 28. The higher the specialist ratio, the higher the mortality in 28.

Controlled only for income inequality

Source: Shi et al, J 1980-1995. J Am Board Fam Pract 2003; 16:412-22.

Primary Care Strength and Premature Mortality in 18 OECD Countries



*Predicted PYLL (both genders) estimated by fixed effects, using pooled cross-sectional time series design. Analysis controlled for GDP, percent elderly, doctors/capita, average income (ppp), alcohol and tobacco use. R^2(within)=0.77.

Source: Macinko et al, Health Serv Res 2003; 38:831-65.

Starfield 10/04
04-247

Of 21 OECD countries, the United States is, by far, the most socially inequitable (poor versus non-poor) in terms of the annual probability of visiting a physician.

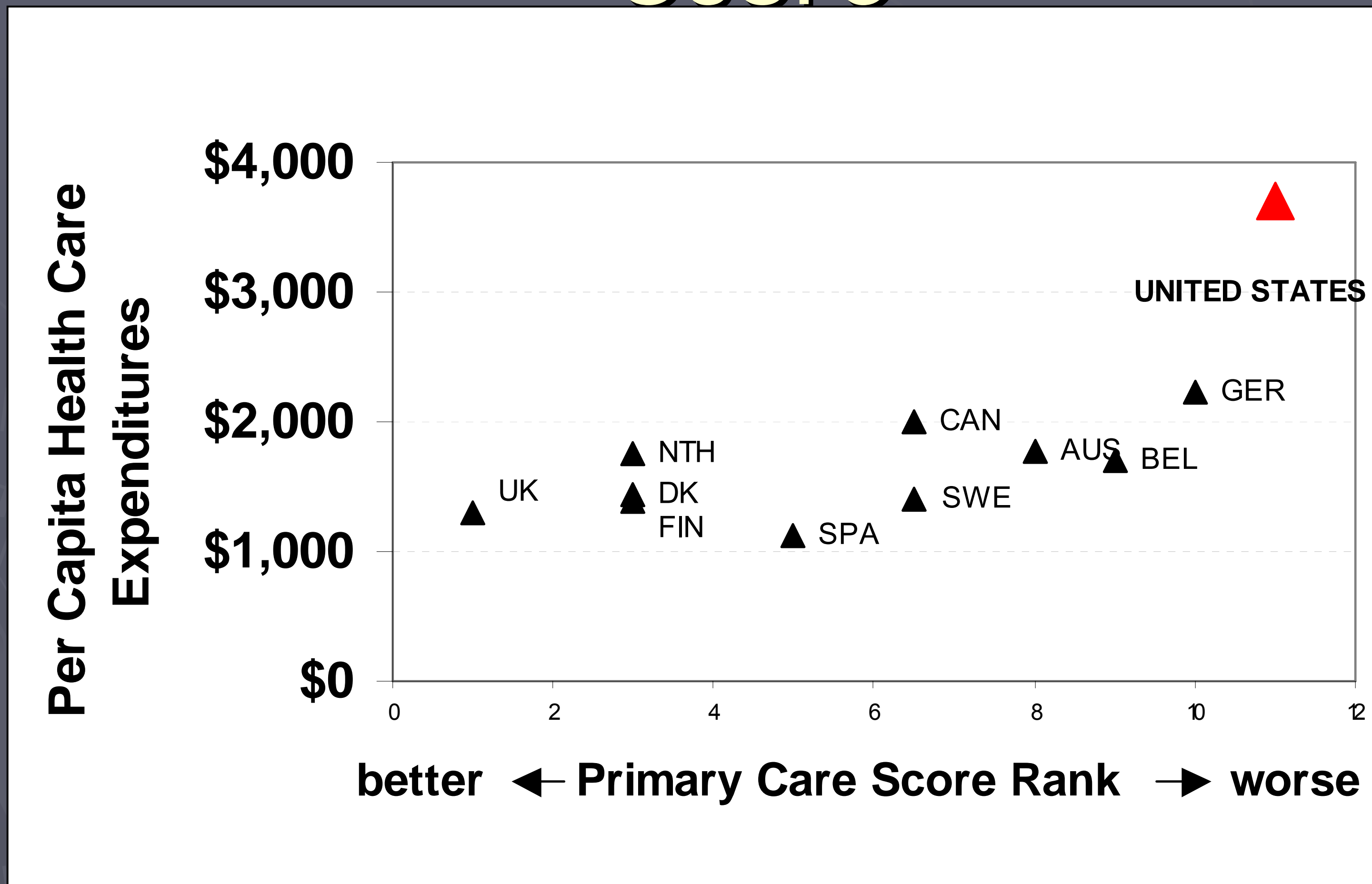
Source: van Doorslaer et al, CMAJ 2006; 174:177-83.

