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No More Lip Service; It's Time We Fixed Primary Care (Part Two)

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Despite at least two decades of rhetoric about the need to build a robust primary care infrastructure, the US health care system continues to limp along with the smallest ratio of primary care providers to specialists of any high-income country; a shortage of primary care providers, especially in rural areas; low numbers of medical students entering primary care residencies; and epidemic rates of burnout in the profession. In Part One of this post, we made the case for training more primary care providers (including physician assistants and nurse practitioners as well as physicians), and implementing policies that would help primary care practices do a better job of caring for their patients, especially those with chronic illnesses.

We outlined the principal causes of our low number of primary care providers and their inability to produce better health through better practices. These factors include a payment system that rewards procedures performed by specialists at the expense of cognitive services and regulatory requirements that are as burdensome to clinicians as they are irrelevant to patient health. We argued that any attempt to provide universal coverage or improve the health of the nation will fall short unless we address these gaps in primary care.

In Part Two, we offer several steps that the US can take to boost the number of primary care providers, reduce burnout, and improve the quality of primary care.

Increase The Number Of Primary Care Providers

The first step toward better primary care is to train more primary care providers. The Association of American Medical Colleges (AAMC) estimates that by 2030, the US will face a shortage of as many as 49,000 primary care physicians. Given that it takes nearly a decade to train a physician (less time is needed to train a physician assistant or nurse practitioner), we need to start now if we want to have enough primary care providers in the future.

There are several ways to boost the number of primary care providers, starting with reducing the differential between primary care incomes and those of specialists who do procedures. To address this income disparity, physician fees can no longer be set by the Relative Value Scale Update Committee, or RUC, the specialist-dominated committee that determines fees for different services. A new advisory committee should be formed. It should be dominated by primary care providers and include patient advocates. The newly constituted advisory committee can begin to equalize pay by raising payments to primary care (and other cognitive specialties), lowering the rate of payment to proceduralists, or both.

Second, since the large amount of debt that medical students incur often dissuades them from entering primary care, the government should either cover the cost of medical school for students who remain in primary care for at least 10 years after certification or incentivize individual institutions to offer loan forgiveness programs. According to a report from the Congressional Research Service, in 2014, the federal government spent $11.3 billion on graduate medical education (physician residencies and fellowships). The Centers for Medicare and Medicaid Services (CMS) currently spends about $10 billion a year on physician residencies. It would cost a fraction of that amount to pay for medical school for any student going into primary care. The AAMC supports such a program.

Third, CMS has the power to determine how many of those residency slots are committed to training primary care physicians, yet it currently exerts little control over promoting training programs with an eye toward increasing the number of primary care residency slots. The federal government provides $137,000 per trainee to subsidize the cost of training. Since we need more primary care providers, CMS can and should shift that payment to primary care fields and pay for fewer specialty slots—a policy that is sure to raise the ire of many training hospitals and specialty societies. Regardless of the inevitable resistance, the time to act is now.

Payment And Delivery Models To Improve The Quality Of Primary Care And Reduce Burnout

A primary-care based health system will not come about simply by training more primary care providers. The US must also encourage and permit primary care providers to reform their practices to deliver more accessible and effective care. We spend the rest of this essay describing two models for accomplishing this goal: the Primary Care Trust, and Direct Primary Care.

These payment models would replace fee-for-service payment, which is a barrier to many aspects of a reconfigured primary care infrastructure and better practices. The models reward providers who collaborate to reduce wasteful spending and unnecessary care, and offer the time and resources necessary for primary care providers to care for chronically ill patients without frequently having to resort to hospitalization and specialty referral. They also increase access to care and improve both patient and primary care provider satisfaction.

We believe, and evidence demonstrates, that such reforms have the potential to not only improve outcomes and cut costs, but also further increase the number of primary care providers, by making primary care a more appealing specialty to medical students seeking impactful, patient-directed, and adequately compensated careers.

Direct Primary Care (DPC)

In a DPC model, primary care providers are paid per patient per month, usually about $100 per month, to manage a smaller number of patients. Patients are offered same or next day appointments lasting as long as necessary, access to the physician's personal cell phone or email address 24/7, a comprehensive annual evaluation including substantial time focused on health and wellness, primary care provider visits when the patient needs hospitalization, and often home or nursing home visits as appropriate. Care is provided by a team.

When primary care providers have time, resources, and reduced administrative burdens, they can provide the comprehensive care for which they were trained, including caring for most chronic illnesses with substantially less reliance on specialists. This can dramatically reduce the costs of care today. Furthermore, under a DPC model, primary care providers can offer true preventive care with a focus on health and wellness, instead of today's total focus on disease treatment.

