

Congressional Health Care Reform Education Project  
October 21, 2008  
Health Care Delivery: Access and Quality

### House Summary

**Robert Graham** of the University of Cincinnati College of Medicine discussed some of characteristics and advantages of primary care. He is chairman of the board of the Alliance for Health Reform and CEO of the American Academy of Family Physicians. Dr. Graham presented slides submitted for the occasion by **Fitzhugh Mullan** of The George Washington University.

Dr. Graham noted that primary care physicians are those in family medicine, general internal medicine and general pediatrics. These make up 22 percent of all U.S. physicians (in contrast with many other countries, in which half of all physicians are in primary care). The “unit of care” for a primary care practitioner is a relationship with a patient over time, he said. Specialty care, on the other hand, aims to provide a successful procedure to the patient, without necessarily leading to a continued relationship.

He presented the definition of primary care worked out by an Institute of Medicine committee: “Primary care is the 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.”

As the number of primary care physicians increases in a region, costs tend to go down and health status tends to go up, Dr. Graham pointed out. The same trend can be seen internationally when it comes to health care expenditures; countries that emphasize primary care tend to have lower per capita health spending than those with where specialty care dominates, particularly true in the U.S.

The need for primary care will grow as the baby boomers age, he said. But the percent of U.S. medical students entering primary care residencies has dropped each year since 1999. This decline has been offset by the increasing number of medical graduates from other countries entering primary care residencies in the U.S. Some primary care residents later go into medical specialties, he added, and do not in the end help grow the pool of primary care practitioners.

Repaying student loans is a good way to entice medical graduates into primary care residencies, Dr. Graham said. This is how Massachusetts is trying to reduce the six- to nine-month wait for patients wanting an initial visit with a primary care physician in that state, a situation that became serious after near-universal coverage was adopted in that state. But efforts to increase the primary care workforce can begin much earlier, by encouraging children as young as elementary school age to consider a medical career and by having medical schools recruit students who are likely to go into primary care.

Among policy action areas to be addressed, Dr. Graham listed: 1) reinvention and recapitalization of the Title VII program, 2) re-energizing the National Health Service Corps, 3) linking Medicare graduate medical education (GME) funds to the training of a certain number of

primary care physicians, and 4) changing Medicare reimbursement to pay primary care physicians more and specialists somewhat less.

**Eugene Rich** of Creighton University School of Medicine reviewed several federal policy options for promoting primary care. The options involve changing physician payment, changing GME funding, and boosting funding for primary care training.

Dr. Rich said the physician payment structure in the U.S. has historically favored specialty care. There is no explicit reward currently for primary care functions such as being available to patients at all hours, coordinating care with other providers or spending extra time with patients. Fees to primary care practitioners could simply be increased outright, he said, or fee-for-service spending for primary care could be allowed to grow faster than for fee-for-service specialty care. An expert panel could be convened to identify physician services that have become overvalued.

Another way to boost payment for primary care functions would be to reward practices that meet the criteria for “patient-centered medical homes.” (Some of the characteristics: a personal physician in a physician-directed medical practice, whole-person orientation, coordination of care, emphasis on quality and safety, enhanced access to care, payment reform.) Rewarding medical homes, however, would involve some policy debates, such as exactly which criteria a medical practice or other setting would have to meet in order to qualify.

Turning to Medicare GME funding, Dr. Rich noted that attempts to boost primary care through GME funding changes failed in the early 1990s. Medical residency positions reserved for primary care consistently go unfilled, and the number has been reduced over the past decade. Nonetheless, GME funding reform of a different type could put more future primary care physicians in the pipeline, he said. Some examples: GME grants through the Health Resources and Services Administration (HRSA), GME block grants to states.

Primary care training could also be boosted by increasing funding for HRSA Title VII. This funding has plummeted 10-fold over the past 30 years, Dr. Rich said.

The final speaker of the session was **Mark Miller**, executive director of the Medicare Payment Advisory Commission (MedPAC). Like the previous speakers, Dr. Miller cited research suggesting that increasing the use of primary care services relative to specialty care can improve the quality, efficiency and coordination of health care delivery.

He agreed that primary care services are undervalued. The current health care system rewards volume of services delivered, he said, not primary care features such as coordination of care. He said this could be remedied by directly linking payment to quality and efficiency.

MedPAC has begun researching whether Medicare payments should be increased for certain services provided by primary care practitioners, Dr. Miller said. Primary care providers could receive a 5 to 10 percent boost in fees. Since such a proposal would be budget neutral, specialists would get a fee cut.

MedPAC also has approved a plan to initiate a medical home pilot project of sufficient size to produce statistically reliable results. Medical homes in the pilot would be settings focusing on patients with multiple chronic conditions. Medicare could also encourage joint accountability and

efficiency between a hospital and its affiliated physicians by reducing payments to hospitals with high readmission rates for certain medical situations, and by bundling payment for an episode of care (combining hospital and physician payments). The episode of care would be defined to include the 15 to 30 days after discharge, as a way of reducing readmissions.

### **Q&A Session**

During the question and answer session, the role of non-physicians in primary care was raised. Dr. Graham said most primary care practices include nurse clinicians and physician assistants (PAs). There is occasional friction between physicians and nurse practitioners, he said, over the question of how much independence nurse practitioners should have.

He said that for patients whose diagnosis is unclear at the initial contact with the medical setting, it is less expensive for a physician to see the patient first, rather than a nurse clinician or PA. For patients with an established diagnosis, such as a chronic disease, the situation is reversed. About three-fourths of patients will see a nurse clinician or PA first.

Dr. Miller said MedPAC has started discussions over whether to require the presence of nurses in a coordinated care team in GME training. Another question MedPAC would like to answer: How much of a patient's medical problem could be resolved in an initial contact with a nurse clinician or physician assistant?

In answer to another question, Dr. Graham explained that family physicians see children, adolescents, younger and middle age adults, and older adults. They often deliver babies. Dr. Rich said internists have a more limited scope of practice, not including children under age 16, obstetrics or major surgery.

"Hospitalists" are physicians, usually internists, whose practice is limited to hospitalized patients of other physicians. The assistance of hospitalists frees up physicians operating outside the hospital, which is especially valuable if the external physician must travel long distances to get to the hospital. Dr. Graham said the use of hospitalists produces greater coordination of care for the patient during the hospitalization, rather than less.

Panelists were asked why medical graduates don't go into primary care. Higher incomes in the specialties, plus a more controllable lifestyle, are disincentives for a life in primary care, they said. Dr. Graham added that academic medical centers typically don't show enough respect for primary care as a field.

A questioner asked how long it would take for federal policy changes to make a difference in the actual number of primary care providers. Panelists agreed that change would not be immediate, given the three-year residency training required. But they also agreed that it was important to begin necessary changes to promote future growth.

A question was posed about whether small practices could ever qualify as medical homes. Dr. Miller said it was inevitable that larger practices will see more and more patients as smaller practices fall behind in the use of new technologies. He noted, however, that with the Geisinger Health System, small practices can be tied to a hospital through health information technology, benefiting patients and meeting many of the criteria for medical homes.

Discussing ways to encourage more people to choose primary care careers, Dr. Graham said medical schools could give a priority to applicants from smaller communities, who might tend to go back to such communities as primary care providers. The National Health Service Corps could also be boosted as a way of getting primary care physicians into underserved areas. Dr. Graham noted again that loan repayment works better than tuition assistance in getting physicians to practice in underserved locales.