Value

- Evidence for Efficiency:
  - Less ER and hospitals use
  - Fewer tests
  - Higher patient satisfaction
  - Lower medication use
  - Less care-related costs

Greenfield S, et al JAMA 1992;267:1624-30.
Forrest CB. Starfield B. JFP:. 1996;43(1):40-8.
Macinko J. Starfield B. Shi L. HSR. 2003;38(3):831-65.

Expenditures vs Primary Care Score



Barbara Starfield, 1994 and 2001

Value

Better Outcomes

Landmark 2005 study shows U.S. counties more oriented to primary care achieve:

- lower per capita expenditures
- lower medication use
- higher patient satisfaction

Increase of one primary care physician per 10,000 population associated with:

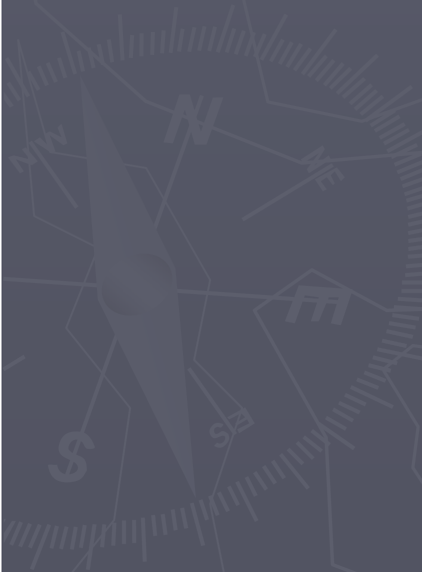
- 6 percent decrease in all-cause mortality
- 3 percent decrease in low birth-weight, and stroke mortality

SOURCE: B. Starfield, et al, *"The Effects of Specialist Supply on Populations' Health,"* Health Affairs (March 2005); W5-97.

There are large variations in both costs of care and in frequency of interventions. Areas with high use of resources and greater supply of specialists have NEITHER better quality of care NOR better results from care.

Sources: Fisher et al, Ann Intern Med 2003; Part 1: 138:273-87; Part 2: 138:288-98. Baicker & Chandra, Health Aff 2004; W4:184-97. Wennberg et al, Health Aff 2005; W5:526-43.

