# Funding Issues in Primary Care and Family Practice: A Policy Perspective

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The issues surrounding reimbursement for services and support of academic training are perhaps the most difficult the young discipline of family medicine has yet had to face. The topics discussed by many of the papers in this monograph provide ample testimony as to the complexity of these issues and document the historic difficulties facing individuals and organizations associated with primary care in their attempts to address and resolve them.

The implications of these issues for family practice are unsettling. After a decade of almost unbroken growth in size, stature, and legitimacy, the specialty now faces a time of uncertainty over future sources of financial support; indeed, the continued viability of some practices and training programs may be in question.

The issues addressed in this review are so complex that resolution of any one of them presents considerable difficulty. Resolution is all the more difficult because each issue is intertwined in a Gordian knot of cause, effect, and common cause. Although the problems to be reviewed are generic in their impact on most types of primary care practices and training programs, this review will concentrate on their relationship to the practice of and academic preparation for family medicine.

## Summary of Issues

The papers in this monograph issue, taken as a whole, have identified three specific problem areas for family medicine. In addition, there exists a fourth, developing, issue which also must be examined.

These issues may be summarized as follows:

1. Family practice services are underpriced per unit of service, and many services are not covered by public or private insurance plans.[1] Family practices run an inordinately high risk of nonreimbursement of services,[2] and must deal with a high degree of patient discretion in seeking initial or follow-up care.

2. Family practice residencies and undergraduate training programs lack access to a stable source of third party reimbursement funds to assure their fiscal viability.[3] Compounding this problem is the fact that family practice residencies share the problems of independent practices in terms of generating adequate patient care revenues when compared to the procedurally oriented or tertiary care subspecialties. The relatively dis-

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proportionate dependence of family practice residencies and undergraduate programs on project grant income makes them particularly vulnerable in times of fiscal retrenchment.

3. Targeted support for family practice research has always been minimal, and in a time of discretionary budget reductions at both the federal and state levels, there is faint hope for increased research dollars. Thus, family practice training programs face the possible reductions of general program revenue, without research funds necessary to support the development of the intellectual basis for the practice of family medicine.

4. In addition, in spite of the recognition of the present inadequacies and inequities of the reimbursement funding base for family practice, new proposals for more "pro competitive" reimbursement systems do not necessarily promise an improvement in the financial position of family practice. Most competitive plans proposed thus far do not deal specifically with the inequities of primary care vs subspecialty care reimbursement, but simply seek to spread the risk and responsibility for payment of services delivered in a different way than is presently the case.[4]

This recitation of problems and issues may appear to be unduly pessimistic; however, the articles in this monograph demonstrate that there are few optimistic words to be said for the financial issues facing family practice. Indeed, if the circumstances are as we believe them to be, there is a clear and present danger to the status of family practice and all primary care practitioners as equal partners within the medical establishment during the next ten years. This is not to say that the problems reviewed in the articles, and analyzed below, are beyond solution. With proper analysis, understanding, and action, the fiscal problems of family practice may be mitigated, if not fully resolved.

## Analysis of the Issues

### *Undervaluing of Family Practice Services*

This issue is the nexus of the interrelated problems that must be addressed and resolved. Nowhere are the conflicting values of public policy related to family practice more clearly illuminated than through examination of policies of federal and state governments in the last ten years. These policies on the one hand seek to encourage the growth and vitality of family practice through generous special project grants; on the other hand, governmental policies hold to outdated and inequitable fee screens and reimbursement policies in payment for family practice services that retard the specialty's growth and attractiveness.

The history of the development of insurance mechanisms as methods of payment for medical services is too complex to review in this paper. Suffice it to say that the basic pattern for reimbursement of services was developed at a time when the major concern was for the reimbursement of inpatient treatment (and not coincidentally the stabilization of financial resources of US hospitals) in the early 1930s. The growth of third party payments since that time has continued to be based upon principles which bear no true relationship to the value of services to overall health status. Most reimbursement formulas to institutions are charge based. Under this method, reimbursement to subspecialty physicians is based upon usual and customary charges which can be substantially influenced by the entry of new physicians or new technologies into a practice setting, where the level of charge is subject to the discretion of the physician. The services of family physicians, typically ambulatory and office based, frequently have been excluded from all but the most comprehensive of insurance plans; even when included, they are based upon usual and customary determinations that are less likely to be influenced by the entry of new practitioners or new services.

