



HEALTH CARE 2009

A Lifeline for Primary Care

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Primary care in the United States needs a lifeline. In 2009, for the 12th straight year, the number of graduating U.S. medical students choosing primary care residencies reached dismally low

levels.¹ Overloaded primary care practices, whose doctors are aptly compared to hamsters on a treadmill, struggle to provide prompt access and high-quality care. Three major factors contribute to this crisis. First, primary care physicians earn far lower incomes than procedural specialists, reducing career attractiveness for medical students with high debt burdens. Second, the work-related stresses felt by primary care physicians tags primary care as the career with more work at less pay. Third, medical education favors training in non-primary care fields. Rescuing primary care requires national policies that address all three issues.

Growing clamor that primary

care's plight may undermine important goals of health care reform has Washington policymakers concerned. Primary care has featured prominently in recent hearings held by Senate and House committees, and the *New York Times* has quoted President Barack Obama as saying that "we're not producing enough primary care physicians." The administration and Congress understand that after Massachusetts expanded health insurance in 2006, many newly insured adults were unable to find a primary care physician, raising the specter of theoretically universal access to care but no primary care to which to have access. Policymakers are also familiar with studies show-

ing that health systems anchored in primary care have lower costs and better quality.²

A bold federal initiative to revitalize primary care is urgently needed as part of health care reform legislation. This initiative must be comprehensive, simultaneously addressing three interrelated issues: physician payment, practice infrastructure and organization, and the training pipeline (see table).

For the first of these, physician payment, Medicare and most private insurers currently use the resource-based relative value scale, which was purportedly designed to reduce the payment gap between primary care physicians and procedural specialists. That gap, however, continues to widen. Under Medicare's sustainable-growth-rate approach to containing expenditures, spending on physicians' services remains a zero-sum game: if expenditures for all physicians'

Revitalizing Primary Care.	
Area of Focus	Changes Needed
Primary care payment reform	Increase in primary care payment under the Medicare fee schedule
	Medical student debt relief for choosing to practice primary care in shortage areas
	Change in the way primary care is reimbursed through the fostering of medical homes centered on patients
Investment in primary care infrastructure and organization	Investment in health information technology for primary care
	Creation of a nationwide system of primary care extension agents to assist practices in making improvements
Attracting more U.S. medical students into primary care	Redirection of substantial portions of Medicare graduate medical education funds to primary care residency programs
	Increase in funds for Public Health Service Act Title VII primary care training

services exceed a congressionally set target, physicians' fees are supposed to decline. Because of disproportionately large increases in spending growth for advanced imaging, tests, and minor procedures, physicians whose income depends on evaluation and management (cognitive) services, especially primary care physicians, have seen a relative reduction in Medicare revenues.³ And commercial health plans frequently amplify this gap between primary care and specialty payment.

Congress is considering options for reducing the Medicare payment gap. For the short term, the Medicare Payment Advisory Commission (MedPAC) has recommended that Medicare primary care evaluation and management services receive an increase of 5 to 10% next year.⁴ Congress is exploring such an increase, perhaps also for additional years. To close the income gap, annual increases of this magnitude would need to compound for several years, and private payers would

have to follow suit. Medicare would also have to split physicians' services into separate buckets so that primary care payments would not be reduced as a result of rapid growth in expenditures for procedures and imaging.

An additional strategy to make primary care financially attractive would be providing more relief from medical education debt for clinicians entering primary care. The stimulus package — the American Recovery and Reinvestment Act of 2009 (ARRA) — included expanded funding for the National Health Service Corps, which provides debt-relief opportunities for primary care physicians. Congress is considering further growth of the corps.

For the longer term, Congress is weighing alternatives to fee-for-service compensation of physicians. Currently, reimbursement for office visits does not capture many activities that primary care practices must perform for their patients, especially those with chronic conditions. Under the

Medicare Patient-Centered Medical Home demonstration, additional payments would be made to qualifying practices for care-coordination activities, including communication with patients and families by telephone and secure e-mail. Even more ambitiously, Congress may expand the modestly successful Physician Group Practice Demonstration for primary care-oriented integrated care systems, such as the Geisinger Health System and Kaiser Permanente. Under this approach, groups would be rewarded for improved performance on quality measures and assessments of patients' experience by being allowed to share in the savings if costs for their Medicare patients were lower than projected. Under both of these approaches, primary care physicians should receive higher incomes. Moreover, these models provide resources and incentives for enhanced practice capabilities and team orientation to make primary care practice more satisfying and manageable.

Payment reform is a necessary but not sufficient measure for revitalizing primary care, which also requires a modernization program for the second piece of the puzzle — practice infrastructure and organization — akin to federal infrastructure investments to shore up aging bridges and outmoded electrical grids. Most primary care physicians practice in small offices and clinics and cannot afford major capital improvements.

The most pressing infrastructure need is health information technology (HIT). Governments in several European countries equip all primary care practices with interoperable, ambulatory

care-focused electronic health records that allow information to flow across settings to enhance the continuity and coordination of care. The ARRA included \$19 billion for HIT but did not specify how these funds should be apportioned; it is essential that a substantial share be channeled toward primary care electronic health records.

