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Late to the Feast: Primary Care and US Health Policy

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As health care spending in the United States increases, discontent among primary care physicians continues to grow, and student interest in primary care continues to plummet.¹⁻³ Policymakers struggle with public concerns about managed care and insurance gaps; physician concerns about malpractice rates and decreases in Medicare fee schedules; and medical school and teaching hospital concerns about new technology costs and Graduate Medical Education (GME) reimbursements.⁴⁻⁷ The juxtaposition of increasing health care expenditures with highly visible demands for extra resources has afforded relatively little attention to primary care.

Perhaps the difficult position of US primary care physicians stems from neither the irrelevance of the primary care role nor inadequacies of primary care professionals, but from structural barriers in financing. In other industrialized nations, primary care physicians remain prominent and achieve better outcomes with fewer resources.⁸⁻¹² This commentary explores the evolution of policies affecting physician, medical school, and teaching hospital revenues, as well as potential barriers to sustaining the primary care role in the United States. For purposes of this discussion, primary care adheres to the Institute of Medicine (IOM) definition as a "provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."¹³

EVOLUTION OF PHYSICIAN FEE SCHEDULES

A combination of private and public policy decisions, beginning with the rise of private health insurance in the 1930s, have influenced the fee-for-service system.¹⁴⁻¹⁷ Hospital administrators, general practice physicians, and patients began preferring that insurance cover expensive procedures and hospital stays, and not cover "little ticket" expenses, such as office-based evaluation and management services.¹⁴⁻¹⁶

With rapid advances in technology, medical and surgical subspecialties manage increasing numbers of technically complex and invasive diagnostic and therapeutic procedures.^{16,18} The development of these specialized modalities provides important health care advances throughout the industrialized world. However, ability to perform more procedures from improved techniques and technology does not include a reduction in fees.¹⁹ These trends have the effect of creating different classes of medical practitioners—those who specialize in well-reimbursed technical services (historically provided in hospitals) and those who specialize in historically under-reimbursed evaluation and management services.

In the 1960s, surgical specialists earned an average of 40% more than general practitioners and 30% more than internal medicine physicians.²⁰ When Medicare was created in 1966, the US government adopted private insurance payment policies guided by billing practices that prevailed in the medical community, thus reinforcing historical imbalances.^{8,16,17} By extending "third party" coverage to a large and growing population of older Americans, Medicare offered new opportunities for delivering procedural services. Demand for surgical and medical subspecialists grew rapidly, and

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incomes for these specialists grew faster than inflation.²¹ By 1989, a general surgeons' average income was 2.5 times greater and a surgical subspecialists' income three to five times greater than that of a family physician.²² Although many specialties still required grueling years in residency and a career of long hours in the hospital, modest additional training yields substantial advantages in incomes and "controllable lifestyle" relative to primary care.^{23,24}

The resource-based relative value scale (RBRVS) was introduced to moderate some Medicare fee schedule problems, but resistance by many specialist physician organizations blunted the impact of proposed changes.^{25,26} The delayed and greatly altered implementation of resource-based practice expense policies is an important example.^{26,27} Although RBRVS offered modest improvements in payment for evaluation and management services, annual adjustments in recent years have not kept pace with rising administrative expenses.²⁸ Many medical specialties did experience an appreciable decrease in Medicare payments. This, when combined with managed care discounts negotiated in the 1990s, contributed to a noticeable reduction in specialty physician income.²⁹ However, most specialty physicians still earn more than primary care physicians, and recent analyses suggest training in primary care does not provide an adequate "return on investment" in comparison with advanced subspecialty training.³⁰⁻³²

THE EVOLUTION OF PRIVATE HEALTH INSURANCE

An alternative to fee-for-service primary care practice began quietly developing in the 1930s.¹⁶ Prepaid group practice—multi-specialty practices financed through capitation payments on behalf of health plan members—were developed into a primary care infrastructure that was integrated, accessible, and accountable.^{8,15,33} By 1990, the spread of these health maintenance organizations (HMOs) was seen as an important solution to 25 years of startling growth in US health care costs.^{28,33} Corporate executives and health plan CEOs touted the advantages of primary care over specialty care. Capitated and integrated delivery systems were seen as the new paradigm where primary care professionals would manage populations of pa-