The result of this trend has been the development of a reimbursement system in which most procedure or hospital based charges place a premium on the level of training of the individual physician rendering service or on the time required to perform the service (or both). This has led to a marked expansion of inpatient secondary and tertiary care centers; coupled with the major contribution of research funding from the Federal Government, the result has been the expansion of teaching institutions whose residents become highly oriented toward subspecialty practice. The flow of resources to these types of centers and practitioners reduces, on a relative basis, the amount of funds available to support burgeoning family practice and other primary care teaching

programs, and provides a disincentive to the establishment of the practices of newly trained physicians who graduate from these programs.[5,6]

In addition to this implicit systematic devaluation of primary care services, the mode of paying more per item of service to a "specialist" than to a "generalist" became the accepted norm of procedure prior to the establishment of family practice as a legitimate specialty in its own right; this practice continues today in most areas of the country despite the enhanced preparation or training of family physicians. It has required litigation on behalf of family physicians to reduce the effect of this inherently discriminatory practice.[7]

A further barrier to an adequate financial base for a family practice stems from the fact that primary care services are frequently viewed by patients in a highly discretionary manner, both in terms of whether to seek care and in terms of how much they are willing to pay for care that is rendered. In contrast, there is little discretion on the part of the patient in deciding whether to seek a subspecialty service (since this decision is usually made upon the advice of a physician) or how much to pay for the service (since subspecialty services are usually reimbursed by a third party carrier at little or no additional cost to the patient). Thus the practice of family medicine is much more sensitive to traditional market forces. The possibilities for increasing reimbursement constraints as a result of inadequate total health care dollar availability (ie, imposition of a Medicaid cap), increasing primary care physician supply and competition, and a general lack of resources on the part of patients have a negative influence upon the fiscal vitality of individual practices.

## *Support for Education*

Many of the issues discussed above regarding the inadequate financial base for family practice services have a considerable influence on the fiscal viability of family practice residencies and undergraduate training programs. As demonstrated in some of the papers, attempts by family practice teaching programs to recover more practice dollars are limited by the instructional requirements of educational programs as well as the reimbursement resources for services delivered.[3,8,9] Attempts to compensate for inadequate reimbursement for services by increasing involvement of residents in delivery of patient care may run counter to the educational priorities that residency programs must observe.

The difficulties of establishing a firm fiscal base for a training program are exacerbated for family practice residencies based in tertiary care teaching centers. Arrangements for provision of quality ambulatory care are frequently less than desirable (outpatient centers are more financially attractive to tertiary care centers than are free standing family practice units), and the teaching hospital's patient mix is skewed away from primary care by its need to attract patient populations requiring subspecialty and technologically complex care. Most major medical schools have recently experienced dramatic decreases in the percentage of their budgets derived from biomedical research grants and contracts and a concomitant increase in reliance upon patient care dollars. This trend—which will continue in the 1980s—places additional pressures on the less financially attractive residency programs.[6]

The financial difficulties encountered by family practice programs in teaching hospitals are compounded in family medicine training programs, which provide educational experiences for undergraduate medical students as well as residency training. Undergraduate students place strains on a faculty already overtaxed by educational and patient care responsibilities. Although family practice has generally found residency training to function more smoothly in a community hospital setting, such sites have not always been able to meet the real demands for quality education and exposure of medical students.

Historically, support for family practice residencies, whether in community hospital or teaching hospital settings, has depended very heavily on state or federal project grants (although a few states fund residents on a per capita basis). As we enter the 1980s, however, it must be acknowledged that these types of project grants have a finite life span, and that the aggregate amounts of federal funding available for family practice education may have already peaked. As the economic difficulties of federal and state budgets cause increasing pressure on discretionary program funding, it is highly likely that special project grants for support of residency programs will begin to dwindle in number and amount, with no clear alternative source of funding on the fiscal horizon.

### Research

Support for family practice research must be considered as a special case in relation to issues surrounding practice revenues and support for educational programs. Nevertheless, there are clear interrelationships among this area and the two previously considered.

