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

- Andy Lazris
- Alan Roth
- Shannon Brownlee

NOVEMBER 20, 201810.1377/HBLOG20181115.750150

We are in the midst of a primary care crisis. Primary care is an essential service to which all Americans should have access, and which should be organized and paid for in such a way that clinicians have the time and resources to care properly for their patients.

There is strong evidence that people who have a primary care provider enjoy better health on average than those who do not, even after adjusting for patient demographics. New data suggest that a small investment in primary care would yield a six-fold decrease in Medicare services and an overall 2 percent drop in total Medicare costs.

And yet, the United States does not have enough primary care providers to go around, and many of those who are in practice find themselves unable to provide the kind of care that can produce the best possible health outcomes for the lowest cost. These are not new facts, and our assertions should not surprise anyone who has been concerned with US health care policy over the past two decades. Indeed, over that period, there have been many calls for better and more available primary care.

Even so, the number of young clinicians entering primary care fields, which include family medicine, general internal medicine, and pediatrics, has dropped to an all-time low of 20 percent. Increasing numbers of primary care physicians are becoming hospitalists or working in urgent care centers, instead of practicing in the community. Approximately 35 percent of all clinicians, including nurse practitioners and physician assistants, currently provide primary care services, a number that stands in stark contrast to other high-income countries, where the ratio of primary care providers to specialists is generally 70:30.

Why are we seeing this decline in primary care providers in this country? First, the number of residency slots is increasingly weighted toward specialties, not primary care.

Some medical schools send not a single student into primary care; many teaching hospitals train no primary care physicians. Second, primary care professionals are paid approximately half what specialists earn. Even if more residency slots were to open, medical students would still shy away from applying to them, in large part because primary care physicians are the lowest paid among their peers.

Medical students also avoid primary care after watching primary care physicians struggle with short patient visits, large patient panels, increasing administrative burdens imposed by electronic medical record keeping and quality metrics, and significant night call responsibilities, all of which are disproportionate to the burden on specialists. Visits last no more than 15 minutes on average, and some providers see as many as 40 patients a day to pay for their overhead and medical school debt, which today averages about $190,000. More than 50 percent of primary care providers show objective evidence of burnout. Given the frantic pace they witness during rotations, only the most dedicated student would willingly choose a career in primary care.

It's time for US provider organizations, payers, teaching hospitals, health care administrators, legislators, and health care policy makers to stop paying lip service to the need for more, and more robust, primary care, and start taking concrete steps to make it so.

In the first part of this two-part post, we explore what primary care can provide; the necessary ingredients for great primary care; and the barriers standing in the way. In the second part, we look at two workable solutions.

What Primary Care Can Do

Primary care clinicians are uniquely trained to diagnose and treat the vast majority of medical ailments and chronic diseases, to reduce overtreatment, and to care for the whole patient. Primary care's value in cutting costs, preventing disease, improving patient satisfaction, and enabling individualized care based on shared decision making has been well established. We know that areas of the country that have a higher ratio of primary care to specialty care medical outcomes are better, fewer health care dollars are spent, hospitalization rates decline, and patients are overall more satisfied with their care. In fact, in areas of the country with the most primary care providers, the average Medicare cost per beneficiary is 33 percent less than in areas with the least.

Robust primary care is vital for older Americans and patients with chronic diseases. Patients with heart disease, arthritis, diabetes, and other chronic illnesses account for approximately 90 percent of the health care dollar, much of which is wasted on fragmented, disorganized care. Several pilot projects have shown that intensive primary care (sometimes called the advanced medical home or "ambulatory intensive care"), which addresses the multiple needs of chronically ill patients, can improve health, reduce emergency department visits and hospitalizations, and bring down costs. Some of the common elements of these successful projects include a team of physician and

non-physician providers; home visits; attention to mental health and social needs; and telemedicine.

There are several necessary ingredients for primary care to grow and provide such optimal care, including:

Time

Patient-centered care requires ample time for the doctor and patient to converse and discuss issues. That time needs to be reserved not for taking of notes or collection of data while the primary care provider stares at a computer screen. Rather, it must allow for the patient to direct the conversation toward issues that matter to him or her.

Resources

In a recent *New Yorker* piece, "The Heroism of Incremental Care," Atul Gawande points out that while surgeons enjoy ample resources to facilitate their work, primary care providers are lucky to be able to hire a nurse. Good primary care requires nimble teams to provide comprehensive care both in the office and in the patient's home. Primary care provider practices need personnel to help with regulatory burdens and electronic record requirements. A true team approach requires a financial investment.

