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REIMBURSEMENT POLICIES FOR PRIMARY HEALTH CARE

Report of a Health Policy Forum
May 24, 1978, St. Louis, Missouri

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Division of Health Manpower
and Resources Development

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Acknowledgments

The St. Louis Forum was the result of efforts by a number of Institute of Medicine staff and members. Major contributions to its conception and planning were made by Stanley B. Jones, Program Development Officer, and Richard M. Scheffler, Director of the Health Manpower and Resources Development Division.

Several Institute members helped develop the Forum agenda and invitation list: Morton D. Miller, Vice Chairman of the Board of The Equitable; Robert M. Ball, Senior Scholar in Residence at the Institute of Medicine; Daniel W. Pettingill, recently retired Vice President of the Group Division, Aetna Life and Casualty Co.; Melvin A. Glasser, Social Security Department Director of the United Auto Workers; and Gerald T. Perkoff, M.D., Director, Division of Health Care Research, Washington University School of Medicine.

Logistical arrangements for the Forum were expertly and graciously handled by Jana Surdi, Project Officer, and Frances Walton, conference secretary, both of the Health Policy Forums Program, Institute of Medicine.

The quality of the Forum discussion is principally attributable to the high caliber of the speakers and participants. Their names are included in this document. It should be noted that the speakers' remarks are their own and not necessarily the official position of the groups they represent nor of the Institute of Medicine.

Sunny G. Yoder,
Research Associate
Forum Coordinator

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REIMBURSEMENT POLICIES FOR PRIMARY HEALTH CARE

Introduction

The Institute of Medicine sponsored a Health Policy Forum* on May 24, 1978, to discuss a series of recommendations on primary care reimbursement policies made in its report, A Manpower Policy for Primary Health Care.** Convinced that the reimbursement policies of public and private third-party payers have a major influence on the availability and quality of primary care services, the steering committee responsible for the report called for some major changes in those policies. (Their recommendations are summarized briefly below). The forum convened a number of experts on health care financing and delivery --public and private insurers, union and industry buyers of health insurance, physicians, and other providers of health services--to examine these recommendations in terms of their ability to effect changes considered desirable by the steering committee and the feasibility of their implementation. The participants also were

*The Health Policy Forums are part of the program of the Institute of Medicine. Sponsored by the W. H. Kellogg Foundation, the Forums are intended to disseminate and stimulate discussion of Institute reports among people who deal with health issues first hand in various sections of the United States.

**Institute of Medicine, A Manpower Policy for Primary Health Care, Washington, D.C., National Academy of Sciences, 1978. An article based on this report, bearing the same title, appears in the New England Journal of Medicine, Volume 298, pp. 1058-1062 (May 11, 1978).

asked to suggest other approaches that might be successful in improving access to primary care services.

Copies of the report were distributed to all participants before the Forum. In addition, papers by two Institute staff members were prepared and distributed in advance.*

Review of Reimbursement Recommendations

At the beginning of the Forum the reimbursement recommendations from the primary care report were reviewed by E. Harvey Estes, M.D., the steering committee chairman, and Richard M. Scheffler, Ph.D., the staff director.** The report recommends that third-party payers reimburse all physicians at the same level for the same primary care services, irrespective of their specialty. In addition, the steering committee suggests--but does not recommend--that specialty differentials in reimbursement levels be limited to services provided by physicians with special skills and only at the request of another physician, usually a primary care physician. The committee believes that assigning "a managerial role to the primary care physician would provide a level of cost and quality control, more clearly separate physicians into primary and referral specialist roles, and provide an operational mechanism for providing reimbursement to all physicians, whether a primary care physician or not, for performing primary care services" (page 49).

The report also recommends that third-party payers should reduce differentials in payment levels between primary care and non-primary care procedures in order to encourage physicians to enter primary care practice and deliver needed services. Believing that comprehensiveness of care, including appropriate health education and preventive services, is essential to providing good primary care, the committee recommends that third party payers

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*Gloria Ruby, "Selected Issues in Public Payment of Primary Care Services," (A staff background paper), May 18, 1978; and Neil Weisfeld, "Legal Considerations in the Reimbursement of Primary Care Practitioners," (A staff background paper), May 1, 1978.

