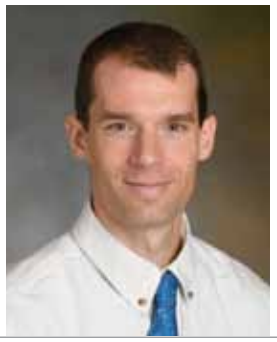


A Primary Care Perspective on U.S. Health Care: Part III: Big Ideas

Thomas Gates, M.D. and Corey Fogleman, M.D.
Lancaster General Health Family and Community Medicine

INTRODUCTION

In Part I of this series, we took a hard look at U.S. healthcare, and found that despite remarkable success throughout the twentieth century, its current state is deficient in comparison with our peer countries, in terms of both poor outcomes and exorbitant costs. We also reviewed evidence that a major reason for that poor performance was the systemic neglect of primary care.[1]

In Part II, we explored some of the current efforts to address these shortcomings, with particular emphasis on what is already happening at our local level, such as the movement toward Patient Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs).[2] Although relatively new, some of these reforms, particularly the PCMH, are beginning to have positive effects.[3]

However, the question remains: are these efforts sufficient to reshape a health care system that is widely acknowledged to be broken, or do they represent only "nibbling around the edges," inadequate solutions that will leave the basic structure of the present system intact? Only time will tell, but it is our sense that the problems we face require far more radical changes than what is currently being enacted.

In this third and final part of the series, we will look at some proposals that are big enough and innovative enough to truly change the system. Many will dismiss these proposals as impractical, politically impossible, too costly, or too threatening—yet every developed country outside of the U.S. has managed to implement some combination of these reforms, to the benefit of their citizens.

GRADUATE MEDICAL EDUCATION

Graduate Medical Education (GME) in the U.S. is largely financed by public funds, amounting to a $13.5 billion annual subsidy ($9.5 billion from Medicare).[4] However, the current system is manifestly not serving the public need: we have a current shortage of 16,000 primary care practitioners, and that number is expected to more than triple (to 52,000) in the next dozen years.[5] Historically, residency training slots were created and funded not in response to public need, but to the needs of academic medical centers, with the priority on training in the procedural specialties. Federal funding for residency slots has been capped since 1997, resulting in freezing of these historic disproportions, and a growing mismatch between what the health care system needs (more primary care physicians) and what the GME system produces (ever more specialists).[6]

The major problem with GME, however, is that U.S. medical students are not choosing primary care. Although 46% of medical school graduates matched in the three "primary care" specialties (family medicine, internal medicine, and pediatrics) in 2012, in fact only about 21% of current internal medicine residents[7] and 45% of pediatric residents will actually practice primary care (the rest pursue sub-specialty training). This leaves only 20% of 2012 medical school graduates projected to practice primary care in 20156—far short of the Council on Graduate Medical Education's goal of 40%.[8]

Because 90% of family medicine residents go on to practice primary care,[6] the number of U.S. graduating medical students choosing family medicine residencies is the best reflection of overall interest in primary care. That number peaked in 1997 (at 2340), fell by more than 50% over the next ten years, and has still not recovered to 1997 levels.[9] In the 2013 match, 1374 U.S. medical school graduates (8.4% of the pool) chose family medicine residencies. The rest of the 2,938 family medicine positions were filled by graduates of osteopathic schools and international medical graduates (a 96% fill rate).[10]

There are many reasons why U.S. medical students are avoiding careers in primary care, but certainly one important reason is financial. The median indebtedness of graduating medical students is now $162,000.[11] Quite understandably, medical students respond to this financial reality by gravitating to specialties with higher incomes. Currently, for family medicine the debt-to-income ratio (which reflects the degree

of difficulty paying off debt from current income) is nearly three times higher than that of orthopedics or cardiology.[12] There is also a direct correlation between the income ratio (mean primary care salary divided by mean specialty salary) and student interest in primary care. That ratio plummeted from 0.78 in 1985 to 0.50 in 2007, with a corresponding decrease in primary care career choice. Experience from both the U.K. and Canada has demonstrated that policies that increase the income ratio to 0.80 can have immediate and positive impact on primary care career choice.[13]

