PATIENT SAFETY BLOG

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Minding the Gap in Doctors' Fees between Primary Care and Specialties

By Patrick A. Malone

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It's a widely, if grumpily, accepted fact that primary care physicians spend less time with patients than either would like. There are only so many minutes in the day, and there's always more paperwork than time to address it.

No medical practitioner is more overburdened than a primary care physician, because in many health plans, he or she is the so-called "gatekeeper" to specialized care. Patients must see one in order to warrant a referral to someone else – a dermatologist, a cardiologist, a psychiatrist, a surgeon.

So no wonder that the American Medical Association recently asked the Centers for Medicare & Medicaid Services (CMS) to reimburse network physicians in fee-for-services health plans for phone calls, counseling and other efforts they expend to coordinate care for chronically ill patients.

No question that the labyrinthian nature of the U.S. health-care system demands much of people obliged to navigate it on behalf of others, and these professionals deserve to be compensated, according to independent health-care journalist Merrill Goozner.

But with shrinking coverage, strained budgets and the inexorable increase in the cost of health care, how will these merit pay raises be funded? How about, Goozner suggests, by the medical establishment reassessing and realigning its priorities? How about by embracing a rational sense of proportion?

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There's an ocean of difference in what providers are paid. Specialists often receive two or three times the fees paid to a primary care doc. Goozner says it's difficult to justify that the "relative value" of back surgery or angioplasty is so much more than other kinds of treatment involved in gate-keeping. These two specialties, he says, are exemplary of "the most expensive and overused procedures in medicine, incentivized by the extraordinarily high fees earned by the surgeons who do them."

Whether or not you agree with the politically driven Congressional mandate that any new spending must be offset by federal budget cuts – known as the "pay-for" rule – maybe Medicare should adopt the same policy. If Congressional Republicans find it acceptable to charge emergency flood relief with a pay-for, if President Obama is OK with sending the bill for his jobs package to the nation's millionaires, maybe medicine should cover the coordination of care pay-for with a reduction in the inflated fees for specialist care.

"Congress needs to come up with nearly $300 billion over the next decade simply to hold physician salaries where they are," Goozner writes. "The permanent fix would set a cap for total physician pay; and allow it to rise over time for inflation. But why not require that CMS adjust payments to the various specialties to meet that cap? Otherwise, in a few years we'll be right back where we are today: a permanent fix that wasn't permanent at all, with new services inflating the total tab beyond the cap."

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