**Chapter 4 of the report contains a full discussion of these recommendations.

institute payments for such services established to be efficacious.

Two of the committee's reimbursement recommendations are designed to encourage physicians to practice primary care in rural underserved areas. First, third party payers should discontinue all geographic differences in reimbursements within a state, thereby eliminating lower fee levels in rural areas as compared with urban areas. Second, payments for the same primary care service, if it is of acceptable quality, should be the same whether that service is provided by a physician, a nurse practitioner, or a physician assistant. Recognizing the difficulty in defining services as "the same," the committee nonetheless believes that services delivered at an acceptable level of quality by nurse practitioners or physician assistants are similar to services delivered by physicians.

Overview of Forum Discussion

The Forum was divided into two sessions, morning and afternoon, each of which had several speakers followed by open discussion. The day's program appears on page 18.

The morning session addressed the question, "How can we get preventive and health education services incorporated into public and private third-party reimbursements?" The group pointed to several areas where progress is needed if preventive services are to be covered by health insurance. First, unions and employers must be persuaded that these services are worthwhile, which will be especially difficult if adding them means higher premium costs. Second, there needs to be persuasive evidence that a proposed preventive benefit is efficacious and effective. Third, health education activities need to be divided into those that can be provided best by individual "tutors" (physicians and other health professionals) and those that can be provided best by schools, employers, and the mass media. Finally, special efforts beyond making coverage available are necessary to promote utilization of preventive benefits.

In the afternoon the discussion turned to the question, "How can we modify third-party reimbursement to increase financial incentives for providing primary care services and to promote the patient management role of primary care physicians?" Insurers pointed out that these objectives go beyond those of today's health insurance

structure and suggested that special strategies would be required to meet these new objectives. Most of the participants endorsed the objectives, although some cautioned against expecting too much from primary care as the solution to all health care problems. Much of the session was devoted to a discussion of the kinds of strategies that might be employed, including fee schedules applicable across specialties, payments for services by physician extenders, health plans organized around primary care physicians, and capitation financing.

Morning Session: Morton D. Miller, Vice Chairman of the Board, The Equitable Life Assurance Society of the United States, Chairman

The primary care steering committee recommended that "third-party payers (federal, state, and private) should institute payments for those necessary services delivered by primary care providers and currently not reimbursed, such as commonly accepted health education and prevention services."* The committee was of the opinion that the lack of coverage for these services tends to limit their availability, even though they are considered generally to be an integral part of comprehensive primary care. They suggested, however, that any preventive benefits be included only when there is scientific evidence of their efficacy and effectiveness. The morning session dealt with a number of practical considerations involved in getting preventive services covered under health insurance.

Laurence B. Huston, Jr., Assistant Vice President, Group Division, Aetna Life and Casualty Company, raised a number of issues faced by private insurers in designing, costing, and marketing preventive benefits. He said that 85 percent of the people insured by Aetna are covered by group policies, in groups ranging in size from two to hundreds of thousands. The scope of benefits varies with the size of the group, with larger groups having more plan design options due to the economics of health insurance. Larger groups also are more likely to have their benefits "designed" through the collective bargaining process, in which the insurer plays the role of consultant rather than decision maker. Millions of people in the

*Institute of Medicine, op cit, page 50.

U.S. have their health insurance benefits determined by the parties at the bargaining table, which is where preventive benefits would have to be determined.

According to Mr. Huston, the principal industry experience in prevention to date has been the annual physical examination, a preventive measure whose efficacy has been questioned widely. A benefit could, however, be designed around preventive/health education services agreed to be efficacious.

