

If Only It Were That Easy: Response to Rabkin and Cook

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For those following health care reform in the United States, it feels as though we are trapped in the movie “Groundhog Day.” The dilemma is familiar: rising costs that seem out of control, too many people uninsured, and uncertain quality of care. The rhetoric is also familiar, with those favoring reform claiming that we can’t continue to endure the economic burden of rising costs and the moral burden of so many uninsured, while opponents respond that things really aren’t so bad, that all it will take are a few market tweaks to fix what is wrong, and that above all we must avoid more involvement by government.

It is in this context that the proposed health policy reform “Balanced Incentives for Health—BIH*” by Rabkin and Cook should be viewed. Linking costs and quality — but not coverage — with the emerging shortage of U.S. trained primary care physicians, they advocate a new Medicare initiative that would empower primary care doctors to provide comprehensive, cost-effective care to a designated panel of patients by working under a fixed, capitated budget that would provide ample opportunities for cost savings if the budget were underspent, but would not put doctors at financial risk in the event savings did not materialize. Their proposal calls for the program to be phased in and to preserve options for patient choice by making election of the capitation plan optional, but with cost-saving incentives in the nature of reduced co-payments for those who do select it. They estimate that the potential worst-case increased expenditures would be relatively small, but the possible Medicare savings could be large. In addition to offering the prospects of lower costs and better management of chronic disease, the proposal has the added promise of invigorating the troubled field of primary care medicine.¹

A key underlying concept of BIH is the realization that health system reform requires changing the cost-inflating, pro-technology use incentives inherent in the American fee for service physician payment scheme. This long-recognized problem^{2,3} was addressed unsuccessfully by Medicare when it adopted the Resource Based Relative Value Scale (RBRVS) in 1989. But like so many health policy reforms, implementation trumped strategy, the intended recalibrations did not occur, and the income gaps between technology-intensive specialties (e.g., radiology, surgery, cardiology) and non-technology intensive ones (e.g., family medicine, psychiatry, and general internal medicine) continued to expand.⁴

So, why can’t Medicare simply adopt BIH as a reasonable cost containing and quality enhancing reform? The answer is twofold: some of its assumptions are shaky, and it is

unclear what public or private interest groups would support it, beyond those policy wonks who desire to restrain Medicare costs.

A major assumption is that the field of primary care is sufficiently robust to absorb all Medicare enrollees who might be interested in BIH. But the reality today is that few U.S. medical graduates are choosing to go into primary care and that in many locations patients are unable to find a primary care physician whose practice is open to newcomers. Primary care residencies are increasingly filling with international medical graduates, while U. S. students opt for variants on “The ROAD to Happiness,” where ROAD stands for radiology, ophthalmology, anesthesiology, and dermatology. These competitive ROAD specialties share the qualities of high income, comfortable life style, restricted fields that are easier to keep abreast of, and lack of encumbrance of managing patients with chronic illness. By contrast, specialties such as general surgery, primary care, and psychiatry are roads less traveled. Perhaps BIH would still work with a primary care workforce composed of international medical graduates, supplemented by physician assistants and nurse practitioners, but whether BIH could be enacted sufficiently rapidly and attractively to reverse the attitudes of current and potential future primary care physicians is problematic. In addition, the ideal of stable relationships between primary care doctors and patients clashes with the realities of geographic and other coverage discontinuities.

Another issue has to do with the new money that would be funneled into the primary care teams. Although those funds might be recovered with interest down the road, it is likely that in the near term increased expenditures would be required. There are only two ways to generate those new funds — raise general revenues or redirect funds currently spent to pay all physicians. It is not hard to imagine the political difficulties incumbent in either strategy.

Another assumption is that the managed care backlash, which was a big factor in curbing containment efforts in the 1990s, would be dampened by the choice provisions in BIH. That would only be true if patients could opt out of BIH at will, but if the escape valve were too leaky, it would vitiate the cost potential inherent in the model. Over time this could result in adverse selection, with healthier patients opting for BIH and sicker ones opting out. And, in the short run, it is likely that further Medicare cost pressures would limit the ability to subsidize BIH, unless it could quickly be shown to produce desired results. Thus, a promising experiment could be terminated before it had been given a fair chance.

Finally, in a field where policy decisions are largely driven by political interests, it is not clear which would support BIH, beyond primary care physicians, who have heretofore been on the losing end of political tinkering with the fee-for-service reimbursement calculations.⁴ Perhaps business and labor could also advocate for such changes, but their interest to date in Medicare cost containment has been unimpressive. And change comes very hard in a system that consumes one sixth of our economy.

Thus, though I was intrigued by the BIH proposal, I wish the authors had ventured beyond specifying an ideal model and had speculated about implementation strategies. Without such considerations we have a good chance of remaining stuck in Groundhog Day.

* Veteran health policy observers will note that BIH also stands for the Beth Israel Hospital in Boston, which Rabkin so ably led for three decades.

References

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