than an abstract public health goal. Demonstrating a willingness to listen respectfully, encouraging questions, and acknowledging parental concerns are essential elements of this strategy. Providing accurate information about both risks and benefits is crucial to maintaining trust; interactions should include discussion of risks associated with both remaining unvaccinated and delaying certain vaccines and a reminder that vaccinations are important in part because effective treatments do not exist for most vaccine-preventable diseases.

Effective communication requires understanding parents’ reasons for resisting vaccination. Physicians should approach such reluctance as they would any diagnostic challenge. “Diagnosing” the reasons for hesitancy will permit a more effective discussion and approach. Parents concerned about the number of shots at a given visit or the side effects of a single vaccine require a different strategy from parents who believe vaccines weaken the immune system, cause autism, or contain mercury. The Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians recently produced resources to assist clinicians in identifying communication strategies, enhancing trust, and providing reliable information (www.cdc.gov/vaccines/conversations).

Even with optimal communication strategies, some parents will remain hesitant to vaccinate their children. Maintaining the patient–provider relationship despite disagreement conveys respect, builds trust, and affords additional opportunities to discuss immunization. Asking parents who refuse to vaccinate their children to seek medical care elsewhere is counterproductive: it rarely gets a child vaccinated, it undermines trust, and it eliminates opportunities for continued dialogue about vaccination.

Finally, clinicians must set an example. We’re unlikely to achieve optimal vaccination rates until health care professionals comply with vaccine recommendations for themselves and their children. The unwillingness of many clinicians to submit to influenza vaccination each year is disgraceful, sets a poor example, and gives patients reason to question the safety and efficacy of vaccines. A logical place to begin increasing public confidence in vaccines is with the example we set.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Keeping Score under a Global Payment System

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It is widely acknowledged that continued growth in health care spending is threatening the viability of the U.S. health care system. Although there are no clear comprehensive solutions to this problem, most observers see payment reform as the next best hope for reining in out-of-control costs. Our current fee-for-service payment system provides incentives to physicians to increase the delivery of services, which results in excessive utilization. Moreover, neither individual physicians nor the patients receiving the services bear the brunt of these utilization decisions. Rather, they’re reflected in ever-rising health insurance premiums or tax-financed government expenditures shared by all. Many observers are therefore calling for fundamental redesign of the ways in which physicians and hospitals are compensated for the care they provide. Most options call for bundling payments to physicians; specific approaches range from prospective payments for discrete episodes of care (e.g., coronary-artery bypass surgery) to global payment or risk-based models of care.

Global prospective payments became prevalent during the heyday of managed care in the 1990s. Such so-called capitation payments were common in many markets, whereas in others physician organizations were actively preparing themselves for a coming tide of capitation that never materialized. In a fast-growing economy, both patients and physicians bridled at the restrictions of choice and ac-
cess associated with such payment arrangements, and capitation quickly fell out of favor. In addition, the information systems and infrastructure necessary to successfully manage risk under global payments were underdeveloped during that period. After a lull of more than a decade, however, global payment is again seen as the potential savior of the health care system.

Among the most important anticipated experiments in global payments are accountable care organizations (ACOs), which were included as part of the Affordable Care Act and are also being developed under the auspices of the Center for Medicare and Medicaid Innovation. ACOs represent a hybrid of our fee-for-service system and true capitation. The ACO regulations, proposed by the Obama administration last March and finalized in October, call for two models of shared savings. In the first model, health care organizations would be eligible to share in savings but would bear no risk for losses for the first 2 years. Under this program, ACOs would be eligible for approximately 50% of the savings accrued by the Medicare program after they surpassed a fixed savings threshold. In the second model, there is both upside and downside risk sharing for participating health care organizations from the start. Because these organizations are taking on risk for losses, they would also be eligible for a larger percentage of shared savings. This latter version of ACOs most closely approximates true capitation. These proposed ACOs are similar to arrangements already present in the commercial sector, such as the Alternative Quality Contract rolled out by Blue Cross Blue Shield of Massachusetts in 2009.1,2

Conceptually, global payment represents an important opportunity for changing the perverse incentives inherent in our current fee-for-service system. To be successful, however, ACOs must pass these incentives along to their member physicians, who continue to be responsible for most utilization decisions. Although organizations can implement various managerial strategies to influence physicians’ decision making (e.g., radiology decision support and prior authorization), ACOs are unlikely to reduce the rate of increase in health care spending without some essential changes in the behavior of member physicians — and therein lies the rub. The fundamental questions become how ACOs will choose to divide their global budgets and how their physicians and other service providers will be reimbursed. Thus, this system for determining who has earned what portion of payments — keeping score — is likely to be crucially important to the success of these new models of care.