Mr. Huston said that marketing preventive benefits is difficult because of the lack of data on the efficacy of preventive services and because most buyers are reluctant to add to their health insurance costs. He said that expenditures for preventive services are predictable and not a catastrophic financial burden for most employed people, the people who are covered under private insurance plans. The most serious barrier to insurance coverage for prevention and health education services is that patients are not sufficiently motivated to use these services. He suggested that better evidence of efficacy and effectiveness, uniform availability of services in all parts of the country, and special measures to encourage utilization by patients, are needed to assist insurers in marketing prevention benefits. In addition, insurance companies need to find ways of reducing the administrative costs associated with processing claims for high volume, low dollar preventive benefits.

The second speaker in this session, James Nuckolls, M.D., a general internist, addressed the issue of reimbursement for prevention from the perspective of a practicing primary care physician. He posed three questions: (1) would primary care practitioners provide more preventive and health education services if those services were reimbursed; (2) would patients feel that they had benefited from such services and (3) would such services reduce disease or misutilization of the health system? In general, his answer to all three questions was "No."

Dr. Nuckolls felt that primary care physicians already do a great deal of teaching about disease and health in the normal course of their practice. Although the availability of reimbursement for these services would allow these physicians to make more money, it was his opinion that paying a doctor as a private "tutor" probably is not the most cost-effective way to make these services more widely available. He suggested two alternative approaches. First, for the general population we might define and disseminate a critical minimum of

information on health and health care that would encourage a better use of health resources. Included could be information on health awareness, the necessity and frequency of periodic health evaluations, the costs of health care and who pays the bill, and what to expect from a doctor visit. A "national concert" of such information organized by third party payers utilizing television, magazines, and other widely read publications, could have a significant influence on how people use the health system. As it is, physicians are faced with patients who say, "I can't leave the hospital, Doc, I still have 30 days on my Medicare." While very much aware of health care costs, most doctors leave the responsibility of limiting these patients' use of health resources to utilization review committees and insurance carriers. General patient education would help, he felt.

Dr. Nuckoll's second suggestion was to use non-physician personnel employed by hospitals to teach patients and their families how to deal with certain chronic diseases such as diabetes, heart disease, hypertension, or any form of terminal illness. "Tutors" such as nurses, pharmacists, social workers, and others could be extremely effective and help make the physician's time more productive.

The success of books such as Take Care of Yourself, and of television programs such as "House Call" in Boston and "Feeling Fine" in Los Angeles indicates people's interest in health and health care. Public education seems to be a better route to prevention than paying the physician to be a private tutor, he concluded.

Avram Yedidia, a consultant on health care organization and financing, told about his experience in setting up a prevention program in the California canning industry. Workers in this industry had a health insurance plan, but both labor and management doubted that it did anything to improve the health of the workers, who tended to seek medical care only in crisis situations, often in the emergency room. During the 1964 contract negotiations labor and management agreed to put one cent per hour into a fund for preventive health care. This agreement was due mainly to the efforts of two men--one on either side of the table--who had been infected with the notion of preventive medicine by Lester Breslow, M.D., when they had worked with him in 1960 on a committee examining health care in California for Governor Edmund G. Brown.

When it came time to set up the program, Mr. Yedidia and the others responsible for it agreed on several

things. They felt it was extemely important to change workers' pattern of seeking medical care only in a time of crisis and to introduce them to orderly medical care. They defined orderly care as a patient seeing a physician early in the course of disease, that the encounter should be scheduled and take place in the physician's office, and that the program should encourage a continuous relationship, in part through stable financing of services. They rejected the notion of an insured benefit for preventive care because the experience of a number of California firms with an annual physical benefit was that utilization was very low.

What emerged from their deliberations was a mobile, multiphasic screening unit that visited the canneries during the 80- to 90-day summer canning season when the number of workers would be as high as 50,000, most of them seasonal employees. The three-van unit could screen up to 300 people per day.

This program is now ten years old. Mr. Yedidia attributed its success to a number of factors. First, all employees, seasonal and permanent, were eligible for the program, and the top management at every cannery provided leadership by their own participation. Second, key people in both labor and management devoted a great deal of effort to securing cooperation of the medical establishment in those counties where plants are located and workers live. Third, they were able to utilize graduate students and others to perform discrete tasks under professional supervision after a short period of training.

