EDITORIALS

Primary Care and the US Health Care System: What Needs to Change?

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KEY WORDS: costs; quality; physician supply; payment reform; physician satisfaction.
J Gen Intern Med 25(10):998–9
DOI: 10.1007/s11606-010-1464-0

Health care in the United States is the world's most expensive, yet America's health outcomes are nothing to brag about.[1] For example, in a study by Nolte and McKee, the US had the highest rate of deaths amenable to health care per 100,000 population of 19 countries studied, with a rate not quite twice that of France, even though France spends roughly half of what the US does on health care[2]. How could we possibly get so little for so much?

While there are a number of reasons for this, one of the most important appears to be our failure to emphasize primary care within our health care system. Countries that do focus on primary care have better health at lower cost[3]. The US has very low primary care ratings—which are scores assessing availability to and use of primary care—compared to other developed countries[4]. Within the US, there is also compelling evidence that primary care works—for example, having more primary care physicians is associated with lower mortality rates, while no such relationship exists for physicians of other types[5], and similar evidence has been developed for costs. Therefore, it is clear that one change we need in our system if we want to reduce costs and improve outcomes is more emphasis on primary care.

We currently have a major gap between the number of primary care providers we have and the number that would be needed to deliver primary care to the full population. Indeed, although the recent passage of the Affordable Care Act of 2010 is exciting and has been projected to make coverage available to an additional 32 million of the uninsured[6], a key issue will be who will deliver primary care to this group. Midlevel providers will be part of the solution, but primary care is quite complicated, especially for patients with multiple chronic conditions, and physicians will remain an essential part of the team. Primary care includes general internal, family medicine, and pediatrics, and few medical students have been going into these specialties in recent years for a number of reasons.

The current primary care gap makes it imperative to understand a number of issues, including to what extent and why medical students select primary care versus other specialties, whether primary care providers are satisfied with their practice, and whether providers are staying in primary care. Medical students' choices of specialty have been explored previously at length[7]. In this issue of JGIM, Bylsma et al. evaluate general internists' practice satisfaction and the extent to which they continue to practice primary care[8]. Key findings are that at mid-career, more providers leave GIM than other domains in internal medicine, and that compared with subspecialists, general internists are less satisfied with their practices. However, their reasons for leaving were mostly because of "a change of interest or to take advantage of a preferred opportunity," and they were not leaving more often from small practices, which many have felt were at particular risk. There was no change in the rate leaving compared to 2004.

If we want to improve health care in the US, it is clear that we need more primary care, and we will need to organize it in ways that ensure that those who deliver it are satisfied in doing so, because overall levels of satisfaction among primary care providers are low today. The Affordable Care Act included a number of provisions that will be favorable for primary care, including a 10% increase in primary care physician payment, and support for medical home demonstrations, though Goodson has argued persuasively that these changes may not be sufficient to slow the overall trend toward a largely specialist physician workforce[9].

In my view, the main issues that must be addressed to revitalize primary care are to pay primary care providers better compared to specialists, and to change practice so that primary care is rewarding again. With respect to payment, the primary care/specialty care ratio could be addressed either by paying primary care providers more or specialists less. While this will not be popular with medical societies, what seems most appropriate is to decrease specialty pay, which is vastly higher than in any other country; indeed, physicians are paid extremely well in the US. This could be done gradually by allowing primary care pay to rise relative to the medical price index, but the discrepancies for some specialties are so great it is likely that will not be sufficient. At a more fundamental level, we also need to move away from fee-for-service as a strategy; this will take time, but payment experiments are badly needed[10].

The evaluation of new practice models is already underway, with a large number of medical home demonstration projects around the US. Early results have been fairly positive, with lower emergency room utilization and hospitalization rates for ambulatory care sensitive conditions, and generally lower

Published online August 10, 2010

costs, with better intermediate quality outcomes for several chronic diseases such as hypertension and diabetes[11–14]. However, it is far from clear that these are the best results that can be obtained, that the results will be generalizable to practices at large or what exactly the best approach for making the transition is. Early results do suggest though that both patients and providers appear to be happier in such practices.

Another thing that might make primary care more attractive and satisfying is using high-quality electronic health records. Using a really good electronic record can make a host of tasks easier, ranging from being on call, to refilling prescriptions, to dealing with populations rather than simply the patient in front of one. However, the transition can clearly be challenging, and things don't always go smoothly[15]. Moreover, the electronic health records of today do not do all the things that are needed to enable a medical home[16]. Particular holes include clinical decision support for chronic conditions, strong registry functions, and tools that enable team care. Helping build these tools and evaluating their impact represent opportunities for general internists.

Overall, our health care system is in crisis, especially because of its costs. But crisis brings opportunity—and primary care has to be a key part of the solution. I believe the net result is that general internal medicine should have several items on its near-term "to-do" list. These include understanding the issues which are truly important to primary care providers with work such as that presented by Bylsma et al.[8] In addition, it is imperative that we be involved in development and testing an array of new delivery approaches like the medical home. SGIM has in fact been a leader in this area, with a recent special symposium that addressed the many issues relating this area led by Landon[17]. In particular, key needs include understanding what a good composition may be for the medical home, for example, how much care coordination, nursing care, mental health resources and pharmacy assistance. This will likely vary with practice type, as small practices will need different arrangements than larger ones. The effectiveness of varying compositions needs to be evaluated with respect to cost and outcomes. Another priority is determining how the electronic health record can best support the medical home and care more generally. More broadly, SGIM members should continue to try to find new ways to improve the safety, quality and especially efficiency of care, as these will be badly needed as the costs of care are already a drag on our economy. Finally, SGIM as a whole will need to advocate more effectively than ever for primary care in general and payment reform in particular.

Acknowledgements: *I thank Jennifer Love for her assistance with the preparation of this manuscript.*

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