DPC practices currently work outside of the insurance market, but we suggest that the model can help enhance the central role of primary care within insurance products. This can start with its adoption by Medicare and Medicaid, perhaps through the framework of accountable care organizations. These entities can pay their primary care providers not based on each visit, but rather with monthly fees calculated by such factors as prior patient spending, socioeconomic burden, and level of chronic illness. DPC enables the primary care team to provide high-value care without the burdens of top-down regulation and fragmented payment methods.

The term concierge has unfortunately been attached to DPC and has left a negative connotation of very expensive care. Despite this, insurers are coming to realize that a system in which the primary care provider can offer comprehensive care instead of fragmented care results in fewer tests, images, and specialty referrals, with better patient outcomes and reduced total costs of care. It means an increase in the upfront cost of primary care per patient but a substantial and rapidly apparent reduction in overall costs. There are already several successful real-world models of DPC involving a wide range of patients.

Primary Care Trust

If primary care is an essential service that all Americans need, like public water systems, fire protection, and universal public education, we should treat it as a public good. Universal primary care can be achieved through a Primary Care Trust, a model for state-based universal coverage for primary care services. Modeled on the Primary Care Trust of the UK's National Health Service, state-based trusts would stabilize and rationalize remuneration for primary care providers, by consolidating all existing primary care funding in one place.

The trust would use a DPC model of a capitated fee or a risk-adjusted global budget based on the population of patients served. All payers would contribute to the trust, which would provide stable financing for primary care providers, and reduce administrative overhead, which currently consumes between 20 percent and 40 percent of primary care revenue. A Primary Care Trust for every state would reduce that overhead to 3 percent to 5 percent or less, freeing up funding to expand primary care and include such services as mental health, home visits, and extended hours.

The primary care provider model would also provide primary care for all Americans, even those who lack health insurance, by offering primary care providers enough of a financial cushion to allow them to care for the uninsured. A bill to establish a framework for such a trust has been introduced to the Vermont state legislature.

For Primary Care Trusts to be most effective, some of the money should be directed toward the establishment of more readily accessible primary care clinics. Rhode Island has begun building the infrastructure for primary care clinics, called Neighborhood Health Stations, starting in the town of Central Falls.

Neighborhood Health Stations are multidisciplinary primary care practices that combine traditional medical care with a number of other services to create a single clinical entity equipped to provide 90 percent of the services each community needs. Services provided include urgent care, dental care, mental and behavioral health care, substance use disorder treatment and recovery support, physical and occupational therapy, nutrition, home health, and emergency medical services. Neighborhood Health Stations are based on the successful Community Health Center System, which now provides the best primary care in the US and cares for 25 million Americans, saving 5 percent to 10

percent in total health care costs, compared to people who use other sources of primary care.

A network of Neighborhood Health stations in every US community would provide every American with access to primary care near home, including urgent care from 8 a.m. to 8 p.m. and on weekends. Estimates suggest that one Neighborhood Health Station is needed per 10,000–20,000 people.

Looking Forward

As members of the Right Care Alliance and its Primary Care Council, we seek a vibrant primary care-directed health care system and are prepared to advocate for it, both within the health care professions and to policy makers. Legislation may be necessary to implement the two models we propose. Even without legislation, however, much could be accomplished to increase the number of primary care providers and adopt Direct Primary Care payment through CMS regulations, particularly since commercial insurers typically follow Medicare regulatory changes with similar changes of their own. In addition, removing regulatory burdens would allow primary care provider groups to design more innovative, patient-centric systems, spend more time and resources on direct patient care, and encounter a much lower rate of primary care provider burnout.

There is no reason, save inertia, why Medicare, Medicaid, and commercial insurers could not implement such payment approaches immediately. In return, they would have to be assured by the primary care provider that he or she will in fact abide by the basic standards of DPC as noted above. With this assurance, the insurer should pay the retainer and no longer request reams of unnecessary and excessive paperwork that only add to overhead costs and do not improve patient care or engagement.

We recognize that changes in primary care, while essential, will face some resistance from primary care providers, who may dream of improved conditions but will be reluctant to embark on a new path unless it is clear that the proposed changes will result in lower physician frustration, no drop in income, and greater patient satisfaction. We believe that with a collaborative effort between CMS and primary care provider organizations, these measures can be instituted in a stepwise way, using both commercial and governmental insurances to take the lead, and state and local governments to help facilitate rules and financing. We on the Primary Care Council will work with any and all groups to help make this happen, for the sake of our patients, our fellow providers, and our entire health care system.