The history of research growth in the United States reflects a consistent pattern of targeted federal support to academic institutions. The National Institutes of Health, the National Science Foundation, and the Veterans Administration provide considerable support to basic and clinical scientists on the faculties of the various US medical schools and the staffs of their teaching hospitals. In addition to generating a high degree of quality research and clinical progress, biomedical research dollars also provide partial support of faculty who provide education and training to residents in the various subspecialties. However, the ability of most academic departments in medical schools and teaching hospitals to generate considerable sums of patient care revenues also provides some degree of flexibility and allows for a richer mix of patient care, education, and research on the part of faculty and residents than otherwise would be the case. In addition to the inadequate patient revenue base discussed above, family practice faculty and residents face the difficulty of developing research agendas and projects in the absence of stable funding from either governmental or private sources. This has slowed the articulation of the intellectual basis for the practice of family medicine and has contributed to the still incomplete acceptance of family practice as a legitimate clinical specialty by a number of US medical schools.

### New Initiatives

From the foregoing analysis the reader might assume that any innovation or experimentation with present reimbursement patterns would be regarded as an improvement over the present status as it relates to family practice. However, reimbursement reform may not signal relief. The motives for reform of reimbursement, whether they be based upon pro competitive or other models, are predicated upon the need to conserve costs or improve access to services within present costs or both.[4] In none of these models, however, do the proponents seriously take into account the need to change the "valuing" of services. If reimbursement reform is adopted in the absence of a commitment to increase selectively the relative value of primary care services while selectively decreasing the relative value of some of the more procedure oriented services, the most likely outcome for family practice will be an even less attractive competitive position among the subspecialties than is presently the case. Perhaps the worst case that could develop from reimbursement reform would be the combination of a nationally mandated catastrophic insurance package, coupled with pro competitive revisions in public and private insurance plans designed to increase the consumer's out-of-pocket expenses for most discretionary health services (including office visits, prescription drugs, and the like). This would force an even more profound shift of reimbursement dollars toward tertiary care services and away from primary care.

The only elements of the pro competitive plans, which potentially benefit family practice providers, involve proposals for a closed panel of specialty providers, with a primary care physician as a "gatekeeper."[10] Although this concept offers a promise of more balanced decisions by patients toward total health care expenditures and some implicit upward revaluation of the contribution of the services of a primary care physician, most of these plans call for the primary care physician to be reimbursed on a salary or capitation basis, rather than by fee for service, while the subspecialist referral physicians would still be reimbursed largely on a piecework remunerative basis.

In addition, no pro competitive or reimbursement reform strategy examined brightens the prospects for academic family medicine and family medicine research in the next five to ten years, given the uncertainty of retention of funding levels of existing general special project grants for family medicine departments and residency training programs in the face of the general negative economic environment for social programs at the state and federal level. Reimbursement reform could help a little—or hurt a great deal. But even the most optimistic of assumptions of increased practice revenues from different reimbursement

patterns as presently proposed are unlikely to make up the deficit lost by diminution of special project funding.

## Recommendations

Having borne thus far through the dour litany of dire outlooks, it is fair for the reader to ask, "If not this, then what?" The comments that are offered below regarding possible steps which the specialty of family medicine might consider taking in order to resolve these issues are not offered as specific strategies, but as the first elements for an agenda of action that deserves serious consideration by the specialty. Although some may be clearly more central than others to the interest of the ultimate viability of family practice as a clinical practice mode, each would contribute to the resolution of the complex and interrelated fiscal problems which confront the discipline.

### *Reimbursement Reform*

The present formula for allocating reimbursement to family physicians for services delivered must be revised to give fairer value to those services based upon the family physician's training and experience, the contribution of his or her services to the overall health of the patient, and the minimization of the eventual need for more complex and costly medical care as a result of provision of these services. In addition to "revaluing" family practice services across the board, reimbursement reform must be designed to assure that a wider spectrum of day-to-day services provided by family physicians, such as counseling, preventive health services, and health hazard appraisal, are reimbursed by both private and federal third party payors. It must be recognized, however, that any reimbursement reform mechanism must be accomplished in an environment of "zero sum," and that significant financial gains for primary care practitioners will likely be accomplished only at the expense of practitioners in other specialties.

