You don’t go into family medicine for the money, so when I received my salary letter from last year letting me know that my salary went down, I didn’t think much of it. But when it went down again this year, I started to get a little nervous as I prepare to send 2 kids to college. I felt like I was working as hard as ever, so I made an appointment with our chief financial officer, to understand this trend.

We printed out the previous 5 years of salary spreadsheet and realized that although my clinical productivity had gone up, our department’s number of admissions to the hospital went down significantly, which was the main source of the decrease in salary. I was initially proud of my colleagues for doing such a good job keeping their patients healthy and reducing the need for expensive hospitalizations. And then my pride turned to anger at a health care system that reduces payment for helping keep patients well.

If you take time to think about our health care system, you realize that it is not based on health at all. What drives our whole system is payment. We have a payment-based model that rewards treating disease and the technology and procedures that try to fix it. My employer bills more than $500 for me to remove an ingrown toenail while billing a fraction of that amount for me to care for a complex human who has hypertension, diabetes, social isolation, and depression. What we incentivize matters, and it drives the focus of everyone’s energy. We need to ask what we need most in health care delivery so we need less expensive acute and catastrophic care. If we incentivize disease care, we will attract more disease doctors. If we incentivize health, we will attract more doctors into primary care.

The challenge lies in primary care’s dependence on profits gained from hospital-based disease care, which are used to subsidize primary care and the training of primary care clinicians. The payment is so lopsided toward disease that we have little incentive to invest in health because if we do, the institutions that help pay our salaries will lose money. This drives the disease-focused system that prevents us from investing in what matters most—which is to keep people well so they do not need the acute and catastrophic hospital-based care that helps pay the bills.

We need expertise in both disease and health, but currently our payment system is weighted almost 9 to 1 toward disease. As we approach the 100-year anniversary of the Flexner Report, which shifted our health care system toward a scientific model that stressed the exploration of disease, we have an opportunity to create another shift. To create a sustainable, efficient, and cost-effective health care delivery model, we need to pay for the development of outpatient community-based interdisciplinary teams. Teams that work together and get paid for creating health for the communities we serve. This cannot be done without a strong primary care foundation.

I will still be able to send my kids to college, but what matters most is that payment directs the type of care that influences our patient’s health. If we do not put a higher importance on health, and incentivize it, our patients will be subject to care that tries to fix an irreversible process that often causes harm and is not economically sustainable.

We need to not only rethink medicine, but we need to rethink the type of medicine we do.

Winston Churchill said, “You can count on Americans to do the right thing, when they have exhausted all other options.” We are at that point. Luckily, we have leaders within the University of Wisconsin system that understand this need. Jeff Grossman, MD, outlined this well in his recent article in the Wisconsin Medical Journal. The combination of leadership insight, an economic recession, and a non-sustainable model of health care provide a “perfect storm” for innovative change.

Imagine a payment system that rewarded health as much as disease. You get what you pay for.

References

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Show health the money

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