

Virtual Mentor

American Medical Association Journal of Ethics
July 2012, Volume 14, Number 7: 567-570.

POLICY FORUM

Vermont's Single-Payer Health Care System: An Interview with Allan Ramsay
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In 2011, Vermont legislators approved Act 48, a bill that could lead to the creation of Green Mountain Care, slated to be the country's first single-payer health care system. Allan Ramsay, MD, a family medicine and palliative physician in Vermont, is one of the five members appointed by Governor Peter Shumlin to the Green Mountain Care Board, which is charged with designing a fully integrated, high-quality health care system accessible to all Vermonters.

Claire Ankuda: First, why did you consider applying for this position?

Allan Ramsay: Why, in other words, would a family medicine physician who spent 37 years seeing patients every day and valuing the physician-patient relationship give that up to move into health policy work? This is not easy to answer. I have felt over the past few years that my ability to have a strong physician-patient relationship has been increasingly compromised by the lack of an integrated health care system and by the way health care was financed. I also have been hearing similar stories from my physician colleagues: "it's not about the patient anymore." My clinical and academic career limited my ability to work on important social change. I also wanted to learn more about health care policy.

Giving up patient care has been a difficult process. However this is a unique opportunity to support both primary care and palliative care in a meaningful way.

Claire Ankuda: How did you start thinking about translating Act 48 (Vermont's Health Care Reform bill) into policy in a way that would improve shared decision making?

Allan Ramsay: At the governor's first press conference about the Green Mountain Care Board, I said that if I could do one thing for my primary care colleagues it would be to get rid of the 10-minute visit. You can't do meaningful shared decision making if you are constantly pressured to see more patients in a shorter period of time.

In Vermont, we have an almost \$5 billion health care budget, approximately half of which is public money—Medicaid and Medicare. As the cost of health care has grown, the one thing that government can do to control costs is to cut back on reimbursements to the physicians. What does that drive physicians to do? Try to see

more patients. That is one of the problems in a fee-for-service system. The system needs to change to focus on improving quality and value for the patient.

Commercial insurance is the other large financier of health care in this country. The actual percentage of the commercial insurance premium dollar that goes directly to primary care services is very low. By contrast, fully integrated health care systems both in the U.S. and in other developed countries invest much more of each dollar in primary care. They know that is how quality will improve and the costs will be moderated. We don't know what the right percentage of investment per dollar is, but we know we must invest more in primary care in this country.

It all comes down to improved quality at a lower cost and what we value in the health care system. More investment in primary care will lead to improved shared decision making between the patient and clinician.

We must design delivery systems with improved quality and patient experience as the primary goal. I practiced through the years of the failed social experiment called health maintenance organizations (HMOs). HMOs focused only on controlling utilization of services. [Ed. note: In HMOs, physicians were paid a flat amount per patient per year, a system known as "capitation." Capitation created an incentive to keep patient use of services at a minimum.] I never want to see my colleagues called gatekeepers again and expected to make decisions based on controlling the utilization of services. Our delivery system first must focus on improving quality, reducing waste, and avoiding procedures or treatments the patient does not want. Integrating palliative care more effectively for people with life-limiting conditions is a good example of this process.

The most important indicator of quality is the patient experience. But we need to focus on the quality of the clinician experience also. It would be wonderful to walk through the hospital and hear all my colleagues talk about how much more they enjoy the practice of medicine, whatever specialty they are providing. If satisfaction scores are low for health care providers, then we know that patient satisfaction scores will not improve.

Claire Ankuda: Can you give some more specific examples of policies that you believe will improve the way doctors and patients make decisions about health care?

Allan Ramsay: Act 48 establishes the Vermont Blueprint for Health and the patient-centered medical home (PCMH) model as the foundation for the delivery of health care services in Vermont. In 2011, the number of advanced primary care practices, which include the PCMH and community health teams, more than tripled in Vermont. More than half of all Vermonters are now in a PCMH for their medical care. The Blueprint goal is to move away from a strictly fee-for-service system and toward compensation for high-quality, high-value care. In Vermont all insurers, including Medicare and Medicaid, contribute to a monthly per-patient quality-based payment to the clinician in addition to the traditional fee-for-service payment. This

additional payment is designed to achieve the outcomes of improved quality, access, communication, and patient-centered services, rather than just a volume of services. All these factors are essential to improving the way decisions are shared between patients and their doctors.

Claire Ankuda: How do you think your experience as a physician has helped policy makers?

Allan Ramsay: The learning curve has been very steep. I think politicians and policy makers work very hard and endure a lot of criticism, while just trying to do the right thing. Those in the position of changing the health care system don't always see things the way we physicians do. All my fellow Green Mountain Care Board members like to hear stories about patient care—they love doctor stories. When we are discussing a complicated situation about regulations or their impact, telling a story about a patient you've taken care of can put things in perspective.

Transparency and openness are essential in this process. I have met with colleagues throughout the state to be sure they are aware of the health care reform process. In addition all our board deliberations must occur in an open and announced meeting, so that any interested party can listen to the policy discussion. My entire career I have been focused on confidentiality as the foundation of the patient-doctor relationship. It has taken some time for me to adjust, but I am convinced that transparency for the public and those providing health care services is vitally important.

Claire Ankuda: Thanks so much for taking the time to chat. Is there anything else you'd like to add about your time as a policy maker?

Allan Ramsay: One thing I'm very hopeful about is the thoughtfulness of Vermonters. I am a family medicine and a hospice/palliative care physician. Vermonters understand how important both these roles will be in the health care debate. Anyone who has experienced palliative care for a loved one or for themselves knows the value this expertise can bring to the patient experience. During the debate of the Accountable Care Act, I was disgusted by the rhetoric about death panels and limiting care for those near the end of life. As I travel around the state, both my colleagues and others mention to me that improving how we care for those at the end of life is critically important. Vermonters are wise and care about each other. That is so important in getting us to the prize of a high-quality, fully integrated health care system for all.

Claire K. Ankuda, MD, MPH, is an intern in family medicine in the urban underserved track at the University of Washington in Seattle. She is a recent graduate of the University of Vermont College of Medicine and the Harvard School of Public Health. Her research interests include the assessment of quality of decision making, especially at the end of life; surrogate decision making; and disparities in end-of-life care.

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