Funding Patient Care, Education, and Research in Family Practice: Interrelated System Problems

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It is timely to consider in some detail the current issues and problems concerning the financing of patient care, education, and research in family practice. Recent federal and state cutbacks have jeopardized the financing mechanisms of family practice in these three areas. This is of particular concern because these financing mechanisms were either incompletely developed (eg, patient care and education) or still largely undeveloped (eg, research).

Family practice has appropriately been viewed by health planners, legislators, and others as an essential field whereby primary care services can be extended more adequately to the population in diverse settings in a cost-effective, coordinated, personal way. Now 12 years old as a specialty, family practice has successfully completed its initial development to a point at which medical students are attracted to the field in substantial numbers, many excellent teaching programs are available, more effective approaches to patient care are being developed, and research activities are taking root. There is ample evidence that the graduates of family practice residency programs are locating their practices in areas of need, are providing a wide spectrum of services, and are both challenged and satisfied with their practices.[1] However, family practice cannot continue to make the contributions to the health care system, which are both expected and needed, unless a number of financing problems are resolved.

These problems are interrelated and cannot be effectively addressed alone. Viable teaching programs, for example, require a sizable practice population and a stable source of revenue from patient care services. Although patient care income at best can only partially finance a teaching program, cutbacks in third party coverage (eg, current Medicaid cutbacks) may decompensate the fiscal base of even well-established programs. Federal training grants were always intended only as start-up and supplemental funding to encourage the initial development and improvement of teaching programs, not to provide for longer term financing of their ongoing operational costs. As these training grants terminate, the full burden for

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ongoing funding shifts to patient care and hospital support, aided in some cases by variable amounts of supplemental state funding (also tenuous in many instances). Thus, in order to assure the future fiscal viability of family practice teaching programs, coordinated revisions are needed in direct reimbursement of primary care services, as well as reimbursement to hospitals, to help defray their educational costs.

The logical and inevitable response to funding cutbacks for medical education programs is to rely more heavily on patient care income to support these programs. But here the lack of a coordinated, national health care policy becomes evident, for those teaching programs which can fully support themselves from patient care revenue are generally in the surplus specialties (eg, surgical specialties and procedure oriented medical subspecialties). Existing gaps and disincentives in reimbursement mechanisms for primary care services, however, permit only partial funding at best for teaching programs in the primary care disciplines, which represent most of the nation's deficits in physician manpower. These disincentives have more far-reaching implications as well in not encouraging (or even permitting) graduates of family practice residencies to practice the full breadth of practice for which they have been trained (eg, preventive medicine, counseling). Current reimbursement mechanisms still work against continuity of care (eg, reimbursement preference for emergency room visits over office visits) and attempts to correct geographic maldistribution of physicians (eg, lower reimbursement levels for rural practice and for practices comprising large proportions of patients on Medicaid, such as in inner city settings).

The purpose of this monograph is threefold: (1) to characterize (and quantitate where possible) the issues and problems in financing patient care, education, and research in family practice, (2) to illustrate the interrelatedness of these issues and make the case for integrated system responses, and (3) to report the experience to date of various programs and projects addressing some of these problems in various settings. Collectively, these papers highlight some of the present inadequacies of health care financing mechanisms and suggest some alternatives for restructuring the financing of health care based on the needs of the patient and the need to distribute comprehensive health care services to presently underserved areas throughout the country.

Reference

1. Geyman JP (ed): Profile of the residency trained family physician in the United States, 1970-1979. J Fam Pract 11:715, 1980