Characteristics of the Health Care System and Health Policy

Health system characteristics that are associated with improved outcomes and lower costs include universal or near-universal financial assistance guaranteed by a publicly accountable body, equitable distribution of health care services with respect to regional health care needs, low or no co-payment for health care services, and comparable professional earnings by primary care physicians relative to other specialties.[1] A system that provides universal access to its senior citizens can only be successful when the needs of all citizens are met in an efficient, effective manner.

Summary

Family physicians and family medicine educators must become well versed in this information, and must develop personal relationships necessary to effectively deliver this message to those who make laws and policies. Our legislators and regulators must understand that policies designed to increase the number of generalist physicians will result in health care of higher quality, personal medical homes for more people, and movement toward universal access to care. They must also understand that such policies likely will result in annual savings of tens of billions of dollars for Medicare and hundreds of billions of dollars for the health care system. The return of our nation to policies that emphasize primary care, preventive medicine, and public health will lead to lower costs and improvements in quality that will be the first step to save Medicare and reform the health care system.

Jerry Kruse, MD, MSPH
And the Association of Departments of Family Medicine

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From the Association of Family Medicine Residency Directors

Ann Fam Med 2005;4:275. DOI: 10.1370/afm.599.

WORKSHOP FOR THE DIRECTORS OF FAMILY MEDICINE RESIDENCIES

Registration for the 2006 Workshop for the Directors of Family Medicine Residencies is now available online. The workshop will be held June 4-6, 2006 at the Hyatt Regency Crown Center in Kansas City, Mo.

Workshops will focus on this year's theme of "Forging the Future of Family Medicine Through Quality and Innovation."

To register or find more information, visit http://www.aafp.org/pdw.xml.

Questions can be directed to Shanna Eiklenborg, Manager, Special Projects, at (800) 274-2237, ext. 6705.

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From the North American Primary Care Research Group

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THE UK NATIONAL HEALTH SERVICE AND PAY-FOR-PERFORMANCE: LESSONS FOR THE UNITED STATES

The 2005 NAPCRG Annual Meeting, held October 15-18, 2005 in Quebec City, featured a plenary talk by Martin Roland, MD, director of the National Primary Care and Research and Development Centre at the University of Manchester, UK, on the promise and perils of "pay-for-performance" in the National Health Service. This policy shift is the subject of spirited discussions in the United States and is showing signs of growing momentum. Currently, more than 35 health plans representing 30 million members offer pay-for-performance programs. Based on current growth trends, at least 80 health plans are expected to offer such programs by 2006, covering some 60 million members.[1] More significant is the apparent decision by the Centers for Medicare and Medicaid Services to move forward with some sort of "P4P" approach to reimbursement.[2]

Dr Roland's center carries out research to inform the development of primary care policy in the UK

National Health Service (NHS). Those attending Dr Roland's session at the 2003 NAPCRG Annual Meeting had already heard about the plan to implement a contract in the United Kingdom for general practitioners that tied income to a detailed set of quality markers. Dr Roland returned for a plenary presentation at the 2005 NAPCRG meeting to discuss physician reimbursement systems and was now able to share some of his work evaluating the anticipated and unanticipated effects of the P4P strategy in the NHS. Expected and realized outcomes include improvements in certain measures of care, increased computerization and administrative costs, and more health care being provided by nurses and larger health care teams. He also discussed the unintended risks and effects of the program, including poor care for unincentivized conditions, more fragmented and less holistic care, and misrepresenting data to achieve practice goals.

Roland's report of the UK experience adds more urgency to finding answers to questions about P4P raised by US physicians. What should be measured, and how should this be done? Many of the demonstration projects involve large groups, but what about small- to medium-sized groups, where the great majority of patients get their care?[3] Although electronic health records and disease registries hold promise for more sophisticated quality improvement programs, they are currently employed in a minority of practices. How can the rest incorporate this costly technology? What is a practice to do in the face of multiple health plans that have disparate frameworks for P4P? As Dr Roland asked, what if physicians focus on the prescribed set of measures but end up ignoring other important items that may affect patient outcomes? What if physicians stop seeing sicker, more complex, or less "compliant" patients because of the potential for financial penalties under P4P? What of those practices that by choice or location serve large numbers of such patients? What is the performance target based on—an agreed- upon standard or benchmark, or improvement from 1 year to the next (which, ironically, may be hard to achieve for practices already performing well)? Finally, do these payments represent new money, or usual reimbursement and a higher bar?[4]

The National Academy of Sciences Institute of Medicine, tasked with advising the US Congress on how to get P4P off the ground, recommended establishing a new federal office within the Department of Health and Human Services to coordinate the development and implementation of quality measures needed for P4P. This would provide guidance for federal payers in the United States and presumably would have an impact on how private insurers roll out their programs.[5] If this accomplished a uniform set of standards for US physicians, it would be an enormous achievement. But the other issues of case mix adjustment and financing the needed investment in IT infrastructure remain to be solved. NAPCRG has an opportunity to provide some insight on these questions, both by means of original health services research and by sharing lessons from many countries. Although the US health care system might be unique in its ability to spend so much on so few to achieve so little (Larry Green, MD, personal communication, October 26, 2004), the need for quality improvement, including efficient use of scarce resources, is felt by numerous countries. NAPCRG would do well to make fostering this work and dialogue a priority in the next decade.

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From the American Academy of Family Physicians

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AAFP's National Research Network Adds Members

New members are making the American Academy of Family Physicians' National Research Network hum.

The network, which began in 1999 with 117 physicians from the former Ambulatory Sentinel Practice Network, now has 345 researchers, including 323 AAFP members. It also has established a residency branch, which now includes 69 family medicine residencies.

For more information on the National Research Network, including details on joining, visit http://www.aafp.org/x3201.xml or call Tom Stewart at (800) 274-2237, Ext. 3172.