Given that any major changes in GME (including lifting the 1997 cap on Medicare-funded positions) would require Congressional approval, and given the entrenched special interests that have a stake in the status quo, is there any hope of reforming GME to reflect the true needs of the nation? Probably not, but Bach and Kocher have offered a bold proposal: make medical school free.[14] Medical school tuition (averaging $38,000 per year) could be waived for the nation's 67,000 medical students, and in turn residents choosing specialty training (about 66,000) would forego their stipends ($50,000 on average).[14] Residents choosing primary care specialties would continue getting stipend support, amounting to a direct subsidy for primary care training. Residents in non-subsidized specialties would stand to lose up to $250,000 for five years of residency training, but this would be more than compensated for by added lifetime earning potential of $1.5 to $2 million (above primary care physicians). Although it is admittedly unlikely that this scheme would ever be implemented, it does have the potential to completely reverse the present financial incentives driving students into specialty training, while at the same time making medical education accessible to applicants from all socioeconomic backgrounds.

CHANGING REIMBURSEMENT

Any remaining doubts about the perverse effects of our current fee-for-service reimbursement model should have been dispelled by the National Commission on Physician Payment Reform (made up largely of physicians, and with former Senator Dr. William Frist as honorary chair). Their conclusion:

"The fee-for-service mechanism of paying physicians is a major driver of higher health care costs in the U.S. It contains incentives for increasing the volume and costs of services, whether appropriate or not; encourages duplication; discourages care coordination; and promotes inefficiency in the delivery of medical services . . . Our nation cannot control runaway medical spending without fundamentally changing how physicians are paid."[15,16]

Primary care physicians have long felt that the current payment system is rigged against them, primarily by the AMA's Specialty Society Relative Value Scale Update Committee (RUC), which sets fee-for-service relative value units that ultimately determine income. The committee is secretive, dominated by procedure-oriented specialists, and has systematically overvalued procedure codes at the expense of cognitive codes.[17] The shortcomings of the current system are widely acknowledged, but entrenched interests continue to resist change

Current reform models like the PCMH and ACOs are evolving toward "blended payment models," which retain the basic core of fee-for service but supplement it with per capita management fees, bonuses based on quality measures, and opportunities for shared savings. These reforms are already having some effect in moderating costs,[3] but it remains to be seen whether the complex and arcane nature of these blended models can actually produce the radical changes called for by the commission.

In the search for alternative payment models, one underground movement bears close attention: "direct primary care." Advocates of this approach point out that insurance is meant for large unexpected expenses, while expenses for primary care are relatively modest and predictable. It makes little sense to pay for these through an insurance model, any more than it would make sense to buy auto insurance to protect from the cost of an oil change or new tires. Instead, patients in direct primary care contract directly with a primary care provider for access to a broad range of office-based primary care services, in return for a monthly or annual retainer fee. Unlike "concierge medicine," the fee is modest (usually on the order of $500-$1000 per year), and can complement high-deductible or catastrophic insurance (which would cover large and unexpected expenses like hospitalization). An element of competition safeguards consumers: practices that don't deliver quality and accessible primary care will quickly lose patients.

For primary care providers, the potential benefits of eliminating the middle-man of third party insurance are enormous: dramatically lower overhead (more than 40% of primary care revenues are now consumed by

administrative tasks such as verifying insurance coverage, billing dozens of different insurance companies, claims processing, appealing denials, etc.)[18], smaller patient panels, more time with patients, a predictable and stable revenue stream, higher income, and virtually no coding and documentation paperwork. Direct primary care is currently small but growing steadily; its advocates predict it will break into the mainstream once large employers discover that the combination of direct primary care and high-deductible insurance is much cheaper than conventional insurance, and begin steering employees toward direct primary care with vouchers or direct subsidies. For primary care physicians long frustrated by the vagaries of third party insurance, direct primary care has the potential to completely circumvent the current system.

UNIVERSAL COVERAGE

Unlike the U.S., virtually all other developed countries have made a moral and political commitment to providing universal coverage to all citizens. Contrary to conventional wisdom, this does not necessarily involve "socialized medicine;" countries like Germany, France, Japan, and Switzerland have achieved universal coverage in the context of competing private (but non-profit) insurance plans, with considerably more "choice" than American consumers have in our system.[19] Lacking such a commitment to universal coverage, U.S. concerns about the increasing cost of health care invariably devolve into strategies to exclude people: cutting Medicaid enrollment, raising the age for Medicare eligibility, exclusion for pre-existing conditions, lifetime caps, or simply pricing people out of the market. By contrast, a commitment to universal coverage can actually introduce certain economies into the system, by abolishing the need for bureaucratic resources to constantly determine "who's in, and who's out," and by drastically reducing the "churning" of the current medical marketplace, which results in up to 20% of the population changing coverage in any given year.