Problems

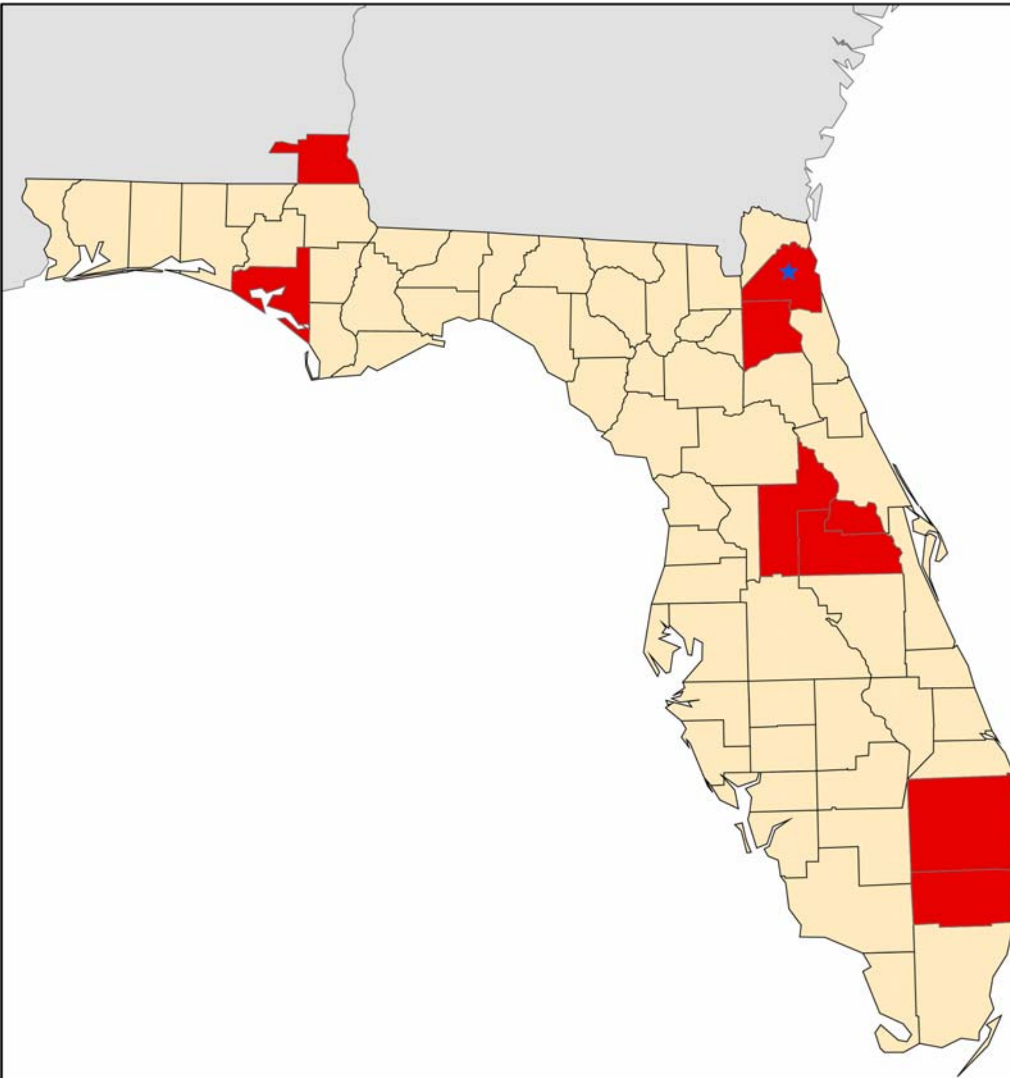


Problems

- Undervalued
- Underinvested
- Underpaid

Problems--Undervalued

- Primary care can't compete for the hearts and minds of US Medical students
  - Average debt now $115k-$150k
  - Lifestyle
- Family Medicine filling >50% IMGs, losing programs
- General Internal Medicine, exodus to subspecialties and hospitals
- General Pediatrics—benefits from feminization, low-paying subspecialties



Losing Programs

Footprint of the University of Florida residency program in Jacksonville

	Number Practicing in Florida	Percent Practicing in Florida	Number Practicing in Rural Areas	Percent Practicing in Rural Areas	Number Practicing in *HPSAs	Percent Practicing in *HPSA
Program Graduates	93	69%	11	8%	123	94%

