

THE THREE “Ps” OF HEALTH CARE REFORM: PAY-FOR-VALUE, PRIMARY CARE, AND POVERTY

by **Richard A. Cooper, M.D. and Arthur H. Rubenstein, MBBCh**

Richard A. Cooper, M.D. is a Professor of Medicine and Senior Fellow in the Leonard Davis Institute for Health Economics of the University of Pennsylvania. He may be reached at cooperra@wharton.upenn.edu.

Arthur H. Rubenstein, MBBCh. is a Fellow of the American Academy of Arts and Sciences. He is Executive Vice President for the Health of the University of Pennsylvania Health System and Dean of the University of Pennsylvania School of Medicine. He may be reached at ahrdean@mail.med.upenn.edu

© **Richard A. Cooper and Arthur H. Rubenstein**

In their recent web essay, Rabkin and Cook describe a systems approach to the health care crisis. They set forth an ambitious agenda to transform medical care from its predominantly fee-for-service mode of payment and specialty mode of care to one in which primary care is the backbone, teams of primary care physicians (PCPs) are the organizational unit of care, and capitation is the mode of payment.¹ Their formulation rests on two popular beliefs: that fee-for-service fails to align providers' incentives with patients' preferences; and that primary care serves an essential coordinating role in the delivery of care.

What Rabkin and Cook actually present is yet another version of the medical home, with groups of PCPs caring for panels of patients, reduced in size but with increased reimbursement per patient because of the “additional clinical management required.” The plan includes a heavy dose of gate-keeping, which has always been problematic, but this time patients would have an incentive to see their PCPs en route to their specialists, because half of their co-pays would be waived, and PCPs would be paid more for the “prudent, efficient, and effective use of resources,” i.e., less care.

From here, the details become somewhat murky. The baseline levels of reimbursement would be determined by patients' “actuarial class,” based on age, sex, and disabilities, but this would fail to adequately adjust for risk. Teams would be expected to pool a sufficient number of Medicare beneficiaries to ensure that they would be “actuarially stable,” but most panels would be too small. And “prudence and efficiency” would be carefully quantitated, although they are largely unmeasurable. These operational details aside, we are assured that the plan would produce better and cheaper care. But whether or not that occurs, PCPs would be paid more – the *sine qua non* of most current-day proposals. And if they were fortunate enough to attract fewer poor patients and healthier patients overall, the rewards would be greater still.

The real issue is not Rabkin and Cook's reborn capitation. Nor is it their reshuffled medical home, for which there is little supporting evidence, which is why the evidence they offered was not about medical homes but about a 30-year experience of house calls to the poor elderly

in Boston. The real issues are the validity of pay-for-value, the wisdom of structuring the health care system around PCPs, and a third issue that Rabkin and Cook side-step altogether: the effects of poverty on health care and health care spending.

PAY-FOR-VALUE

Enthusiasm for pay-for-value and concerns that fee-for-service incentives are perverse spring largely from studies showing variation in resource inputs among hospitals and geographic regions, with no accompanying differences in outcomes.^{2,3} But these studies were specious. Actual differences among hospitals were not discerned because the measure used – inputs at end of life – was based on the assumption that, since all patients had the same outcome (death), illness levels must also have been the same.² Clearly that was not the case. While patients had all died, there is no reason to believe that the illnesses leading to their death had been similar in complexity or in their demand for services.

A different set of issues was created in the approach to studying “regions,” which were not true geographic regions but collections of scattered geographic areas that happened to have similar levels of Medicare spending. One problem was that it was assumed that Medicare spending reflected health care spending overall, but that is not the case. There is no relationship between Medicare spending and overall health care spending.⁴ Moreover, it is *total* health care spending, and not spending from Medicare or any other single source, that influences staffing levels, resource availability, and outcomes in Medicare and other patients.⁵ Moreover, because Medicare spending was the metric for sorting geographic areas into “regions,” they were random with respect to other important characteristics, such as income, race, education, population density, and more. Averaging these randomly dispersed variables yielded values that were predictably “average,” and outcomes followed accordingly. Nothing was different despite greater Medicare spending, which led to the now familiar mantra: “more is less.”² But more *total* spending is actually “more.” It is associated with better health outcomes, as logic predicts.⁵

Despite these confusing assessments of regional variation, shouldn't there be greater pay for higher value? Yes, if value in relation to spending could be readily measured, as it is in paying for a meal or a car. But in health care, the greatest spending is for the sickest patients, many of whom are poor. Their readmission rates are higher and outcomes are worse despite the greater spending.⁶ While it is possible to adjust for income, risk, and health status, these needed adjustments are not possible from the data typically available. The result is that providers of care for the poor appear to provide low value care, a tragic conclusion that is rampant in the rhetoric of current health care reform.

These problems are magnified when pay-for-value focuses on the use of particular diagnostic or therapeutic modalities that were shown to be effective in controlled studies. The danger is that such modalities might not be appropriate in specific clinical circumstances. Value is not achieved by micro-managing physicians' decisions, but through medical education, research, decision analysis tools, and similar aids. Pay-for-value is a dangerous game that subverts the ability of physicians to exercise sound clinical judgment.⁷ In the last analysis, physician autonomy is the friend of value.