Although the Affordable Care Act of 2010 (ACA) eliminates some of the more egregious tactics of excluding people from coverage, and may eventually decrease the number of uninsured by up to 50%, it will not achieve universal coverage. Even if the ACA works as intended, we will still be left with between 20 and 30 million uninsured, the marketplace "churning" will likely increase, and for-profit insurance companies will still face strong incentives to find ways to avoid enrolling individuals perceived to be at risk for high costs. We cannot achieve an efficient and equitable health care system without a commitment to universal coverage: "everybody in, nobody out."[20]

SINGLE PAYER

A single payer system has long been advocated by some as the most efficient and equitable health care model.[21] Medicare (1965) is essentially a single payer system for the elderly (hence, the single payer call for "Medicare for all."). Internationally, Canada, Taiwan, and the Scandinavian countries have instituted variations of this model. Unlike the "Beveridge Model" of socialized medicine, where the government owns hospitals and employs physicians (as in the U.K., or the Veterans Administration), single payer systems have public financing but private delivery of services.[19] Physicians and hospitals remain private enterprises; they simply submit bills to a single government entity, rather than to one of dozens or hundreds of competing insurance companies. The obvious advantage to such a system is the potential to save hundreds of billions of dollars currently devoted to administration in our complex system.[22,23]

But despite administrative savings, simply changing who pays the bills is unlikely to change underlying cost escalation in a fee-for-service system. A single payer system may or may not be necessary to U.S. healthcare reform, but by itself it is certainly not sufficient. Although it would solve the problem of universal coverage, it would not address reimbursement or GME reform. Absent a robust primary care component, a single payer system that relies on fee-for-service reimbursement for our present procedural and specialty-oriented care is likely to slow but not stop the march toward insolvency.

For reasons that are sometimes hard to fathom, a single payer system has been deemed politically impossible, and has not been given a fair hearing since Senator Kennedy's advocacy in the 1970's. Although organized medicine has been staunchly opposed (as it opposed Medicare in 1965), polling data (pre-Obamacare) indicate that a majority of individual physicians (59%) answered in the affirmative to the question, "Do you in principle support government legislation to establish national health insurance?"[24]

The Obama administration never seriously considered a single payer proposal, evidently considering it to be too politically risky. Representative John Conyers continues to introduce a single payer bill into each new

session of Congress. A recent economic analysis shows that it could cover all Americans at lower total cost than our current system, and that fully 95% of households would see cost savings.[25]

In our current state of political polarization and deadlock, it seems inconceivable that we could move toward a national single payer system anytime soon. However, there are indications of reform on the state level. In May 2011, Vermont passed Act 48, putting that state firmly on the road to a statewide single payer system.[26] Under the provisions of the ACA, they have now instituted a statewide health exchange website, while laying the groundwork for a single payer system. The critical step will be applying to the federal government for waivers starting in 2017, which—if granted —would allow the state to incorporate Medicaid, SCHIP, and Medicare funds into a single payer system.[27]

A similar bill has been introduced in Pennsylvania: Senate Bill 400, "The Pennsylvania Health Care Plan." A detailed economic analysis suggests that universal coverage can be achieved with an immediate savings of 10% of total health care expenditures, increasing to almost 20%, or $3000 per capita, by 2024.[28] Although the prospects for single payer in Pennsylvania currently seem distant at best, at least one democratic candidate for governor in 2014 has endorsed the single payer proposal. Similarly, in Massachusetts, Dr. Donald Berwick is running for governor on a platform of single payer health care.

Under the ACA, states can opt out of the federal law beginning in 2017, but only if they can demonstrate a state plan that achieves comparable or better coverage. Given the state of political polarization and paralysis in Washington, it seems possible that the road to single payer might well run through the states. If even a few states take advantage of this provision and demonstrate success with a single payer system, momentum for change might build. This is essentially what happened in Canada: Saskatchewan, perhaps the most conservative province, elected Tommy Douglas premier in 1944 on a single payer platform, and by 1961, every Canadian province had adopted the Saskatchewan model.[19]

CONCLUSION

This is a time of unprecedented change for U.S. healthcare. From our primary care perspective, some of the changes hold the promise to finally nudge the system in the direction of primary care. However, we fear that these reforms are too little, too late; are in constant danger of being co-opted by entrenched interests;[29] and are too small to bring about the needed change. In this article, we have presented a series of "big ideas" that in our opinion can produce the necessary changes. From the vantage point of the present, all of these seem unlikely; they will certainly be impossible without support from the medical profession.