Problem – Underinvested

- Medicare voluntary reporting P4P program
  - 1.5% bonus

VS

- UK General Practice contract
  - 25% bonus

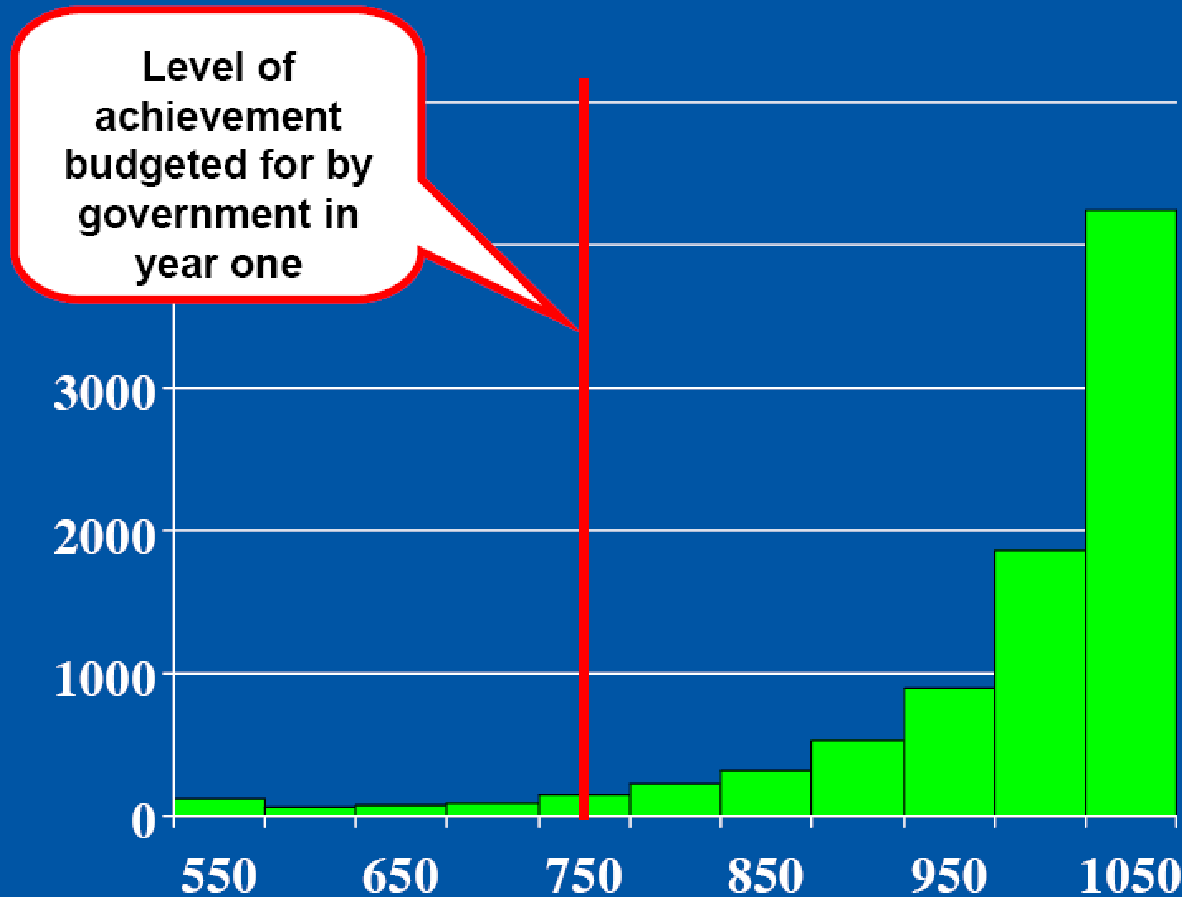
UK Experience

- Actually began in 1990
  - Payment for health targets, prevention
  - GP fundholding
    - Contractual leverage over hospitals (cost control)
    - Build-out primary care services (access)
  - Primary Care Organization development
    - Primary care trusts now control 80% of NHS budget
    - Responsible for <u>Quality, Access, and Costs</u>

The New GP Contract

- In 2005, point-based bonus payments 136 measures:
  - GP income related to achieving disease specific quality standards
  - Patient experience indicators
  - Organisational indicators
- New money - Up to $77,000 more per physician possible

Practice performance in first year of new contract



Quality points per practice, out of a maximum of 1050

N=8105 practices www.ic.nhs.uk/services/qof

US vs UK

- Comparison of US and UK practices on common measures:

US practices 41% UK 97%

Problem-Underinvestment

- UK invested a decade and billions to reorganize and empower primary care
- P4P was icing on the cake

Problem--Underpaid

- Piecework payment for outpatient services
  - greater fragmentation of medical care
  - greater use of outpatient technological service
- Less attention given to continuity, integration of care, preventive medicine
- Decreased payments to primary-care physicians and increased pressure to see more patients
  - reduced time spent with each patient
  - the quality of primary care suffered

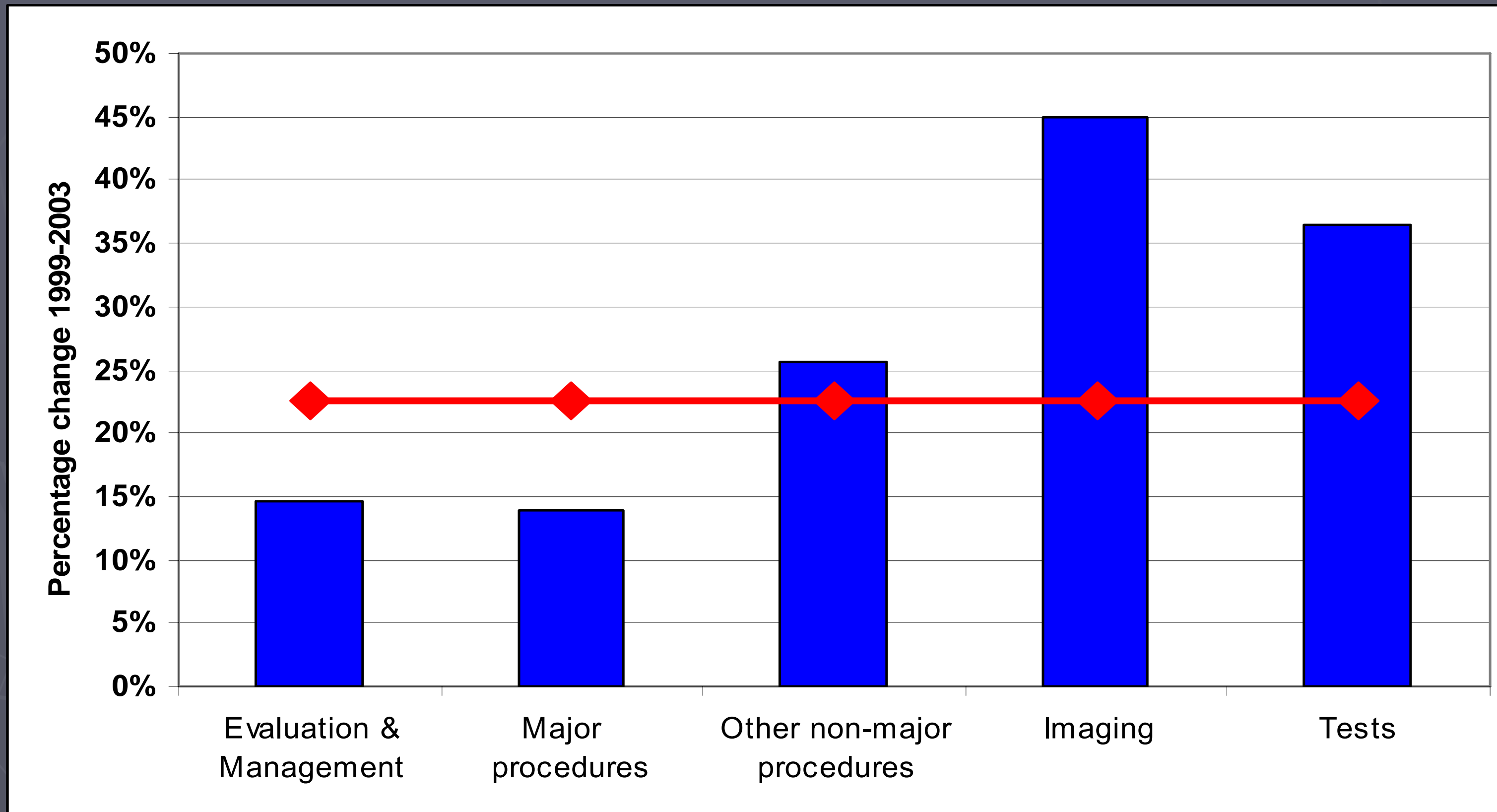
Relman, AS.
Medicine And The Free Market. The Health Of Nations. *The New Republic* 3/7/05