Mr. Yedidia concluded that simply making funds available for preventive services is not enough. Neither providers nor insurers have an existing prevention "product" to sell that will assure appropriate utilization, follow-up, and continuity. A successful prevention program requires real commitment by labor and management in order to design a workable plan, to obtain cooperation from physicians, and to bear the cost of disrupted production when screening is done in the workplace.

Discussion. In the ensuing general discussion, pediatricians pointed out that preventive services are central in pediatric practice. Several physicians asserted that insurers have an important role to play in getting preventive services incorporated into health insurance benefits and that they can do more than they have in the past. While generally agreeing, insurance industry spokesmen argued that the cooperation of unions, industry, and

providers is required if there is to be significant change in coverage or financing methods for preventive services.

Private industry spokesmen agreed that unions and employers are crucial because benefit patterns for the entire private sector are established largely through labor negotiations. That this process does not necessarily produce rational results is illustrated by recent negotiations at Ford Motor Company; the fact that the negotiations resulted in new hearing care benefits may be attributed largely to the presence of several hard-of-hearing men on Ford's bargaining team. Labor negotiators must represent the priorities of their constituents. The priority placed on preventive benefits will increase only if unions and employers are persuaded of the importance of preventive services.

A number of participants raised the issue of costs. Employers and unions clearly are reluctant to add benefits that will increase their health insurance costs, even if those benefits are proven to be efficacious. They are even more reluctant to add preventive and health education services, where the evidence for efficaciousness is fragmentary. On the other hand, some participants argued that adding preventive services probably would decrease costs. After some discussion of this point it was agreed that the cost effects of adding preventive benefits are not known at present; they would have to be determined through experience.

Several participants raised doubts that the availability of reimbursement for preventive services would either change the utilization behavior of consumers or significantly improve their health status. One physician spoke of "ambulatory concerned" patients who go to a doctor for reassurance that they are healthy--for a checkup, in other words. These people avail themselves of this service with or without insurance to cover it. On the other hand, some people will not seek medical services unless and until they are quite ill, even if the services are covered. The blue collar worker protecting his "macho" image was given as one example. The need for an organized system of delivering preventive services was reiterated; for example, the schools are a good base for children's screening programs.

Although reimbursement for preventive and education services may have negligible impact on health care consumers, it was thought to have significant effect on providers. Several physicians assured that students' choices of specialty and practice location were affected by

differences in earnings among physicians, and that more of them would choose primary care practice if the remuneration were better. Reimbursements made to nurse practitioners and physician assistants would attract more people into these fields as well.

A number of participants suggested various financing approaches that might be more likely to affect consumer behavior than traditional insurance benefits. Capitation payments and health maintenance organizations were suggested as having received too little emphasis in the primary care report. Another approach suggested was rebates on health insurance premiums to people with healthy lifestyles--nonsmokers, for example. It was pointed out that with experience rating there would be no savings to return to such participants, but that it might be possible to rate differentially certain sub-groups of a larger group. Finally it was suggested that insurers could give their policyholders coupons redeemable for specified prevention services considered desirable (efficacious, cost-effective). This financing mechanism, which has seen great success in the food industry, might be more effective in getting consumers to utilize preventive services.

It was generally agreed that practicing physicians, employers, unions, insurers, and consumers were all in need of better information about what preventive services are worth providing, reimbursing, and utilizing. Third-party payers were seen as having a special responsibility to help unions and employers make the wisest use of their premium dollar and to educate the public, with physicians and other health experts providing the technical information needed to make informed decisions.

Afternoon Session: Robert M. Ball, Senior Scholar in Residence, Institute of Medicine, Chairman

Mr. Ball opened the afternoon session with a summary of the perceived problems and recommended policies contained in the primary care report. First he pointed out a basic assumption of those responsible for the report, that money has a significant effect on the extent to which people choose to enter primary care, stay in primary care, and the distribution of primary care physicians geographically.

