Family Practice And The Health Care System

Implications Of Health Reform For Family Practice

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The United States presidential and congressional elections have triggered much speculation and cautious optimism about the likelihood and substance of health care reform during the Clinton administration. The reflections in this article are drawn from conversations with many health policy analysts and those representing special interests in Washington, DC, who were interviewed from September to November 1992 as part of the orientation of the 1992–93 Robert Wood Johnson Health Policy Fellowship Program. My comments are also in larger part personal reflections of an academic family physician on sabbatical exposed to a wholly political view of health care. Impressions of the current position of family practice at the federal level and the repercussions of health care reform on clinical family practice, family practice education, and research are discussed together with suggestions for actions that family practice can take to achieve a leadership position in primary care.

It may be a surprise to some that few in Washington have the slightest idea what family practice is. Many are confounded by the meaning of "primary care" or "generalist physician." There are many reasons for this confusion. Organized family medicine has only relatively recently been established as a political presence within Washington. Few at this time would say that this presence is weighty. Second, the organizational home of family practice is located quite far from the nation's capital. Sporadic or even regular visits to Washington, DC, by organizational leaders are qualitatively different from a constant presence within the capital.

Third, academic departments of family medicine in the immediate vicinity of Washington, DC, not unlike most areas of the country, are politically weak and barely visible presences in their own institutions. This and other factors result in the undeniable fact that few in or out of government have any personal experience or contact with a family physician.

Fourth, organized medicine has traditionally been represented at the federal level by the American Medical Association (AMA) or, in the case of academic medicine, by the American Association of Medical Colleges. Despite rhetoric to the contrary, these two organizations have simply not promoted family practice or primary care at the federal level with any degree of conviction.

Finally, family practice organizations have not yet cultivated effective grassroots support either among members or patients to create a vocal constituency that has the attention of legislators. Meaningful alliances with powerful consumer special interests, such as the American Association of Retired Persons, the Children's Defense Fund, and others, have yet to be established. More important, coalition building among the various primary care organizations is still in its infancy and is not yet apparent to policy makers.

Health Care Legislation and Clinical Family Practice

A series of developments will be expected to impact family physician reimbursement during the Clinton administration. As the rate of growth of medical expenditures is targeted not to exceed that of the gross domestic product (GDP), the resource-based relative value scale (RBRVS) will continue to be revised with new codes being added. For family physicians and for all primary care providers, implementation of RBRVS has certainly not fulfilled its promise

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to reverse long-standing payment inequities. The likelihood is that this process will continue to be incremental with multiple modifications and revisions.[1]

The AMA is attempting to broker these revisions by convening discussions among representatives of all specialty organizations. Such a forum has set primary care disciplines (family practice, general internal medicine, general pediatrics) in the minority of nearly 29 specialty organizations, which continues to disenfranchise these disciplines.

Medicare payments to new physicians will likely receive attention in the next year. Modifications of the Clinical Laboratory Improvement Act are not likely to occur in the short term, because of the pressing nature of health system reform. Implementation of a single transaction system for Medicare payment is expected within the next 2 years. The extent to which other payers adopt a Medicare fee schedule is open to speculation, but clearly there is federal interest in moving to an electronic claims processing system and a single claims form. These developments are very dependent on the health care reform package that emerges in the Congress. Insurance market reform and malpractice reform initiatives are likely to be proposed in the context of overall health care reform. All will be expected to impact on the practice of family physicians.

Health Care Legislation and Clinical Family Practice

Perhaps the greatest change in the next few years is likely to occur in medical education. Restructuring the physician work force in the context of broader health care reform issues is not a detail to be worked out later. A widespread perception of a shortage of primary care providers and an oversupply of limited specialists already exists within Washington. The causes for the shortage are thought to include low reimbursement, low prestige in academic medical centers, lack of role models, and medical school curricula that reinforce specialism rather than generalism.[2,3] Only within the past year or so are serious discussions occurring at several levels within the federal government to redress this situation.

The interrelated missions of academic medicine — research, education, and patient care — are linked together by funding. Patient care revenues account for 42 percent of medical school revenues sources and are rising. Federal research dollars now account for about 20 percent of revenues. Other federal contributions, state and local government payments, tuition, and miscellaneous income account for the rest.[4] Approximately $5 billion is spent each year to support training in the health professions. This support comes from such diverse agencies as the Health Resources and Services Administration (HRSA), the Food and Drug Administration, the Department of Defense, the Veteran's Administration, the National Institutes of Health (NIH), and the Health Care Financing Administration (HCFA). Most of these revenue sources could be levers for change.

Medicare, for example, pays for hospital and physician services provided to beneficiaries under Parts A and B in teaching settings. It also provides graduate medical education payments to teaching hospitals. These payments include those for direct teaching costs based on historic costs per resident trended forward by an inflation factor and multiplied by the number of residents in a teaching hospital. Payment for indirect teaching costs supposedly accounts for various factors that increase teaching hospital costs. No criteria have ever been set as to the particular mix of trainees to be produced by a given institution.

Perhaps for the first time centralized work force planning is being contemplated by HCFA and HRSA that links the financing of health care with medical education.[5,6] Preferentially assigning training funds to primary care means that institutions producing less than a designated percentage of its graduates in primary care would lose a proportionate amount of training support, and those institutions without primary care programs would fail to receive funds at all. Indeed, some have suggested that only by channeling these training funds directly to primary care departments will lasting and meaningful change occur.