PRIMARY CARE

The second of the three “Ps” is physician-directed primary care, a feature of Rabkin and Cook’s paradigm. Physicians have traditionally directed primary care. But as more therapeutic options emerged, physicians expanded their repertoire of care. Medical education followed accordingly, as did the expectations of both physicians and patients. In the wake of this progress, other professionals were trained to do what physicians formerly did, and physicians increasingly filled their time with elements of care for which they were uniquely prepared and licensed.

Increases in science and technology have not decreased the need for front-line primary care, nor for care coordination and patient education. The crucial question is, who should provide it? The answer is bound up in the reality that there will be too few physicians in the future to do all that physicians could do.⁸ If medical education is diverted to producing practitioners of primary care, it cannot produce adequate numbers of specialists in oncology, cardiology, orthopedic surgery, and dozens of other disciplines that provide what Americans rightly identify as health care. Instead, highly educated physicians will do what lesser trained professionals can readily do at fees lower than those demanded by PCPs and proposed in current health care reform legislation. While the notion that there should be more PCPs is politically popular, it is neither desirable nor feasible.

POVERTY

The third “P” is poverty, the least discussed and most important element in health care reform.⁹ Low-income patients utilize almost twice the resources as the rest. This is due not only to higher readmission rates, but to more frequent in-hospital deaths and other excesses that are the natural consequences of their poorer health status and inferior social support systems.¹⁰ If the amount of care utilized by the poorest could be reduced to that used by the rest, health care spending would decrease by approximately \$300B annually. To accomplish this would not only take efforts within the health care system; it would require community efforts related to education, language proficiency, home care, transportation, and other structural elements. Yet this would not only lower health care spending; it would produce other socially useful outcomes.

Sadly, current health care reform legislation has proposed cuts in reimbursement for providers who care for the poor and whose patients, as a result, have high utilization rates. And it proposes to reward providers in counties that spend the least, oblivious to the fact that most counties that spend the least have the lowest density of poverty. Peter Orszag, Director of the OMB, complains that if only Medicare spending in Newark could be like the Mayo Clinic, the nation could save billions, failing to acknowledge that half of Newark’s population is black, compared to less than 5 percent in Mayo’s area, and 25 percent of Newark’s population lives in poverty, compared to less than 10 percent in Mayo-land. Mayo is a worthy institution, but it would be interesting to see how cost-effective it would be in Newark.

It is time for health care reform to face up to the three “Ps.” The strategies proposed for pay-for-value will fail to add value, as proposed strategies for more PCPs will fail to provide more primary care. The absence of a comprehensive approach to poverty leaves a gaping hole. Approaching these issues with clarity and vigor would lead to better access, broader equity, greater physician autonomy, and more cost-effective health care. That would be real reform.

NOTES

1. M.T. Rabkin and J.S. Cook, “Health Care Crisis: Systems Insight to a Practicable Approach,” American Academy of Arts and Sciences, 2009.
2. D.C. Goodman, T.A. Stukel, C. Chang, and J.E. Wennberg, “End-Of-Life Care at Academic Medical Centers: Implications for Future Workforce Requirements,” *Health Affairs* 26 (2) (2006): 521–531.
3. E.S. Fisher, D.E. Wennberg, T.A. Stukel, D. Gottlieb, F.L. Lucas, and E.L. Pinder. “The Health Implications of Regional Variations In Medicare Spending: Part 1. The Content, Quality and Accessibility of Care,” *Annals of Intern Medicine* 138 (4) (2003): 273–287.
4. A.B. Martin, L. Whittle, S. Heffler, M.C. Barron, A. Sisko, and B. Washington, “Health Spending by State of Residence, 1991–2004,” *Health Affairs* 26 (6) (2007): w651–663.
5. R.A. Cooper, “States With More Health Care Spending Have Better Quality Health Care – Lessons for Medicare,” *Health Affairs* 28 (1) (2009): w103–115.
6. J. Billings, G.M. Anderson, and L.S. Newman, “Recent Findings on Preventable Hospitalizations,” *Health Affairs* 15 (3) (1996): 239–249.
7. J.F. Wharam and D. Sulmasy, “Improving the Quality of Health Care: Who is Responsible for What?” *Journal of the American Medical Association* 301 (2) (2009): 215–217.
8. R.A. Cooper, “Weighing the Evidence for Expanding Physician Supply,” *Annals of Intern Medicine* 141 (9) (2004): 705–714.
9. R.A. Cooper, “Regional Variation and the Affluence-Poverty Nexus,” *Journal of the American Medical Association* 301 (10) (2009; in press).
10. P.A. Braverman, C. Cubbin, S. Egerter, S. Chideya, K.S. Marchi, M. Metzler, and S. Posner, “Socioeconomic Status in Health Research: One Size does not Fit All,” *Journal of the American Medical Association* 294 (22) (2005): 2879–2888.