He noted that the steering committee perceived three problems with the supply and distribution of primary care manpower: (1) there are too few primary care physicians

compared with physicians in other specialties; (2) there is inadequate geographic coverage by primary care physicians in rural and other underserved areas; and (3) current reimbursement practices discourage an active role by non-physician providers of primary care, particularly the nurse practitioner and physician assistant. He briefly summarized the recommendations from the primary care report including, first, an abandonment of geographic fee differentials within a state; second, payment of the same fee for the same service to any physician providing that service; third, reducing the differences in reimbursement for primary care services as compared with other medical services; and fourth, reimbursing the same amount for a primary care service regardless of whether that service is provided by a physician or a non-physician.

Although it was not a recommendation, the committee suggested that a specialist's fee should be paid only in cases where two tests are met: the specialist should be identified as someone with a special skill, and there should be a referral from a primary care physician. This "management" role of the primary care physician received a great deal of discussion during the session.

The first speaker, Lawrence Morris, Senior Vice President for Professional Affairs of the Blue Cross-Blue Shield Association, suggested that private health insurance has worked quite well in meeting its original objective, relieving individuals of the financial burden resulting from large medical care costs. However, if we now want to use the reimbursement system to promote primary care, including preventive and educational services, and the management role by primary care physicians, traditional insurance models will not be very helpful. Although prevention benefits can be incorporated into major medical coverage, the cost sharing* that typically characterizes this type of coverage does not promote utilization. A different set of problems arises if benefits are included in basic coverage. The fixed administrative costs are an unacceptably high proportion of benefit costs, which tend to be low for these services. In addition it is difficult to control utilization of health education services. The insurer may be exposed to the costs of patients who doctor shop or physicians

*Cost sharing refers to the practice of having beneficiaries pay part of the cost of their medical care in the form of co-payments or deductibles.

who fill unused office time talking to patients.

Mr. Morris suggested that the new objectives recommended in the Institute report would require new strategies by third party payers. In his opinion, the basic goal should be to promote "management"--rational, cost-conscious, and coordinated use of medical care in general, not only of primary care.

Bringing management into health care requires acceptance by patients and physicians first of all. Second, it requires that alternatives be available to the physician through expanded coverage. Third, the managers must have information with which to know and evaluate the results of their decisions. Finally, there must be an incentive system which makes both the rewards of success and the risks of failure tangible.

In order to design coverage around these requirements, Mr. Morris said that insurance carriers have to make a number of responses: they must package the primary care and the management role and be willing to cover both; they must limit patients to a single entry point or install an effective utilization review program to prevent abuse; they must develop an efficient system to pay for care, incorporating acceptable administrative costs and reasonable incentives for controlling benefit costs. The payment system may be different for primary care than for referred care, and it does not have to be the same system that gathers and reports data. Such coverage design establishes the primary care physician as a manager and as a purchaser of services on his patients' behalf. It provides the physician with both the incentive and the means to buy conservatively and selectively.

Mr. Morris described a currently operating health plan that fits these principles, the Health Maintenance Program of the Madison, Wisconsin Blue Shield. Its success is indicated by the fact that it has 140,000 subscribers, 1,700 participating physicians, and that it has inspired a number of similar programs since it began 6 years ago. Over 85 percent of people offered this plan accept it; perhaps even more revealing, the re-enrollment rate is nearly 100 percent.

Under the Health Maintenance Program the primary care physician is paid on a capitation basis for providing defined primary care services including physical exams, office care, and in-hospital care. Each primary care physician receives a single monthly check in an amount equal to the agreed-upon capitation rate multiplied by the number of enrolled persons who have selected him or

her to provide and manage their primary care. This physician selection/capitation financing feature means that the physician and patient have a commitment to each other. Only care provided by a patient's own primary care physician or on that physician's referral is covered under this plan, with emergency services constituting the only exception. Referral services are paid by fee-for-service, which is probably the most efficient method of payment for these low volume, higher cost services. Because the primary care physician is provided cost and utilization information on these referral services, he or she is in a position to evaluate their cost, process, and outcome.