Fair Pay

Until primary care providers are paid a salary that is closer to that of their specialist colleagues, few students will pursue that career path. There are many barriers to fair pay, all of which can be easily addressed.

None of these requirements is being met. Unfair fee-for-service payment, along with increasingly onerous regulatory and administrative burdens stand in the way of a robust primary care infrastructure and effective primary care practices.

New Payment Models: Things Can Get Worse

It's hard to imagine a worse payment model for primary care than fee-for-service, and current changes underway are not helping. Under the Affordable Care Act (ACA), several federal agencies, as well as private insurers, are attempting to improve care by paying providers for "value" rather than for volume. Through its Medicare Access and CHIP Reauthorization Act (MACRA) program and accountable care organizations (ACOs), Medicare has shifted some degree of provider payment away from merely seeing patients to what has been defined as "high-quality and value care." If a doctor belongs to an ACO, and that ACO saves Medicare money by having its patients collectively spend less than pre-set benchmarks, then some of that saving will be distributed to providers. Similarly, with MACRA, if providers can successfully navigate a

series of regulations intended to assure higher quality, they could get a small bonus, while others who are less successful will see their pay decline.

All of these solutions rest on, but do not fundamentally alter, fee-for-service compensation, imposing additional administrative burdens on practices and providers that serve mostly to distract from patient care. Moreover, many of the so-called “quality metrics” have not been validated and often promote overtreatment while being antithetical to shared decision making and individualized care. None of these solutions has been shown to bolster primary care, enhance patient satisfaction, improve quality, or meaningfully reduce costs.

Fee-for-service rates that favor specialized and procedural care also lies at the heart of our national failure to train more primary care physicians. Today, primary care accounts for only 5 percent of total health care spending. The pay gap between primary and specialty care can be traced back to the Relative Value Scale Update Committee, or RUC, a small, secretive, specialist-dominated committee, which is administered by the American Medical Association. The RUC advises the Centers for Medicare and Medicaid Services (CMS) on how to set the relative rates of reimbursement for everything from a primary care office visit to a lung transplant, and every possible *International Classification of Diseases* (billing) code in between.

The RUC bases its recommendations on surveys of practicing physicians, who estimate the time needed to perform a service. CMS routinely accepts the RUC’s recommendations in setting Medicare fee schedules, despite several reports by the Government Accountability Office and others that have found many of the RUC’s estimates to be inaccurate and often biased in favor of procedures when compared with “cognitive” services, such as those primary care delivers.

Residency programs are heavily weighted toward training specialists, in part because hospitals depend on their labor to increase their throughput of patients into higher-margin service lines. There has been some effort made with the passage of the ACA to bolster primary care residency slots and train residents in nonhospital-based settings, which is where most primary care is delivered. However, the $20 million allocated to this program expired in 2017, and such residencies are expected to be self-sustaining thereafter—a sure way to see those slots disappear as training programs revert to using specialty residents.

Regulatory Burden

Much of the time clinicians must spend during visits is now devoted to the escalating regulatory burdens mandated by insurance and government programs—such as the electronic medical record, quality indicators, and new reporting requirements—all of which detract from taking care of patients. Medicare and commercial insurers require primary care providers to: type notes in a very specific format that is time consuming and often diverges from what may be clinically relevant to the patient; implore patients

to get certain tests and procedures (for example, mammograms) that the payers deems essential; and treat risk factors, such as blood pressure and cholesterol, in ways that may be harmful to older patients. The average time a primary care provider now spends per patient visit in actual “face time” is about 10–12 minutes.

When presented with a complex, and thus time-consuming patient, primary care providers often resort to the pen—they write a prescription or refer such patients to a specialist, which immediately escalates costs, fragments care, and frustrates patients. Too little time means that the patient’s anxiety, the root cause of perhaps 40 percent of visits, is never addressed.

Resource Poor

Most primary care practices must pay for expensive electronic medical record systems and tech support, staff to contend with increased regulations and fee collection, and sometimes scribes and nurses to satisfy regulatory demands. To finance their practices, primary care doctors need to see large volumes of patients in short visits, while devoting a large part of their time to resource and personnel management instead of patient care. As more reforms touting quality and value are thrust upon primary care providers, even more time and resources are diverted from patient care.

In Part Two of this post, we will discuss two potential solutions to our primary care crisis: subsidies for primary care training to boost the number of primary care providers; direct primary care, a payment model that allows primary care providers to invest in resources and team members; and universal primary care achieved through primary care trusts.