

The Future of Primary Care — The Community Responds

In a collection of Perspective articles published in the November 13 issue of the Journal and a videotaped roundtable discussion posted online, experts in the field discussed the current crisis in primary care in the United States and possible solutions. Readers and viewers were invited to contribute their ideas in an online forum. What follows is a small selection of these comments, with responses from the roundtable participants, Thomas Bodenheimer, M.D., Barbara Starfield, M.D., M.P.H., Katharine Treadway, M.D., Allan H. Goroll, M.D., and Thomas H. Lee, M.D. The video of the roundtable and all the comments can be viewed at www.nejm.org.



GREAT IDEAS — NOW WE NEED ANALYSIS

I was excited to see the ideas on display here, yet these new building blocks are a beginning, and research will be needed to ensure that they produce the reforms we seek.

I was struck by Dr. Bodenheimer's model for transforming primary care. It shows great promise in breaking down traditional medical-system silos. As in a basketball team, the physician would act as medical point guard, directing the on-court effort, while ensuring that the patient gets passed off to the correct team member.

If this new delivery system is to work, we will need to know just what kind of team we want. How best to integrate team members? Do we want a hierarchical model? What are the roles for nurse practitioners and physician assistants — are there different panel designs for different demographics? At what point do teams lose effectiveness, both medically and economically? Plans must be flexible, not rigid.

Likewise Dr. Goroll's payment proposals. This breathtakingly fresh idea will need serious analysis before it enters the unforgiving arena of physician payment. Where do we get our outcomes data, how reliable is it, how resistant to gaming? Which outcomes do we measure, and how big a reward is needed to change outcomes? Which risk-adjustment calculations are fair, accurate?

These issues have thwarted previous attempts at reform. In health care, as in basketball, repeating yesterday's mistakes will not help you win today or prepare you for tomorrow.

Richard Scheffler, Ph.D.

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DR. BODENHEIMER REPLIES: Many thanks for a thoughtful commentary. I love basketball, too, but teams in basketball don't have a patient. So the analogy is great but not perfect. Effective teams are very difficult to create; one needs clear division of labor, training so that each team member is excellent at his or her responsibilities (and cross-training to be able to fill in for other team members), and a mode of communication that works but doesn't consume too much team energy (which must mainly be directed toward patient care). We cannot get away from some aspects of a hierarchical model, since the physician has considerably more knowledge than other team members. On the other hand, other team members will be better at certain things than the physician, so it needs to be a mixed hierarchical and democratic model. We have been experimenting with teamlets (teams of two) because they are easier to manage than

larger teams. But there is no doubt that building high-quality, efficient teams is a huge challenge.

WORKFORCE

The crisis in primary care is largely the result of the lack of will to revise the system that educates medical professionals to address primary care needs. Patients, and the U.S. health care system as a whole, would be better served if the content and level of primary care education were better matched to the needs of patients. The physician assistant (PA) model of medical education, with its emphasis on physician–physician assistant teams, a role-delineated curriculum, and competency-based education, needs to be expanded. It addresses the key issues, including quality and cost of patient care, reducing primary care physician burnout, and restoring the practitioner–patient relationship.

Paul Lombardo, M.P.S., R.P.A.C.

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DR. STARFIELD REPLIES: Primary care is not defined by who provides it. Rather it is a set of functions — first-contact care; person- (not disease-) focused care over time; comprehensiveness in attending to the needs of populations, subpopulations, and patients; and coordination of care when services have to be received elsewhere or from others. Therefore, who best provides primary care is an empirical issue, not a theoretical one. What type of professional best achieves the functions? In most of the world, primary care providers — usually family physicians — are the providers of primary care, and thus physicians are generally considered as the “gold standard.” But it does not have to be that way. It is almost certain that the education of physicians for primary care could learn a lot from the training of other health professionals.



PRIMARY CARE TEAMS

I wholeheartedly agree with the team approach, to start with the “patient–physician team” and then the coordination of care as an offshoot of this team. Team building *must* begin in residency, almost in a retreat format at least once a year during the years of training, with emphasis during the training process (putting residents and attendings in a functional dyad is an idea).