The financing arrangements also provide incentive for the primary care physician to be concerned with costs and utilization. For groups of primary care physicians, accounts are set up against which are charged all professional and hospital services. Any balance remaining in the account at the end of the year is divided among the physicians and those who paid the premiums, usually employers. Periodically each physician in the group receives a report of his or her own experience. The physicians also receive the high, low, and median utilization profiles of their group, to which they can compare themselves. The groups are encouraged to review their practice patterns through discussions, something too infrequently done by primary care physicians.

Clearly, said Mr. Morris, this plan would not be universally acceptable. The two major hurdles to its acceptance are capitation financing for primary care and the restriction on patient entry. While neither is necessary for a successful primary care management system, capitation financing has advantages for physicians in that they receive payment more quickly than under fee-for-service and also experience a reduction in overhead costs by not having to submit a claim for every service. For physicians who do not find these advantages sufficiently attractive, the sight draft--by which the physician pays himself and submits data in a single process--is one alternative. Mr. Morris expressed the belief that eliminating entry restrictions would seriously weaken this kind of program, although an appropriate utilization review system could compensate for this weakness. He concluded that health plans like the Health Maintenance Program would promote preventive and primary care while supporting an effective management role for the primary care physician.

The session's second speaker, George Schieber, Ph.D., a senior economist with the Health Care Financing Administration (HCFA), described current thinking and activities regarding physician reimbursement in that agency. Medicare and Medicaid, the two programs for which HCFA is responsible, account for approximately 20 percent of total expenditures for physician services in the United States, he reported. The current HCFA administrator is on record as opposing the way these programs pay for physicians' services, particularly the "usual, customary, and reasonable" (UCR) method. Adopted at the inception of Medicare in 1965, UCR reflects long standing practice in the private health insurance industry, where physicians are paid on the basis of historical prevailing fees in a community. UCR is criticized as inflationary. It is also pointed to as contributing to undesirable differences in fees paid to physicians in different specialties and geographic locations and to overutilization of high technology medicine.

The Health Care Financing Administration. according to Dr. Schieber, is considering changing its method of paying physicians to statewide fee schedules, with uniform procedure codes across all specialties. Its ability to influence the system is limited due to several factors. First, accounting for only 20 percent of the total, its physician reimbursement policies cannot dominate. Second, paying physicians involves dealing with 350,000 people whose responses to different payment methods presently are not well understood. Third, about 30 percent of physicians do not accept the fees allowed by Medicare as payment in full for their services, while 32 percent of physicians do not treat Medicaid patients at all. In spite of these limitations, HCFA is continuing to explore physician reimbursement alternatives, including incentives for physicians to accept assignment and to treat Medicaid patients, concluded Dr. Schieber.

The remaining three speakers in the afternoon session gave brief comments on the use of financial incentives for promoting primary care and some specific reactions to the IOM report.

Jacob Hurwitz, Senior Health Care Consultant, United Auto Workers, said that although it was rare for him to do so, he had to agree with third-party payers that they are not solely responsible for changing the reimbursement system. From his perspective, opportunities to give primary care a starring role in the health care system are limited. Although the Madison, Wisconsin plan

described by Mr. Morris is very interesting, major unions need programs that can provide equal benefits to their members across many states. He suggested that opportunities for effective implementation of primary care programs are greater in the public sector than in the private sector.

Mr. Hurwitz echoed the concern for costs expressed in the previous session, suggesting that the health care industry can and will absorb any level of resources that we allow, and questioning whether increased spending for primary care would provide sufficient benefits to consumers. He concluded by asking if expanding primary care reimbursement under the fee-for-service system is wise.

Richard S. Wilbur, M.D., Executive Vice President of the Council of Medical Specialty Societies, discussed the historical developments that led to the need for a report on primary care, particularly the post-war enchantment with biomedical research that all but eliminated the family physician role model from medical schools. The trend toward specialization and the rapid development of medical technology has shifted only recently, he said, and again we may be overdoing a good thing.