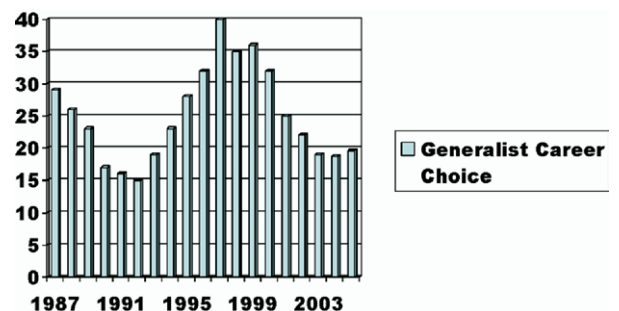
tients and control access to specialized services.^{34,35} Recruiting and organizing primary care networks transiently increased income for primary care physicians in many metropolitan areas, whereas specialists' incomes stagnated or decreased.²⁹ Student interest in primary care greatly increased (Figure) and primary care residency programs expanded.^{3,36,37}

Unfortunately, successful practice organizations could not grow quickly enough. Primary care practices developed in the fee-for-service model found that they could not rapidly develop the required information systems and administrative infrastructure to achieve care coordination. Specialist physicians, with declining incomes, became hostile to primary care's efforts to provide coordinated and comprehensive care. Without an opportunity to realize the benefits of a robust primary care infrastructure, patients became concerned about potential loss of access to specialized services and public support for HMOs dropped precipitously.^{4,38}

By 2003, physician payment by capitation had decreased substantially.³⁹⁻⁴¹ Many integrated delivery systems reorganized, and hospitals divested themselves of primary care practices.³⁹ Prepaid enrollments stagnated, and HMOs decreased while discounted fee-for-service, open access forms of managed care plans grew.^{41,42} Thus, the financial rationale for an insurance-funded, physician-based primary care function became less clear. Rather, health plans identified care coordination as one of their value-added services and began to contract with specialized vendors and national organizations to deliver both disease and case management.^{40,43}

PERSPECTIVES VIEWPOINTS

- The history of physician fee schedules and private health insurance in the United States has negatively affected primary care.
- Several practice, institutional, and cultural barriers exist to hinder the success of primary care medicine.
- The future of primary care medicine depends on administrative policies affecting the distribution of health care expenditures.



Source: AAMC Graduation Questionnaire

Figure Percent medical graduates choosing generalist careers (FM, GIM, GPEDs).

PRACTICE BARRIERS TO DELIVERING PRIMARY CARE

While differences in fee schedules created substantial differences in earning potential among US physicians, additional problems presented barriers to building and sustaining practices meeting the IOM definition of primary care.¹³ Fee-for-service payments could arguably reward continuity because the provider receives a fee each time the patient makes a visit, but the financing of “accessibility” has proven more difficult. With high overhead expenses and limited fees, primary care practices have to be careful regarding unused capacity.⁴⁴ Physicians earn more income with scheduled appointments rather than open slots for urgent access. In the past, physicians may have “fit in” extra patients. Family obligations and the cost of employee overtime render this a difficult option for modern primary care practices. Coordination of care outside of office visits has not been paid for at all, because Medicare and private payers do not reimburse for telephone calls or other integrative services.⁴⁵ Even comprehensiveness of care is discouraged under current fee-for-service incentives, with insufficient payment to justify time for risk factor assessment and preventive care advice.⁴⁶⁻⁴⁸

With the shift from indemnity insurance to managed care, administrative burdens for all physicians increased substantially.⁴⁹ Federal regulations regarding self-referral for radiology and laboratory services, requirements for laboratory certification, new billing documentation requirements, and Health Insurance Portability and Accountability Act compliance imposed new administrative burdens on many physician offices.⁵⁰⁻⁵⁴ Because primary care practices had relatively higher costs initially, the regulations had a greater impact on their infrastructure.^{30,44} In addition, because most specialized physicians receive their greatest revenue through large fee-for-service payments, they can afford to invest much more effort in successfully managing each payment while still realizing a lower cost for billing as a percent of total revenue.³¹

