EDITORIAL

Primary Care Needs Real Change

For "real change" to be more than a political sound bite, the new administration in Washington will need vision and courage to promote and sustain high-quality and affordable health care. Part of that vision will need to be a strong primary care workforce.

Our system of medical education attracts some of the best and brightest students, educates them well in our medical schools, and provides unparalleled training in its postgraduate programs. Our research institutions, private industry, and universities have given us new therapies and technologies that are among the finest in the world.

Despite these advances, we still have 45 million people without health insurance who have insufficient access to primary care. It is a system we cannot afford. Health insurance premiums increased 114% between 1999 and 2007, while workers' earnings increased by 27%. Health care spending in the United States is 16% of the gross domestic product and increasing yearly.

Primary care can be a powerful force to control costs and maintain a high-quality health care system by using prevention strategies to combat diabetes, heart disease, and other chronic illnesses that account for 75% of health care costs. Primary care also can improve coordination of care via the patient-centered medical home and health information technology, and can reduce hospitalization rates (5 million admissions per year, costing $26.5 billion) and use of technology, which accounts for one-half to two-thirds of health spending growth.

BY N.S. DAMLE, M.D.

Here are some of the factors that serve as barriers to maintaining the vibrant primary care workforce that's needed to improve our health care system:

▶ **A declining interest in primary care.** Interest in primary care peaked in 1998, when 9,348 residents entered general internal medicine. Since then, the number of new primary care physicians has fallen to 1995 levels, while the U.S. population has grown by 12%. At present, only 2% of medical students are considering a career in general internal medicine, and 62% of internal medicine residents enter subspecialties.

▶ **A widening gap between supply and demand for primary care.** As the population ages, the shortfall in primary care during the next 15 years could reach 20%-27% (35,000-44,000 physicians). This deficit is further exacerbated by an uneven supply in certain geographic areas.

▶ **The culture of physician training and preferences.** The clinical curriculum for third- and fourth-year medical students is centered on tertiary care. This environment is also the setting for postgraduate education. Many of the mentors during training are subspecialists, and the medical problems are often complex and require subspecialty care that involves procedural and surgical solutions. Also, studies have shown a trend among medical students toward seeking a balance between work and leisure time, and primary care is viewed as less able to satisfy these preferences.

▶ **Income disparities.** Many studies demonstrate a two- to threefold difference in compensation between primary care and procedural-oriented subspecialties or specialties other than internal medicine, and the income gap is widening.

Although loan forgiveness programs and scholarships for entering primary care and practicing in underserved areas are helpful, they will not solve the problem without changes in reimbursement.

We need to create a hybrid system of reimbursement for primary care—one that combines care management with fee-for-service and quality incentives—to bring primary care income to parity with that of procedural subspecialists in internal medicine, as well as other medical specialties. Also, the relative value scale must be updated to reflect the importance of evaluation and management services, and the sustainable growth rate formula should be changed or eliminated.

To some degree, funding will need to be shifted from procedural and imaging services to cognitive services. Decreased hospitalization rates, technology cost control, disease prevention, and management of chronic illness will help curb costs. Finally, we should establish an institute that evaluates the costs, effectiveness, and safety of medical, procedural, and surgical interventions.

Health care reform is a complex issue with multiple stakeholders. Real change must start with a strong primary care workforce in an affordable health care system. ■

DR. DAMLE, who practices in Wakefield, R.I., is governor of the Rhode Island Chapter of the American College of Physicians.