Under ACOs and many commercial global payment products, providers will continue to receive traditional fee-for-service payments, and hospitals will receive their usual contracted payments, through either the diagnosis-related-group (DRG) system or per diem payments. All spending for each patient that is attributed to the ACO will then be tracked and compared with the calculated budget retrospectively at the end of the performance year in order to calculate savings or losses. Thus, standard fee-for-service payments remain the de facto method for keeping score, which works against the very design of the program. The inequities of the fee-for-service system, which reward proceduralists and specialists at the expense of cognitive specialties and primary care, remain embedded in the payment system. Although organizations can receive surplus payments, additional revenue from any surpluses will not flow into organizations until at least 18 months after the program begins.

As global payment systems are currently designed, primary care physicians stand to be among the big winners. However, to earn rewards, they will also have to shoulder the largest burden of the work needed to succeed under risk-sharing arrangements.3 In a well-functioning health care system, primary care physicians are the point of access, are responsible for care coordination and management, have perspective on the whole patient, and have the ability to manage the care of a patient population. Moreover, most quality incentives being incorporated into the payment systems for ACOs and other new global payment contracts also fall under the purview of primary care. To accomplish the care-management and quality goals, however, primary care physicians will need substantially more resources — for hiring care managers and other personnel to pursue population health management, for coordinating and managing care, and for implementing processes to ensure adherence with quality measures.

Although many ACOs will direct future surpluses to primary care, infrastructure payments to facilitate the development of the care-management functions noted above have not been built into the design of the ACO program or many new versions of capitation. Since most of these organizations will continue to rely on fee-for-service payments for the purpose of keeping score, making funds available to invest in...
this infrastructure would require a transfer of funds from specialists or hospitals to primary care, and it may be difficult for organizations to unilaterally alter the flow of funds to accomplish these aims. Moreover, although organizations may face strong incentives to control costs, specialist physicians who continue to be paid through the fee-for-service system and hospitals, which continue to receive DRG-based payments, face no such inherent incentives — and in fact will continue to benefit from practicing in much the same way as they do now.

Over time, if global payments become the norm, there is likely to be a resurgence of subcapitation and budgets for particular specialties, and systems will be designed to provide similar incentives to specialists while also enhancing funding for primary care. In addition, ACOs and their aligned hospitals must share incentives to control hospital costs. This transition, however, is likely to be painful and prolonged under the current design of the programs. Certainly, adjustments to the fee schedule that limit specialist pay and divert funds to primary care will be helpful, but even more helpful would be upfront payments that organizations can use to invest in their care-management and primary care infrastructure to facilitate this transition without taking funds from specialists or hospitals, at least until they achieve surpluses that ensure the continuation of this funding stream. Tightly managed multispecialty or primary care groups without strong alignment with a hospital may be well positioned to manage this transition.

The health care system is placing tremendous hope in changing incentives to control the ever-increasing costs of care. Hybrid approaches such as ACOs that incorporate global incentives but continue to keep score using fee-for-service payments will face serious challenges as they attempt to place increasing burdens on the already-stressed primary care system without providing additional resources for achieving the aims of global payments — slowed growth in costs and higher-quality care.

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Opportunity in Austerity — A Common Agenda for Medicine and Public Health

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Faced with the growing pressure to reduce the federal budget deficit, government leaders have increasingly turned their attention to reducing health expenditures. In this atmosphere of austerity, public health programs are likely to be hit particularly hard as they compete for funds against the health care delivery juggernaut and as state and local governments, which carry out the bulk of public health activities, are forced to make further cuts.

The political vulnerability of public health financing was clearly illustrated in 2011 by Congress’s attempt to repeal the Prevention and Public Health Fund created by the Affordable Care Act (ACA), with House Republicans labeling it a $15 billion “slush fund.” The Obama administration, though initially threatened to veto a repeal bill, ultimately mounted a more tepid defense, proposing to cut $3.5 billion from the fund as part of the President’s deficit-reduction plan. Many public health leaders believe this move is shortsighted and will hamper efforts to improve population health and reduce medical spending.

Taking a longer view, disease-prevention advocates assert that skyrocketing health care costs must not crowd out investments in public health; they point to what should be common goals in both fields and an arguably disproportionate allocation of resources to the health care delivery system. Indeed, whereas inadequate medical care accounts for 10% of premature deaths in the United States, behavioral patterns, social circumstances, and environmental exposures have a far greater effect, accounting for roughly 60% of deaths.1 Yet de-