Dr. Wilbur had a number of criticisms of the Institute of Medicine report. He felt the recommendations that primary care physicians, nurse practitioners, and physician assistants be paid at the same level as specialists might not result in lower costs and that the quality of care might suffer. He objected to the recommended statewide fee schedules, arguing that practice costs are higher in inner cities and that equal fees would both hasten the departure of physicians from these areas and institutionalize "Medicaid mills." While endorsing the concept of "paying more for thinking about, communicating with, and caring about the patient in comparison with doing something to the patient," and also the concept that patients and their families should have a health care advocate in the form of a family physician, he took issue with what he took to be the report's implication that primary care is "cheap" and that it can be equally well provided by a nurse practitioner or physician assistant as by a primary care physician. He feared that the report could have the effect of perpetuating the misconception that a family physician does not have to be very bright or skilled, deterring the best medical students from selecting primary care careers. On the contrary, he stated, "It is hard to be a good primary care physician. It demands a wide multiplicity of skills and knowledge

which are increasing in complexity." In his opinion the report should have placed greater emphasis on this complexity along with the idea that primary care skills should receive a higher level of recompense.

Finally, Dr. Wilbur took issue with a "gatekeeper" role for primary care physicians. He felt that many patients prefer to be allowed to select their own specialist. He also questioned the wisdom of a financing scheme which offers financial rewards to the primary care physician who does not make referrals, arguing that such a scheme offers the physician a financial incentive to attempt unfamiliar procedures.

The final speaker in the session was Willis B. Goldbeck, Director of the Washington Business Group on Health, which represents some 150 business firms that collectively provide health benefits for approximately 35 million persons. He offered some comments on the Institute report, the role of private industry in health, and concluded with his perceptions of the context in which these discussions are taking place.

On the report, he stated unequivocally that business is in full agreement with its emphasis on primary care and the family physician. He endorsed the underlying assumption that changing the financial incentives of the reimbursement system is the key to changes in health care. On specific recommendations, Mr. Goldbeck saw no problem with the concept of fee schedules, but termed it "inconceivable" that New York City and upstate New York should have the same fee schedule. Mr. Goldbeck agreed with the recommendation of equal payments for work performed by non-physician providers, but called it imperative that leveling of fees be downward, not upward. (He did not see how it would be possible to lower the fees of non-primary care physicians to the primary care level, but expressed the hope that IOM would tackle that problem in a future report.) He suggested that the federal government, as the largest purchaser of health care and a major provider of that care, would have to make special efforts to foster the development of primary care.

According to Mr. Goldbeck, although industry traditionally has not been involved in shaping health care, its attention has been "grabbed" by the sharp rise in costs since the removal of Economic Stabilization Program controls in 1974. This awakened interest, which also can be associated with changing societal views on company paternalism, has brought about a number of actions such as changes in health benefit design and shifting financial

incentives toward ambulatory care. Industry has become an active, demanding purchaser of health care, increasingly asking if it is receiving the best health return for the dollars spent. Some firms even have become their own providers, employing physicians to provide care to their employees and their dependents.

Labor and industry are largely in agreement in their perceptions of limited resources for health, of a health care system which contains a great deal of waste, and of the importance of individual behavior in determining health. He concluded by calling for a commitment to primary care and to health education, asking if we can afford not to make that commitment.

Discussion. The general discussion raised the point that plans like the Madison Health Maintenance Program can be less costly than traditional insurance and are worth offering as an option even though not all people will choose them. It was also noted that in the course of the afternoon, the term "management" had been used by different people to mean management of a system, management of an institution, or management of an individual patient. This lack of a consistent definition may have led to misunderstanding. All three kinds of management are needed for good medical care.

Several people expressed skepticism about the impact of the recommended policies. It was suggested that changing the criteria for selecting medical students and changing the setting for their clinical training would have more effect on their career choices than changing reimbursements. Third-party payers were concerned that physicians would not accept fee schedules; indeed, some of the physicians present indicated they would not. Finally, several speakers cautioned against promoting primary care as the answer to health care problems. They argued that there is no single answer, and that a great deal of creative thinking and hard work are required to effect desirable changes in health care.