Medical education does not emphasize this team-building approach even in the preclinical arena, as individual students are too busy themselves trying to achieve the highest scores and get the most prestigious residency positions.



I am very glad that primary care is getting its due regarding the “right thing” for patients. I am not that concerned about payments, as the “right thing” is its own reward!

Walter Morris, M.D.

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DR. TREADWAY REPLIES: You are very correct that team building must begin in medical school and continue in residency training. There are obviously many ways that this can be accomplished, beginning with helping students understand that helping each other will ultimately help patients. Teaching techniques such as simulator sessions, small-group learning, and as you suggest, pairing trainees with senior faculty are but a few ways to begin this. In addition, learning the role of other health care professionals — nurses, physical and occupational therapists, social workers, and nutritionists — who are also part of the team that is necessary to provide expert care to patients is important as well. All of this is grounded in developing a mutually supportive and respectful environment in which to learn beginning on day 1 of medical school.

THE TIME HAS COME TO REDRESS PAYMENT INEQUALITY

The payment system has failed primary care. Payment for traditional procedures provided by these physicians has been restrained, while that for newly introduced ones has been excessive. This inequality in reimbursement is a major factor explaining why new graduates choose highly paid specialties rather than the relative drudgery of primary care.

While access to primary care is a problem today, can you imagine what it will be like once the United States provides universal health care to its citizens? It will take years to train enough practitioners to meet these new demands, even if an equitable payment reform were put into place immediately.

Current U.S. health care spending is hard to bear today, but we all know that these costs are going to rise exponentially in the years to come. Payers care little for our “inside baseball” concerns over payment for primary care. It is inconceivable that payers will see the light and increase payment for primary care while continuing excessive reimbursement for procedure-oriented specialists. In my view, the only practicable solution is to lower payment for procedure-oriented physicians and used these funds to substantially raise it for the provision of primary care. There is really no other solution to this problem. The time for solidarity between the primary care community and the specialists is over. The only thing that primary care has gotten out of this deal is the economic shaft, while our partners in this enterprise have prospered well beyond their due.

Grattan Woodson, M.D.

Primary Care Physician
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DR. GOROLL REPLIES: The solution is not an intramural “food fight” over payment. The way to get money redirected to primary care is to improve care management and coordination by the primary care physician through payment reform that enables and incentivizes better initial diagnosis and evidence-based workup and treatment. In this manner, we avoid a zero-sum fight over level of payment and instead focus on elimination of discoordinated care, unnecessary imaging, and other wasteful procedures and treatments that add little value.

THE CRISIS

The panel seemed to discuss only one component of this “Crisis.” The neglected components are the extraordinary cost of medical care on a national basis that has been and continues to be greatly exceeding the growth rate of the nation’s gross domestic product, and the lack of access to primary as well as nonprimary care for a large proportion of individuals in our society. Unless these components are simultaneously addressed, I doubt that a revolutionary or evolutionary response to the primary care crisis can be undertaken. A “Medicare for all” single-payor system (in order to remove wasteful, nonproductive, and burdensome administrative costs), expanded utilization of PAs and nurse practitioners in primary care practices, as well as more stringent controls on charges and payments for medications, devices, and procedures, in my mind, must be incorporated in any potentially successful endeavor to improve primary care as well as national health care delivery in an acceptable and affordable manner.

Alan Hartstein, M.D.

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DR. LEE REPLIES: I certainly agree that reinvention of primary care has to be part of a broader effort to change the payment system, and that such an effort has to make meaningful attempts to control costs as well as improve quality. I don’t know that “Medicare for All” is the answer (although some of my friends would agree with you). Aside from the political hurdles to getting there, my bigger concern is that Medicare for all could just be a system like Medicaid that holds down costs by holding down fees and dragging out payments — rather than actually driving change in health care delivery. I actually think delivery system reform (which you seem to support) can happen with more than one approach to payment reform. And I don’t think any cost-containment approach can succeed without delivery system reform.