Even if this restructuring takes place, the primary care work force will still be inadequate to meet the needs of an expanded population base (37 million uninsured persons) without some short-term solutions. Among these solutions include retraining some cohort of specialists to provide appropriate primary care services. How this retraining is to be done and which specialists might be willing to provide such services have yet to be considered.

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Implications for Family Medicine Research

The implications for family medicine research that stem from the health reform initiatives of a Clinton administration are unclear. While primary care is the cornerstone of every discussion of health care reform, it rarely receives much discussion from policy experts.

A case can be made that family medicine research is endangered at the federal level. First, there is real confusion in Washington about what constitutes primary care research and how this research is different from health services research. The Agency for Health Care Policy and Research (AHCPR), the major candidate for funding family medicine research, has been unable and unwilling to make such a distinction, perhaps because the AHCPR was created by combining the National Center for Health Services Research with the National Center for Technology Assessment and was the result of hard lobbying efforts by the health services research community. The consequence is that family medicine researchers compete for the same limited amount of research funds with health services researchers who frequently have lengthy track records of successful grants.

This dilemma is compounded by priority funding areas that are unclear and rarely focus on clinically relevant issues, by funding programs that are idiosyncratic and inefficient, by wholesale disinterest in supporting an infrastructure to build research capacity in family medicine, and by grant review study sections that are made up almost entirely of health services researchers. The situation at the NIH for family physician researchers is far worse than described here for AHCPR.

Even if these issues were redressed within AHCPR, budget constraints limit the ability of the agency to fund only the very highest scored proposals. Recent grant funding at AHCPR was less than the 10th percentile (less than 10 percent of all scored grants were funded), while that for the NIH was more than double this level. The funding levels for small grants of $50,000 or less at AHCPR fare markedly better, approaching 18 percent in recent grant cycles. In 1993 the AHCPR budget is $128.5 million compared with the $340 million appropriated for the Department of Defense health care research and development. Even this amount approaches a rounding error when measured against the 1993 NIH budget of some $8.9 billion!

The good news is that most experts in health care reform recognize the need for better information systems, more assessment of health care outcomes and new technologies, and guidelines to assist primary care providers in delivering effective care. Many, in fact, contend that meaningful health care reform cannot take place without such research. Cost, quality, and access — the funding themes that receive repeated emphasis from congressional experts on health — are also the priority areas for AHCPR funding. To date, however, substantially increased congressional appropriations for such research have not been forthcoming.

The major obstacles to this increased funding are political. In a budget-neutral climate, support for primary care research can occur only by reducing support from its competition — principally, biomedical research at the NIH. As everyone in Washington knows, the NIH lobby is among the strongest and most effective in Washington. This ever-present lobby will not be counteracted by occasional visits to Washington by prominent leaders in family medicine or primary care. An alternative to this interagency competition for funds is the creation of a separate institute within the NIH devoted to primary care research. To create such an institute would require congressional support that is currently absent. Another option calls for a restructuring of AHCPR that creates a separate center for primary care research with its own budget and grant-review process. Without a change in the administrator and without targeting congressional funding, however, restructuring would also be unlikely.

A second obstacle is the intra-agency allocation of funds that puts policy-relevant research at higher priority than clinical practice-based research. The competing demands by the Congress on the AHCPR itself to produce guidelines, fund medical effectiveness research, assess costly technologies, and so on, make family medicine and primary care research an unlikely area for substantial funding.

Conclusions

The next 4 years will undoubtedly bring major change. Some form of health care reform will most certainly be enacted, which will have a profound impact on family practice and all of medicine. While much reform is likely to improve the

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funding and prestige of all primary care physicians, organized family practice cannot afford to sit idly and watch what happens at the federal level.

Greater political effectiveness at the local and national level is of critical importance to family medicine. Articulate leadership now and for the future should be developed and promoted. For family practice to be visible in Washington, DC, more family physicians must become involved in legislative affairs at every level of government. There simply must be greater family physician presence on every health care panel and at every health policy forum in Washington. To present a strong and unified voice at the federal level, individual family practice organizations must collaborate in their legislative efforts. Unless the family practice organizations wish to spend precious capital distinguishing the specialty from other primary care specialties or distinguishing their physicians from generalist physicians, a consortium of primary care specialty organizations would undoubtedly be politically advantageous to all.

Family practice is still not particularly well understood by a large segment of the public. Grassroots support by our patients is our profession's most powerful constituency. Family practice must be understood at all political levels as critical to the implementation of health care reform. Because family physicians are not simply the health care providers to the poor and rural populations, we must make greater attempts to be perceived as the only alternative for high-quality, cost-effective primary care for all citizens.

Family practice organizations must make greater attempts at wider representation, enlisting far more members from health maintenance organizations and other practice settings. This broad base of support, in turn, requires organized family practice to become more relevant to different practice settings and more responsive in finding new ways of advocating for the broad interests of its members.

In education, new strategies must be employed to make others aware of curricular innovations in family practice. More family physicians must enter academic medicine as teachers, researchers, and as clinicians. They must get promoted, not only within their own departments but also as deans of medical schools and presidents of universities. More family physicians need advanced training in administration, leadership, economics, health policy, public health, decision making, computers, ethics, and other fields. More must enter government service at all levels and in all capacities.

Restructuring our nation's health care system is far too important to leave to politicians who appear to be unfamiliar with the important contributions of family physicians. The political opportunities for family practice have never been better. Family practice can and must take a leading position in health care reform in this country if only it has the will. If ever there was a time to act, it is now.

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