Conclusions

Stanley B. Jones, Program Development Officer of the Institute, closed the day's discussions by thanking the participants for providing an excellent list of issues worth further consideration:

--What is the best means of providing health education? When is it best to work through institutions (such as schools) and when should we pay the physician to act as a "private tutor"?

--Costs and tradeoffs: are the recommendations a cost add-on, and if so, what are we willing to trade for primary care?

--What are we actually buying when we buy primary care: reassurance for patients? improvements in morbidity and mortality? cost savings by forestalling more serious illnesses in the future?

He pointed out the need for designing new approaches (such as Mr. Yedidia's mobile clinics for prevention programs); for better information on how to change the behavior of consumers, providers, and third-party payers; and for overcoming the communication problems stemming from the different vocabularies and perspectives of these groups.

Mr. Jones stated the Institute's intention to work further on these problems and invited the conference participants to contact him if they wished to volunteer or to offer further ideas.

INSTITUTE OF MEDICINE
HEALTH POLICY FORUM

"Reimbursement Policies for Primary Health Care"

May 24, 1978
St. Louis, Missouri

9:00 a.m.	Coffee available in meeting room (Lincoln Room, Ramada Inn)
9:30	Welcoming remarks Stanley B. Jones, Program Development Officer, Institute of Medicine
9:45	Highlights of Institute of Medicine report, "A Manpower Policy for Primary Health Care" E. Harvey Estes, Jr., M.D., steering committee chairman Richard M. Scheffler, Ph.D., staff director
10:15	HOW CAN WE GET PREVENTIVE AND HEALTH EDUCATION SERVICES INCORPORATED INTO PUBLIC AND PRIVATE THIRD-PARTY REIMBURSEMENT? Chairman: Morton D. Miller, Vice Chairman of the Board, The Equitable Life Assurance Society of the United States
	WOULD THE AVAILABILITY OF THIRD-PARTY PAYMENTS MAKE A DIFFERENCE? James G. Nuckolls, M.D.
	DESIGNING, COSTING, AND MARKETING PREVENTIVE/HEALTH EDUCATION BENEFITS Laurence B. Huston, Jr., Assistant Vice President, Group Division, Aetna Life and Casualty Company
	CONSUMER DEMAND: EXPERIENCE OF A CALIFORNIA INDUSTRY Avram Yedidia, Consultant, Organization and Financing of Health Services
11:00	General discussion

12:30 p.m. Lunch (served in meeting room)

1:15 HOW CAN WE MODIFY THIRD-PARTY REIMBURSEMENTS TO INCREASE FINANCIAL INCENTIVES FOR PROVIDING PRIMARY CARE SERVICES AND TO PROMOTE THE PATIENT MANAGEMENT ROLE OF PRIMARY CARE PHYSICIANS?

Chairman: Robert M. Ball, Senior Scholar, Institute of Medicine

OPPORTUNITIES FOR CHANGE IN THE PRIVATE SECTOR

Lawrence Morris, Senior Vice President for Professional Affairs, Blue Shield

OPPORTUNITIES FOR CHANGE IN THE PUBLIC SECTOR

George Schieber, Ph.D., Senior Economist, Office of Policy Analysis, Health Care Financing Administration, DHEW

Discussants:

Jacob Hurwitz, Senior Health Care Consultant, United Auto Workers

Richard S. Wilbur, M.D., Executive Vice President, Council of Medical Specialty Societies

Willis B. Goldbeck, Director, Washington Business Group on Health

2:30 Break

2:40 Discussion among session speakers

3:00 General discussion

4:15 Closing remarks by Mr. Jones

4:30 Adjournment

INSTITUTE OF MEDICINE
HEALTH POLICY FORUM

"Reimbursement Policies for Primary Health Care"

May 24, 1978
St. Louis, Missouri

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