Medicare Payments

- Basal payment (Conversion Factor, “SGR”)
  - Evaluation & Management (E&M) affected by growth in imaging, procedures
  - Expect 10-15% cuts next 2 years
- RBRVS “defies gravity”
  - Real increases for primary care not possible
    - 20% increase in E&M really only 5% for FP and GIM
  - Distortions, lack of data for basing relative value

Gingsberg PB, Berenson RA. NEJM 356(12). 3/22/07
Dodoo et al, in review

Number and Intensity of Medicare services (1999 – 2003)



Source: Medicare Payment Advisory Commission (MedPac), Analysis of Medicare Claims data, "Testimony before US House of Representatives", Nov 17, 2005

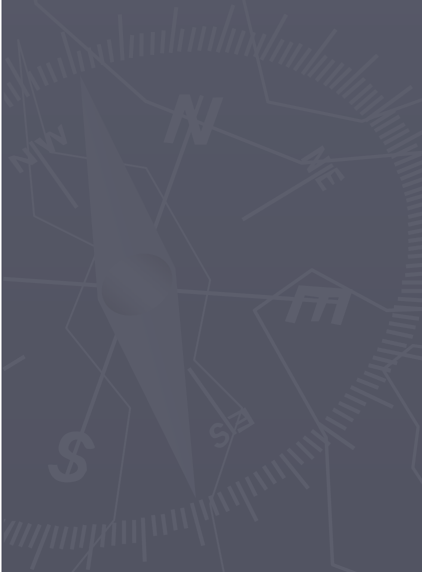
Problem—Is any change possible?

- "when those boomers start retiring en masse, then that will be a tsunami of spending that could swamp our ship of state if we don't get serious...We suffer from a fiscal cancer...*<u>the real problem is health care costs</u>*"

U.S. Comptroller General David Walker

60 Minutes March 4, 2007

Propositions



Proposition

- Patient Centered Medical Home
  - Transform organization and financing of primary care = better value, accountability, transparency
  - ERISA Industry Committee
  - National Business Group on Health
  - IBM, GM, GE

Proposition

- Change Medicare, others will follow
  - Blow up “SGR”
  - Split “SGR” into E&M; Non-E&M and purposefully bolster E&M
  - Change Relative Value Update process
    - Reinstate laws of financial gravity
    - Purposefully revalue primary care

Proposition

- Abandon current Medicare Policies for Primary Care
- Goroll Proposition—Comprehensive Primary Care Payment
    - PC panels of 1250 - 2000 pts per physician
    - $500 per pt per year ($1M per physician)
    - 25% to physician ($250k per year)
    - 75% to invest in infrastructure
    - 3% increase overall spending, greater offsets are likely outcome