We do not take lightly the advocacy of parity for family medicine in the context of reimbursement reform. There are procedural complexities and enormous professional and political implications involved in such reform, particularly at a time when redistribution of dollars to reimburse primary care practitioners more adequately must come from a relatively dwindling supply of medical care dollars. Nevertheless, reimbursement reform is the single most critical issue facing family practice as a specialty over the next ten years. Without its successful resolution, we share the concerns of many as to whether family medicine as it is presently practiced will hold sufficient financial attraction for the next generation of medical students and potential family practice residents. Although reimbursement reform will not resolve all of the issues related to family practice education and research, the accomplishment of reimbursement reform in a manner that makes individual or group nonteaching family practices more fiscally viable will inevitably have a major positive effect in shoring up the present fiscal posture of a large number of family medicine teaching programs at the graduate and undergraduate level.

### *Training Support*

Serious consideration must be given by the specialty of family practice to seeking, at the state and federal level, a revision of the present special project grant support for family medicine graduate and undergraduate training. In its place is proposed some type of capitation support. Likewise, federal reimbursement mechanisms must be altered to reduce the unattractiveness of family medicine programs to health centers. Examples include payment to residents in ambulatory care settings on a fee-for-service basis, or a wholesale restructuring of today's system of reimbursement of teaching costs, involving direct payment to cost centers on a formula unencumbered by considerations of eligibility of the patient for Medicare or Medicaid reimbursement.

Although special project support can, in some instances, provide greater resources to individual projects than would be possible under alternative mechanisms, the experience with capitation based approaches for federal and state priorities, whether they be academic or service delivery, indicates that they are a far more stable source of support than that of special projects; restructuring the present mechanism for reimbursement of teaching costs probably would have a similar result. Advocates of family medicine can appropriately argue

that while special project support has addressed the needs of the specialty in its first decade, allowing it to design and initiate large numbers of new residency and departmental programs, new methods of training support are necessary to meet the challenges for more stable long-term funding during family medicine's second decade.

Revisions in support for family medicine training are not unreasonable in the face of the substantial, albeit less visible, amounts of taxpayers' dollars contributed to other residency training programs. Informal estimates by Health Care Financing Administration staff indicate that Medicare and Medicaid dollars contribute at least $600 million annually to the costs of residency training. Because these costs are based upon eligibility of Medicare or Medicaid recipients, most of this amount goes to the so-called nonprimary care residencies. It is reasonable, therefore, to seek a special type of ongoing support for family medicine because of the disproportionate federal contribution to other residencies as well as the continuing public interest in increasing the percentage of residents in primary care training programs. Such across the board revisions in public supplements to these training programs will be required, even if reimbursement reform in other areas is accomplished, in order to ensure that residencies and undergraduate programs will be as fully viable as those of subspecialty training within the academic center.

### *Family Practice Research*

Although the critical step to be accomplished to assure a functioning base for family practice research is a combination of reimbursement reform and long-term support for family practice training programs, it is also appropriate to consider the initiation of a targeted, federally supported research initiative in family practice and primary care. We envision an initiative being based on the cross-cutting, multidisciplinary intellectual underpinnings of family practice, including not only elements of basic science and clinical medicine, but also disciplines such as social and behavioral psychology, anthropology, and sociology. Such a research focus might be appropriately considered as the next logical evolutionary step in the growth and development of family medicine research within the National Institutes of Health. Although its total funding resource need not necessarily be large, the existence of an NIH institute or research center, perhaps using as a model the recently created National Institute on Aging, would provide both a point of focus for the further development and elucidation of the family practice research agenda as well as some assurance of an ongoing source of a modest amount of research dollars.

## Conclusion

The decade of the 1970s has been one of enormous success for the specialty of family medicine. The discipline has wide acceptance by the public, the Congress, and the medical profession. This success was accomplished by a combination of federal and state support, community pressures, and student interest. The critical agenda for family medicine in the 1980s is the development of a firm financial basis upon which practitioners, educators, and researchers can rely. Only through fulfillment of this agenda, which will be more difficult to achieve than was congressional support and professional parity, will family medicine be able fully to meet its expectations and responsibilities.

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