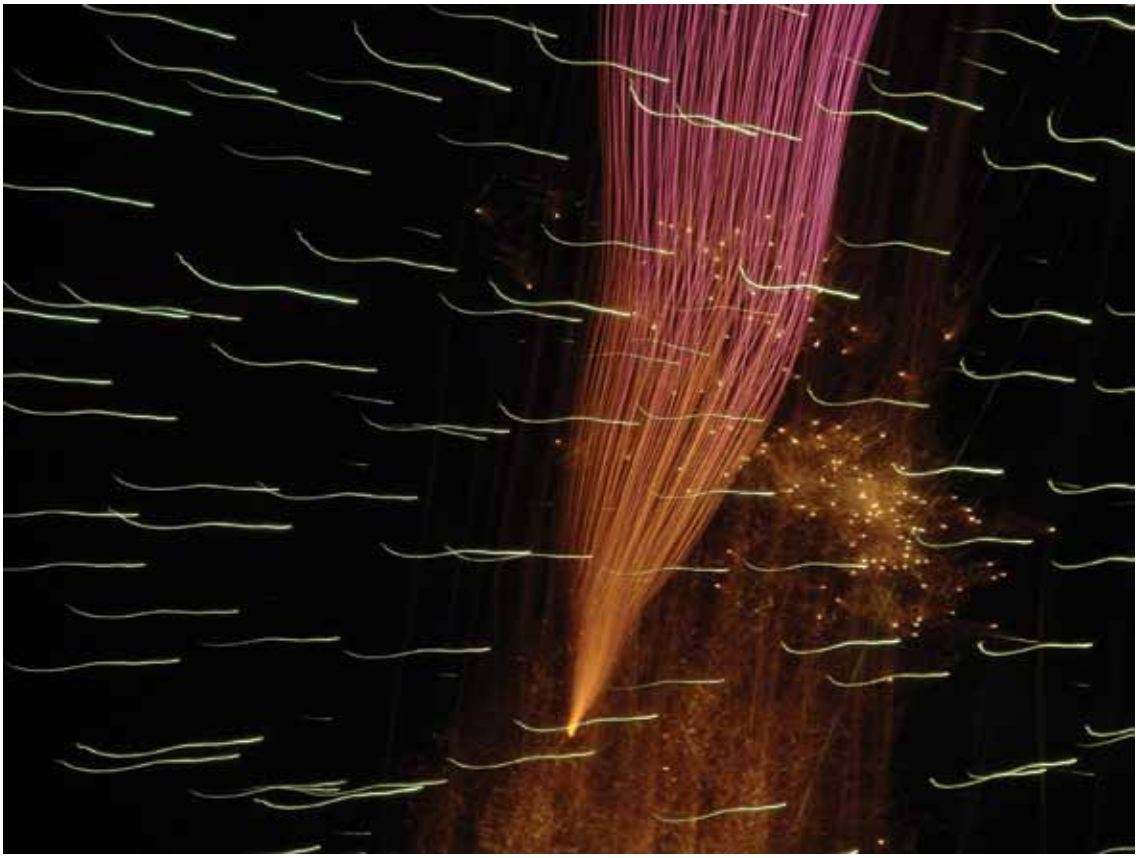
REFERENCES

1. Gates T, Fogelman C, O'Gurek D. A Primary Care Perspective on U.S. Health Care, Part I: The Good, the Bad, and the Ugly. Journal of Lanc Gen Hosp 2013; 8 (2): 37-43.
2. Fogelman C, O'Gurek D, Gates T. Part 2: Thinking Globally, Acting Locally. Journal of Lanc Gen Hosp 2013; 8 (4): 101-105.
3. Nielsen M, Olayiwola JN, Grundy P, Grumbach K. The Patient-Centered Medical Home's Impact on Cost and Quality: An Annual Update of the Evidence, 2012-2013. Patient Centered Primary Care Collaborative. January 2014. www.pcpcc.org/sites/default/files/resources/4%20-%20Executive%20Summary%20and%20Evidence.pdf (accessed January 12, 2014)
4. Goodman DC, Robertson RG. Accelerating Physician Workforce Transformation through Competitive Graduate Medical Education Funding. Health Affairs 2013; 32: 1887-92.
5. Peterson S et al. Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025. Annals of Family Medicine 2012; 10: 503-509.
6. Schwartz MD. The US Primary Care Workforce and Graduate Medical Education Policy. JAMA 2012; 308: 2252-53.
7. West CP, Dupras DM. General Medicine vs Subspecialty career Plans Among Internal Medicine Residents. JAMA 2012; 308: 2241-2247.
8. Council on Graduate Medical Education (COGME): Twentieth Report. Advancing Primary Care. www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/reports/twentiethreport.pdf (accessed January 17,2014)
9. Pugno PA, McGaha AL, Schmittling GT, Fetter GT, Kahn NB. Results of the 2006 National Resident Matching Program: Family Medicine. Fam Med 2006; 38: 637-46.
10. Biggs WS, Crosley PW, Kozakowski SM. Results of the 2013 National Resident Matching Program: Family Medicine. Fam Med 2013; 45: 647-51.
11. AAMC. Trends in Cost and Debt at U.S. Medical Schools Using a New Measure of Medical School of Attendance. Vol. 12, No. 2; July 2012. aamc.org/download/296002/data/aibvol12_no2.pdf (Accessed January 17,2014)
12. Asch DA, Nicholson S, Vujicic M. Are We in a Medical Education Bubble Market? N Engl J Med 2013; Oct 30, 2013.
13. Kruse J. Income Ratio and Medical Student Specialty Choice: The Primary Importance of Mean Primary Care Physician Income to Mean Consulting Specialist Income. Fam Med 2013; 45: 281-3.
14. Bach PB, Kocher R. "Why Medical School Should Be Free." New York Times, May 28, 2011.

