Population-based funding: A better primary care option?

The experience of practices using a capitated funding model suggests there are many benefits.

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There is a growing suspicion among the citizens of BC that the current system of health care delivery is largely unsustainable under current conditions. This suspicion is well founded, as evidenced by numerous statistics that point to a looming crisis in the not-too-distant future. It may even be upon us already, if daily rounds at the hospital are anything to go by. The BCMA and Ministry of Health, to their credit, have moved to address the crisis by implementing numerous initiatives through the General Practice Services Committee (GPSC) to stem the decline of family practice and facilitate the provision of longitudinal care.

However, one initiative that is receiving little attention may point the way toward a more sustainable health care system, in particular in the primary care area. This initiative integrates many of the current GPSC initiatives, especially as they pertain to the management of patients with complex conditions. I refer to the decade-old "blended funding model" as it exists in a number of family practices in Langley. Although these practices represent only 20 physicians, approximately, and about 35 000 patients, they are engaged in a unique initiative, namely involvement in a type of practice that is funded largely based on the illness burden of their patients and not on the reimbursement of individual services rendered to those patients. This model is often referred to as population-based funding or capitated funding, and represents a significant change in the traditional reimbursement model for primary care physicians in this province.

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While the mechanisms and operating costs of this model of care are more complex than traditional fee-for-service arrangements, one could argue that the overall costs to the system are significantly reduced. As Kaplan and Porter[1] argue in a recent *Harvard Business Review* article, health-care costs should be measured for the full cycle of care needed to treat individual patients with specific conditions, and cannot be considered as a simple aggregate of different services. A model that aligns funding with clinical outcomes, as this model does, can potentially reduce the cost to the system for individual patients and for specific groups of patients. For example, if a practice (defined here as a group of providers who share in the management of a patient's care) is reimbursed based on the average provincial expenditure for that patient's illness burden, an incentive is created to reduce the expenditures incurred at the practice level, and increase the operating margin for the practice. The illness burden is fairly easy to determine using a model pioneered at Johns Hopkins,[2] whereby patients are categorized according to adjusted clinic groupings (ACGs). Funding is then allocated to practices based on the average provincial expenditure for each ACG. The net effect of such a shift in funding orientation at the primary care level can produce significant benefits:

- Older, sicker patients with complex conditions carry more funding, and from a business perspective can be seen as financial assets to the practice.
- Care can be rendered on a non-visit basis, without the usual reimbursement issues.
- Care can be provided by nonphysicians, as they are effectively employees of the funded practice.

Practices operating in this way are financially incentivized to:

- Optimize care.
- Prevent unnecessary visits.
- Streamline referrals.
- Minimize admissions to hospital.

Failure to optimize care results in higher resource utilization for the practice (more office visits, increased staff time, etc). For example, inade-

quate management of a patient with poorly controlled diabetes can result in many office visits, eventual admission to hospital requiring daily visits, and numerous follow-up visits after discharge. Under the fee-for-service system there is no alignment of reimbursement with the quality of care. Under the ACG model, the funding is fixed, and the practice and clinicians are motivated to prevent hospital admission and excess visits—a fundamental realignment of motivation.

While a rigorous study to measure and clarify the presumed benefits and savings has not been done, the fact that many practices are already operating under this system and their experiences suggest that such a system does in fact produce changes in practice and clinician behavior:

- These practices operate as health care teams, with numerous practice-funded ancillary providers, such as LPNs, RNs, and NPs.
- These practices have patient rosters far in excess of the average, suggesting increased capacity is possible with this model.
- All practices have embraced electronic medical records as necessary aids to the team-based care they provide.
- Hospital admission rates are significantly reduced for patients of these practices.
- All practices remain actively engaged in their local community hospital, with clinicians retaining admitting privileges.
- Patient acceptance and satisfaction is high.
- Physician satisfaction is high, with significant interest in the model among new family practice graduates.
- Attachment rates (patients receiving the majority of care) for these practices are extremely high (85% to 90%) compared with fee-for-service practices, which typically exhibit fragmented care and rates of 45% to 55%.

Given the above observations, and the fiscal imperative to manage our health care system optimally, a detailed cost-benefit analysis of the population-based funding model of primary care is critically important.

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bound to defer to the relevant professional bodies to reach an opinion as to whether the care provided met appropriate standards. For example, a patient who felt that being prescribed a homeopathic remedy by a "professional" was poor care, would not be able to have their case heard by the court and have a scientific standard applied. Rather the court would allow the professional college to make the determination about whether the treatment given was appropriate.

Such a situation could, as the saying goes, put the fox in charge of the hen house and thwart the expectation that the best evidence and marriage of science and reason would be brought to bear for the benefit of the public.

Examples like these raise the spectre that logic and science are fragile gifts that, despite their beneficence, can easily be sidelined or lost. Hopefully, progress will continue. The gains made so far are sufficiently obvious, and the social and legal safeguards too important, to allow the course of reason in public policy to be trumped by politics and profit.

—Lloyd Oppel, MD
Chair, Allied Health Practices Committee

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