Yet primary care needs more than computer chips and keyboards. Primary care clinicians require technical assistance to reorganize their practices into modernized medical homes, which will entail the formation of teams to assist physicians in providing proactive preventive and chronic care, the institution of same-day appointment scheduling, the substitution of e-mail and telephone encounters for face-to-face visits when clinically appropriate, and improvement of the coordination of care with specialists, hospitals, and other service providers. Recognizing these needs, Congress included a section in the ARRA calling for the creation of HIT regional extension centers to assist practices and hospitals in implementing HIT. This model draws from the Department of Agriculture's Cooperative Extension Service, a collaboration among federal and state governments, agricultural experts at land-grant universities, and farmers. Extension field agents in every county provide technical assistance to local farmers, spreading agricultural innovations. Believing that what worked for family farmers may also work for family doctors, Congress is considering broadening the scope of a health-oriented extension program beyond HIT to facilitate more

profound reorganization of primary care.

The final area requiring action is federal funding of medical education. Medicare spends \$8.8 billion annually on graduate medical education (GME), almost all of which flows to hospitals rather than directly to residency programs. Appreciating that this payment mechanism inhibits training in nonhospital ambulatory care settings, which is critical for the development of primary care skills, MedPAC and the Council on Graduate Medical Education are calling for more flexible approaches to Medicare GME payment.⁵ Advocacy groups for family medicine have gone further and proposed that Medicare GME funding for primary care residency training be wrested from hospital control and paid directly to residency programs, raising the politically charged question of whether GME funding should fundamentally be payment for medical education or a subsidy to hospitals.

The federal government also administers smaller but strategically important programs supporting primary care education under the Public Health Service Act: Title VII (for physicians, physician assistants, and dentists) and Title VIII (for nurses). Despite research documenting these programs' effectiveness, Title VII training funds were reduced from \$88.8 million in 2005 to \$41.3 million in 2006. The ARRA provided \$200 million in one-time funding for Title VII and Title VIII programs, and Congress may increase the base level of funding in the 2010 appropriations bill. Far-reaching medical-education reform would redirect a substantial

portion of Medicare's GME billions to strengthening primary care residencies and preparing residents to lead the implementation of innovative models of primary care.

This triad of reforms to primary care policy would result in a comprehensive and interlocking solution to the causes of distress in primary care. Reducing the payment gap would help to refill the pipeline of physicians going into primary care, as would reform of training programs. Changes in reimbursement would pave the way for practice reorganization and be symbiotic with a technical-assistance program. Practice reorganization, in turn, would improve the satisfaction, performance, and productivity of the primary care workforce.

As it writes health care reform legislation, Congress is deliberating over measures that would offer a three-stranded lifeline to rescue primary care. Successfully weaving these strands together is a political challenge, particularly if shifting resources to primary care is viewed by specialists and teaching hospitals as coming at their expense. But for health care reform to succeed in improving access, quality, and affordability, Congress and the Obama administration must make the primary care lifeline strong; otherwise, they risk watching primary care go under.

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Easing the Shortage in Adult Primary Care — Is It All about Money?

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As Americans debate health care reform, it is easy to forget that success may depend as much on the availability of primary care physicians for adults as on the specifics of the reforms themselves. Access to health insurance does not ensure access to timely medical care, particularly in places where doctors are in short supply, are not accepting new patients, or are not accepting patients with some types of insurance. Effective primary care can improve the quality of care and health outcomes and save money. But to the extent that easing the shortage of primary care physicians will require additional funds, the initial costs of reform will increase.

Primary care physicians include family medicine doctors, internists, pediatricians, and in some instances, obstetrician-gynecologists; of course, not all such physicians practice primary care. Currently, primary care accounts for about one third of the physician workforce, but far fewer U.S. medical students are interested in careers in adult primary care than were a decade ago.¹ The percentages of U.S. medical students entering residencies in family medicine and internal medicine have declined substantially (see graph). In 2009,

only 247 residency positions were offered in primary care internal medicine, a decrease of 328 from 1999. Although the percentages of U.S. students entering residencies in obstetrics-gynecology and pediatrics have also declined, those decreases have been more modest. The overall number of pediatricians has increased substantially, and the proportion of pediatric residents entering primary care pediatrics has remained relatively constant.²

As interest in adult primary care has decreased, more students have entered anesthesiology, radiology, and other specialties. As compared with graduates who become office-based generalists, those who become specialists, hospitalists, or emergency medicine physicians can often expect to have greater control over their lives, a wider variety of professional experiences, sufficient funds in the short term to pay off student debt, and higher incomes over the long term. Over a 35-to-40-year career, the difference in income results in a \$3.5 million gap, on average, between the “return on investment” for primary care physicians and that for subspecialists.¹ Of course, primary care physicians are well compensated relative to most Americans — but typical incomes for

radiologists and orthopedic surgeons, two high-paying specialties, approach three times those in primary care. “Concierge practices,” which typically collect premiums from well-to-do patients, allow some primary care doctors to avoid the hassles of routine practice but make their services unavailable — and unaffordable — to most people.

The diminished interest in primary care among U.S. medical students has led to an increased dependence on international medical graduates (IMGs). In 2005 and 2006, about one quarter of all visits to office-based physicians in the United States were to IMGs.³ Some 57.0% of IMGs were in primary care specialties, as compared with 46.2% of U.S. medical graduates; outside metropolitan areas, 67.8% of IMGs — and only 39.8% of U.S. graduates — practiced in areas with primary care shortages.³ In 2009, IMGs filled about two fifths of first-year residency positions that could produce primary care physicians.

What can be done to alleviate the adult primary care shortage and increase the percentage of such doctors who are trained in the United States? The way in which primary care practices are organized and collaborations among doctors, nurse practition-