15. Report of the National Commission on Physician Payment Reform, March 2013 www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404629. (accessed January 17, 2014).
16. See also Schroeder SA, Frist W. Phasing Out Fee-for-Service Payment. N Engl J Med 2013; 368: 2029-32.
17. Edwards HS. Special Deal. The Washington Monthly. August 2013. www.washingtonmonthly.com/magazine/july_august_2013/features/special_deal045641.php?page=1 (accessed January 16, 2014).
18. Direct Primary Care Coalition. http://dpcare.org/dpc. Accessed January 14, 2014.
19. Reid, TR. The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care. New York: Penguin Books, 2010.
20. Young Q. Everybody In, Nobody Out: Memoirs of a Rebel Without a Pause. Copernicus Health Care. Friday Harbor WA, 2013.
21. Himmelstein DU, Woolhander S. A National Health Program for the United States. N Engl J Med 1989; 320: 102-108.
22. Berwick DM, Hackbarth AD. Eliminating Waste in U.S. Health Care. JAMA 2012; 307: 1513-16.
23. Woolhandler S, Campbell T, Himmelstein DU. Costs of Health Care Administration in the United States and Canada. N Engl J Med 2003; 349: 768-75.
24. Carrol AE, Ackerman RT. Support for National Health Insurance among U.S. Physicians: 5 Years Later. Ann Intern Med 2007; 148: 566.
25. Friedman G. Funding HR 676: The Expanded and Improved Medicare for All Act. How We Can Afford a National Single-Payer Health Plan. http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13.pdf (accessed January 116, 2013)
26. Grubb LK. Lessons from Vermont's Health Care Reform. N Engl J Med. 2013; 368; 1276-77.
27. Dyer O. America's first single payer system. BMJ 2014; 348: g102 doi: 10.1136/bmj.g102 (published online January 10, 2014).
28. Friedman G. The Pennsylvania Health Care Plan Impact and Implementation. healthcare4allpa.org/temp/wp-content/uploads/2013/03/EconomicImpactStudy3513.pdf (accessed January 16, 2014)
29. Starfield B. Family Medicine Should Shape Reform, not Vice Versa. Family Practice Management, July/August 2009; www.aafp.org/fpm/2009/0700/p6.html. (accessed January 17, 2014).

Thomas J. Gates, M.D.
Associate Director, Family & Community Medicine
717-544-4940
tjgates@lghealth.org

Corey D. Fogleman, M.D.
Associate Director, LGH Family & Community Medicine Residency Program
717-544-4940
cfogleman2@lghealth.org



Fire in the Sky
Jonathan Crothers