

# Virtual Mentor

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### Overcoming Obstacles in US Health Care Delivery with a New Practice Model for Family Practice

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Despite brisk advances in science and technology and a bounty of medical knowledge, tools, and techniques to enhance patient care, US physicians still labor daily to provide the highest quality care to their patients at reasonable cost. They struggle against a complex collection of economic and business hurdles and obstacles imposed by the health care system. These challenges have made the current system unworkable for many physicians. Policy analysts have argued that the system cannot continue this way for much longer and have speculated that health care service delivery in the US will soon become a crisis unless it undergoes a major overhaul. This essay will highlight some of the hurdles and obstacles that have hindered physicians and present brief summaries of some proposals currently being discussed to overcome them.

### The Economic and Business Pressures on Physicians

Numerous financial obstacles confront physicians in the US today. There are, for example, increasing threats of lawsuits that result in escalating malpractice insurance premiums [1], and soaring practice overhead costs. Physicians also face unfunded legal mandates, including the HIPAA confidentiality regulations and the demand for independent translators for non-English speaking patients, while they find themselves providing increasing levels of uncompensated care. Meanwhile many primary care physicians' compensation has either declined relative to the cost of living or leveled off at best. Many face increased work hours in order to perform growing administrative tasks that add little or no value to patient care [2]. Some practices have hired additional nonclinical staff to handle some of these tasks.

The new administrative tasks physicians have to perform include increased billing and coding, resubmitting denied claims, phone calls with pharmacies to resolve formulary drug issues, verifying insurance coverage, co-payments and deductibles for patients, and negotiating or renewing insurance contracts with multiple health plans. A large portion of US health care dollars goes to paying for the ever-expanding bureaucracies that insurers set up to handle these tasks and the staff hired by physicians to deal with these bureaucracies. So large bureaucracies have evolved not to deliver care, but to negotiate payments and, in many cases, to try to avoid paying for care. Physicians are then compelled to increase their overhead expenses as they fight to make sure somebody pays for the services they provide.

Financial pressures also come from steadily falling reimbursement rates in government health programs like Medicare and Medicaid. The reimbursement rates for these programs are relatively low, and physicians are finding it increasingly difficult to

participate. Many also believe that the formulae for updating the Medicare reimbursement rates are flawed. Despite these concerns, beginning next year, the Centers for Medicare and Medicaid Services plans to go even further and use the same flawed formulae to cut reimbursement rates by more than 30 percent over 6 years [3]. Because third-party payers frequently use the Medicare rates as a reference point, they are likely to cut their own rates as well in the near future.

**Family physicians are exposed to even more pressure.**

The financial pressures on primary care and family physicians are even greater. Primary care physicians see, on average, fewer patients per day and bill for fewer high-reimbursement procedures per day, than do specialists. They perform fewer tests per patient visit and treat more patients for conditions whose complexity is often not valued by the reimbursement systems, even though these are conditions with important psychosocial components. Because family physicians see patients with virtually any clinical problem and experience amplified exposure and sensitivity to the financial pressures noted, they are frequent leaders in the search for health care system improvements. Responding to these pressures, leaders in family medicine have proposed a groundbreaking and landmark new model of practice and care in 2004 [4].

**A Solution: the New Model of Practice in Family Medicine**

The new model [4] stresses a patient-centered, health care team approach; elimination of barriers to health care access; organized chronic disease management; advanced health information systems, including electronic health records and computers that can automatically exchange information; redesigned, more functional offices; a focus on health quality and outcomes, including computer analysis capabilities in each office; and enhanced practice finance. The model also commits family medicine to providing a comprehensive basket of medical services for everyone in the population. Subsequent to the new family medicine care design, Task Force 6 formulated a financial model to sustain it [5], with a focus on practice reimbursement and health care finances. The report of Task Force 6 suggests that full implementation of the new model of care within the current fee-for-service system of reimbursement would result in a 26 percent increase in compensation for each physician in a 5-physician practice, if they maintained their current number of work hours [5].

If the present reimbursement system were to be revamped so that all Americans—rather than the current half—had reliable sources of primary care, the new model forecasts a 5.6 percent decrease in the national cost of health care, or a savings of \$67 billion dollars per year, in addition to improvements in the quality of health care [5].

But the forecast is not simply for increased compensation. For example, greater access and better outcomes from enhanced prevention and disease management may mean that, even though physician panel sizes increase, the number of physician visits or patient contacts will actually decrease. It is also true that, if the current fee-for-service system of reimbursement is maintained, innovative features of the new model like chronic disease management can easily become a drain on physician revenue streams. Thus it is imperative the current reimbursement system be scrapped and replaced for these reforms to be viable.

Meanwhile the American Academy of Family Physicians (AAFP) has invested millions of dollars in a practice resource center. The center will implement and evaluate a national demonstration project that would transform up to 20 family medicine practices to the new model of care advocated in the Future of Family Medicine project report.

### **Additional Solutions**

An important component of the proposed reforms is the introduction of secure electronic health technologies into every physician's practice. This should result in greater practice efficiency and lower cost of operation and should support many of the features of the new model for family physicians. The high cost of acquiring the technology has created the need for adoption incentives for physicians (particularly those in solo or small group practices) before this can be fully implemented.

Another solution proposed to relieve some of the pressures on physicians has been tort reform that places legislative limits on physician exposure to malpractice liability. Alternatively, direct caps on insurance premiums and limits on attorneys' fees have been suggested. Despite numerous attempts at the federal level, only some state efforts have been successful at imposing legal limits [6].

### **Conclusion and Some Next Steps**

This essay has highlighted some of the numerous financial pressures on physicians, and the amplified exposure and sensitivity of primary care physicians to these pressures. It has also provided a synopsis of some proposals to overcome these pressures. The AAFP new model offers landmark innovation in the delivery and funding of primary care. Without physician buy-in, however, the model remains merely a concept. Interested physicians can become part of the reform movement by: (1) learning more about the new model of practice [4] and the report on financing the new model [5], (2) adapting to the changes in the profession and becoming lifelong learners, (3) using new innovations and advances, (4) organizing their practices to provide care through multidisciplinary teams, and (5) engaging other partners outside their practice to form teams and develop collaborative relationships. Educators can translate the new model concepts into guidelines for patient-oriented training of physicians. Students and practicing physicians can seek and demand training to provide the full basket of the new model services. And, above all, every physician should join the debate on the merits of cutting out the administrative bureaucracy of insurers and providing health coverage for all.

Economic pressures on the health care delivery system in the US have been mounting for several decades. The system is close to a breaking point now. Avoiding a collapse will require a complete revolution or paradigm shift. All physicians should obtain as much information as they can so they can play their rightful roles in this reform effort.

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