

as a means of stimulating resident research activities and fostering the development of our future family medicine scholars.

Through overcoming challenges and by seeking strategic partnerships, the AFMRD is actively pursuing many of its stated goals and central mission of serving as a resource for family medicine residency directors.

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From the North American
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UK LESSONS FOR US PRIMARY CARE

Primary care is now acknowledged to be a foundation of effective, sustainable health care for populations, with favorable effects on access to care, comprehensiveness, continuity, efficiency, and equity.¹ In addition, variation in health care arrangements and policies across nations presents opportunities to compare and learn across national boundaries about what is working and how well in primary care.

The relatively poor performance of the US health care system has provoked a willingness to change that in a well-performing system would probably not exist.² Primary care physician offices in the United States are being redesigned somewhat haphazardly with numerous opportunities to improve and some opportunities to diminish the desired effects of primary care. The United Kingdom's primary care system, despite being strong, is also in the midst of dramatic changes orchestrated through the National Health Service.³ This combination in the United States and the United Kingdom is potent and presents immediate opportunities for decision makers in both countries to guide the "remake" of primary care with more real-world experience than is available in either nation alone.

In early June 2005 there was a face-to-face exchange visit between representatives of the Wash-

ington, DC-based Robert Graham Center and the National Primary Care Research and Development Centre in Manchester, United Kingdom. Six examples of "30,000-foot level" conclusions reached on the basis of the specifics learned during the visit are:⁴

1. In both the United Kingdom and the United States, policy makers have begun to realize the great potential in primary care. However, the systems of care delivery and business plans for primary care are not adequate. Some revisions now underway may be converting the physician's role as a trusted personal physician doing hugely meaningful work, to a job-holder with a rule-book. The net impact of such changes may not be positive for physicians, patients, or health care systems.

2. Experiments in primary care delivery abound in both countries, and decisions are being made quickly, with little or no evaluation. Imbedding evaluations in new approaches/programs and responding to findings in nearly real time is possible in both countries. Sharing findings from real-time evaluations can also occur quickly, to mutual advantage.

3. No one knows how to structure practice and primary care physician compensation to incentivize and cover the full costs of robust primary care, but it is clear that further investments in primary care are necessary to garner its powerful, salutary effects for entire populations. The United Kingdom is making deliberate investments into its primary care infrastructure, while the United States seems to be bleeding revenue out of primary care while increasing its overhead. With an amazingly thin evidence base, both countries are pushing toward paying for performance improvements in practice, and this approach is having an effect on primary care practice—sometimes for the better. If some portion of primary care payment is based on performance measures, it will be necessary in the United States, as already done in the United Kingdom, to establish a denominator (eg, a register of patients for which the practice can be held accountable) for practices to use in assessing their performance.

4. Teamwork is no longer elective in primary care, but a huge gap still exists between the teamwork that is feasible through asynchronous, information technology-enabled care and what is currently happening. Many case studies are in play in both countries, under differing conditions. Training and educational strategies for teamwork among health professionals are lagging badly in both countries, and this is likely to emerge soon as a rate-limiting step in providing high-performance primary care.

5. Both countries are overconsuming international medical graduates from developing countries, probably to their own advantage but likely to the detriment of the donor nations.

6. Measuring physician practice, difficult as it is, is progressing in both countries. Both qualitative and quantitative methods are required to understand practices, and routine data from practices are essential. Standards for information systems are being established more slowly in the United States. To be sufficient, primary care information systems must be able to aggregate data necessary to measure performance and incorporate ordering principles (classification) and terminology capable of creating and analyzing episodes of care as they occur in primary care.

It would be advantageous for key US organizations devoted to optimizing primary care to sustain for the foreseeable future exchanges with other countries to enable the United States to see itself more clearly, import innovations of relevance, and elude avoidable mistakes. While there is much to learn in many countries, UK-US exchanges present immediate opportunities with particularly great relevance. It is not as if there is little to learn from one another. Rather it is how much can be learned that can find prompt application in the redesign of primary care that is underway.

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SHAPING THE FUTURE OF PAY-FOR-PERFORMANCE PROGRAMS

Whether it's driven by private insurers or the federal government, pay-for-performance (P4P), a concept that offers health care providers payment for meeting certain performance measures, is here to stay. Recognizing the potential impact P4P will have on family physicians, the American Academy of Family Physicians is working to ensure that family physicians are involved in shaping the future of P4P.

"Pay-for-performance is an incentive to *prove* the quality of care we already provide and to *improve* our care," says AAFP Board Chair Mary Frank, MD, of Mill Valley, Calif. "Think of it first as quality improvement and then as positive financial recognition."

"It's here, it's going to stay, and it's going to change the way we practice," Ron Bangasser, MD, says of P4P. A family physician in Redlands, Calif, Bangasser is a member of the National Committee for Quality Assurance's Committee on Performance Measurement. He's also past president of the California Medical Association.

Bangasser speaks to groups all over the country about pay-for-performance. He estimates that between 100 and 120 P4P programs — overseen by the federal government or private insurers — currently operate across the country. "There are tens of millions of patients covered under these programs now, and soon there are going to be hundreds of millions," says Bangasser.

An example of these programs is Integrated Health-care Association, a nonprofit, California-based entity, which has a P4P program that will pay out a total of \$88 million to 235 California medical groups, including Bangasser's, in 2005. These types of programs appear to have boosted the quality of care in the California market. According to Bangasser, a comparison of health care data between 2002 and 2003 reveals that:

- Nearly 150,000 more women received cervical cancer screening
- 35,000 more women received breast cancer screening
- An additional 10,000 children got 2 needed immunizations and
- 18,000 more people received a diabetes test.