British Petroleum and Pay-for-Performance in Primary Care

The last government employee to inspect the Deepwater Horizon oil rig before it exploded on April 20, 2010, was Eric Neal, an inspector with the U.S. Minerals Management Service (MMS); he was still in training as a drilling inspector.1 Despite checking well pressures 20 days prior to the catastrophic oil spill, he admitted under testimony on May 11, 2010, that he didn’t collect some of the key data that could have assisted investigators after the fact to determine why safety systems failed.

Notwithstanding the fact that the majority of the actors responsible for the spill work for British Petroleum (BP) and the MMS, many Americans are blaming U.S. President Barack Obama for the fiasco. A CBS news survey published May 14, 2010, showed that 87% of Americans thought President Obama was not doing enough to contain and clean up the spill.2 Whether one is an Obama fan or not, who can honestly declare that he is significantly responsible for the debacle? He has no personal experience with deep sea oil exploration, did not personally hire and train Eric Neal, nor did he approve of BP taking safety shortcuts. And yet… he has taken criticism from across the political spectrum.

In a similar vein, physicians are sitting in the crosshairs of those aiming to cut medical costs, whether or not reduction in physician pay is warranted. The editorial by Fairman and Curtiss in the June 2010 issue of JMCP provided a welcome and extensive overview of pay-for-performance (P4P) and the lack of evidence supporting retrospective incentive payments based on aggregate outcomes.3 As a family physician caught in the middle of the P4P debate, I can relate to President Obama in this instance.

At present, more than 20% of all visits to family medicine physicians are from Medicare patients, making them a substantial portion of practice revenue; however, my ability to substantially alter patient outcomes is severely constrained by systemic factors I cannot control. For example, Medicare patients have the choice to self-refer as they see fit. This practice creates skewed care patterns and disjointed medical care. A 2007 analysis of Medicare beneficiaries showed that each patient saw a median of 2 primary care physicians and 5 subspecialists working in 4 different practices per year.4 Additionally, for 33% of beneficiaries their assigned physician changed from one year to another.

Primary care pillars include first contact with patients, person-focused care (not organ system-focused), continuity over time, comprehensive services, and coordination of all care.5 As currently configured, Medicare beneficiaries are not receiving the full potential value of primary care. In fact, with so many “-ologists” making independent, organocentric treatment decisions from their highly trained yet stove-piped perspectives, any attempt to make the primary care physician responsible for composite outcomes in Medicare patients with current P4P measurements is simply unjustified. Using the data above, it would be akin to having a food critic rate a meal cooked by 7 different chefs from 4 different kitchens. Even those who blame President Obama for the oil spill would not want to eat such a dish.

Brian K. Crownover, MD, FAAFP
Lt. Col., MC, USAF
Nellis Family Medicine Residency Program Director
Brian.Crownover@us.af.mil

DISCLOSURES
The author discloses no potential bias or conflict of interest relating to this editorial.

ACKNOWLEDGEMENTS
The opinions and assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of any organization, including the U.S. Air Force medical department or the U.S. Air Force.

REFERENCES