Nonetheless, promising new techniques for primary care practice have developed, including “direct access” office schedules, group visits, primary care teams, and chronic illness care, but the methods to finance and disseminate these innovations to patients, providers, and settings remain to be resolved.⁵⁵⁻⁶² Electronic medical records and other office informatics innovations hold promise to enhance quality greatly, but the current financial environment may limit use in primary care offices.⁶³ There is tremendous potential for growth in various forms of “asynchronous” physician-patient communication in primary care, including improved office responsiveness to patient telephone calls, electronic outreach, e-mail, patient education, electronic data sharing, and possibly image transmissions between patients and physicians.⁶⁴

Managed care organizations increasingly use their own information systems to identify health risks and implement care coordination and disease management services.⁴³ Recent trends in plan design offer “consumer-directed” features, including provider choice, physician profiles, shared decision-making, and higher out-of-pocket costs.⁴ The distinct role and value of primary care is not well articulated in these insurance products. With primary care under-funded by private insurance, the “concierge” or “boutique” practice has emerged where patients pay physicians directly to provide personalized medical and care-coordination services.^{65,66}

It is hardly surprising, therefore, that student interest in primary care careers has decreased once again (Figure), and the physician workforce in the United States has become unusually weighted toward medical, surgical, and hospital-based subspecialties.^{3,8,24,67} These specialists manage greater financial resources, influencing not only physician compensation but also facilities and staff. Thus, in many settings, subspecialists have greater access to the resources needed to provide accessible, coordinated, and patient-oriented care.^{68,69}

INSTITUTIONAL BARRIERS TO SUSTAINING PRIMARY CARE

Teaching hospitals also have played an important role in developing and sustaining primary care practice in the United States. Hospitals have strong incentives to support specialized practice because surgical and other specialized procedural services have long provided their main sources of profit.^{16,70} With the introduction of the Medicare Prospective Payment System (PPS) in the 1980s, these incentives became more intense and hospitals developed robust infrastructure to support and market specialized services.^{13,71,72} Although there was transient development of primary care networks during the managed care scare of the mid-1990s, many hospitals now focus on providing specialized services and are investing in specialized “product lines.”^{41,73,74}

Medical schools and teaching hospitals also have influenced primary care through emphasis on medical student education.^{13,24} These institutions have benefited from substantial societal investment in specialized practice and hospital-based services. Demand for specialized resident positions and an economic imperative to leverage federal funding for residents to enhance investments in specialized programs resulted in disproportionate growth in specialized training programs until recent changes in Medicare GME payments.⁷⁵ Thus, by the early 1990s, prominent clinical programs, clinical faculty, and residency positions in many medical schools and teaching hospitals were related to subspecialty practice.^{8,13,24}

Even if financing clinical programs at these institutions did not drive them toward a specialized infrastructure, the highly specialized orientation of biomedical research would have presented a challenge for cultivating the primary care perspective. Since the Flexner report, medical schools and teaching hospitals have focused on clinical and biomedical scholarship.⁷⁰ Federal funding for health care research has, for many years, been substantially directed toward biomedical science. Funding opportunities for generalist-oriented scholarship, such as medical education, clinical epidemiology, or health care delivery research, have remained modest. Therefore, medical schools and teaching hospitals necessarily invest substantial resources in specialized biomedical science research rather than research typically conducted by generalists.

CULTURAL BARRIERS TO PRIMARY CARE PRACTICE

Much has been written about “American Culture” in the evolution of the US health care system.^{76,39} Pundits suggest that Americans emphasize individual, rather than community rights and responsibilities.³⁹ This preference has been blamed for the decline of the public health infrastructure, the marginalization of safety net health care provider systems, the tolerance of high rates of uninsured, the acceptance of for-profit entrepreneurship in delivery of health services, the emphasis on illness treatment rather than disease prevention, and reliance on “choice” as a proxy for “quality.” Americans appear fascinated by technical, scientific solutions and prefer quick action and straightforward solutions as evidenced by the prominence of scientific advances and specialized medicine so visible in the news media and popular television shows.^{16,39}

Although the many exciting advances in biomedical science do not highlight primary care, they certainly need not detract from it. Germany and Switzerland also have achieved major advances in biotechnology and have invested in substantial high technology medical resources.¹² Nonetheless, primary care physicians in these countries are more prevalent and better compensated when compared with specialized physicians.¹² In the United States, however, the pervasive incentives disadvantaging primary care have led to an unusual degree of prominence of specialist physicians in both numbers and affluence relative to other industrialized countries. This status likely affects the relative visibility and attractiveness of primary care in the community and media.

EMERGING TRENDS RELEVANT TO THE FUTURE OF PRIMARY CARE

As previously discussed, the fee-for-service payments long prevalent in the United States do not provide

support for key primary care functions such as comprehensiveness, coordination, or accountability. Furthermore, most physicians do not have the financial wherewithal to develop the information systems and interdisciplinary teams required for sophisticated interventions to manage chronic illness.⁷⁷ There are a growing number of problems caused by the resulting lack of care coordination.⁷⁸

Recent studies suggest rising health care costs may be complicated by the decline in primary care infrastructure.^{11,79-81} The United States faces rapidly growing numbers of older individuals with multiple chronic illnesses.⁸² The benefits of increased access to specialized physicians may be subverted by failures in care coordination among multiple independent specialist offices. Indeed, a survey of consumer experiences with patient safety and quality information recently found that two thirds of respondents felt “coordination among the different health professionals that they see is a problem.”⁸³ Similarly, in a survey of Medicare beneficiaries, investigators found a decline in the continuity and integration of care by primary care physicians, as well as in the quality of primary care interactions with patients.⁸⁴

Securing substantial enhancements to traditional fee-for-service payments for primary care may prove difficult at a time of record health care expenditures. Nonetheless, the Centers for Medicare & Medicaid Services (CMS) recently published the “Medicare Program Five-Year Review of Work Relative Value Units under the Physician Fee Schedule,” proposing substantive changes to several outpatient evaluation and management codes and offering meaningful relief to primary care physicians.⁸⁵ However, simply enhancing fee-for-service payments for traditional face-to-face encounters will likely not be sufficient to establish the needed primary care infrastructure. The American College of Physicians recently issued a report on the “advanced medical home,” and the Society of General Internal Medicine has extended this work with its report “Redesigning the Practice Model for General Internal Medicine.”^{76,86} Both reports outline in greater detail the administrative and financial rationale for fundamental payment reforms to support comprehensive, coordinated primary medical care in the United States. Policymakers and employers are undertaking a re-examination of traditional fee-for-service and considering providing support for inter-visit communication, non-visit-related management, information systems, chronic disease management programs, and quality improvement initiatives.^{61,87,88} Business leaders have initiated programs such as Bridges to Excellence to provide non-fee-for-service payments for improved chronic illness care, and CMS is introducing incentive programs to support chronic illness care and quality improvement.^{81,87,89} The challenge will be to sustain and expand such reforms in the face of near-term resource

constraints to realize long-term improvements in efficiency and effectiveness.

CONCLUSION

The problems confronting primary care in the United States are longstanding, complex, and not amenable to easy solution, either by policymakers or academics. Thoughtful, articulate, and evidence-based advocacy will be needed to address them. The share of the nation's wealth devoted to health care may be appropriate, but it has been distributed inappropriately by past and current administrative decisions. It will take courageous leadership to rectify this. Primary care can be saved and expanded by redistributing reimbursement away from technical specialties to the providers at the front lines of continuing health care for the nation's population. In doing so, the US health care system will mirror other industrialized nations' health care priorities, as well as provide better outcomes and greater efficiencies.

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