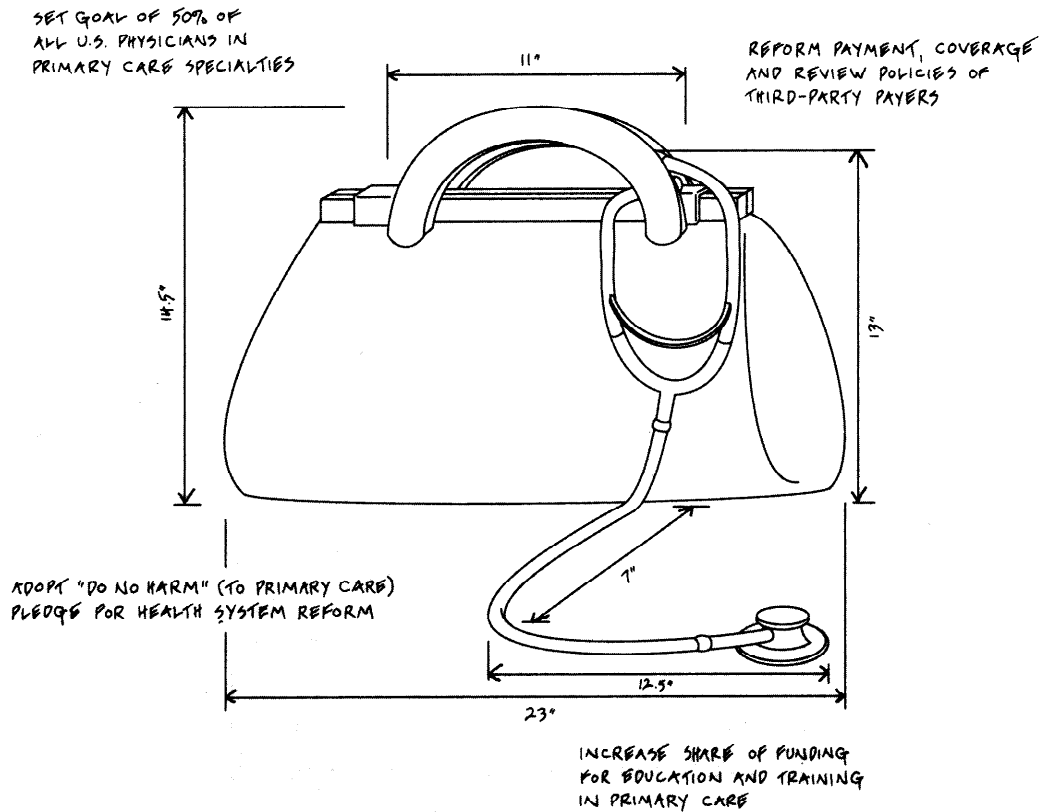


A BLUEPRINT FOR THE FUTURE

REBUILDING PRIMARY CARE

March 1993



asim 
american society of internal medicine

2011 Pennsylvania Avenue, NW
Suite 800
Washington, DC 20006-1808
(202) 835-2746
FAX: (202) 835-0441

Note:

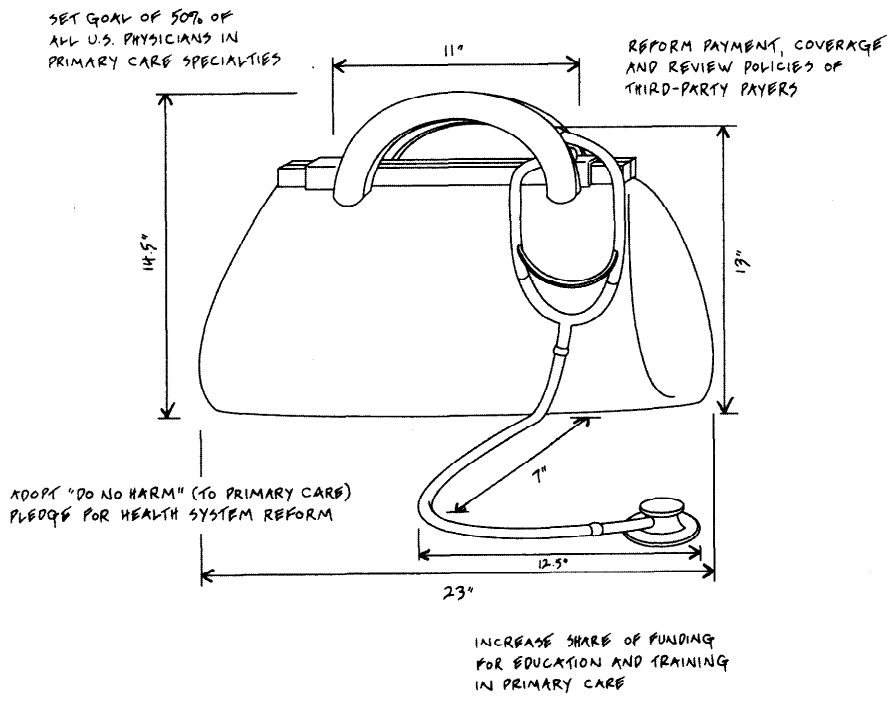
Material quoted or reprinted from this publication must be attributed to the American Society of Internal Medicine



2011 Pennsylvania Avenue, NW
Suite 800
Washington, DC 20006-1808
(202) 835-2746
FAX: (202) 835-0441

Table of Contents

Executive Summary	5
Introduction	11
The Crisis in Primary Care	13
Primary Care and Internal Medicine	17
Why Are Physicians Not Choosing Primary Care?	22
Goals and Objectives	28
Recommendations for Improving The Practice Environment for Primary Care	29
Reforms in Medicare Payment, Coverage and Regulatory Policies	30
Reforms in the Regulatory Policies of Other Federal Programs	38
Reforms in the Payment, Coverage and Review Policies of Private Insurers	40
The Impact of Health Reform	43
Recommendations for Improving The Training Environment for Primary Care	47
GME Funding	47
Direct Financial Incentives	48
Training in Ambulatory Settings	49
Medical School Reforms	51
Other Training Reforms	52
Conclusions	53
Endnotes	54



Executive Summary

The American Society of Internal Medicine (ASIM) prepared this paper to document the extent of the decline in the number of primary care physicians and to propose solutions to reverse this trend. Citing studies and actual reports from primary care physicians, the paper presents several key conclusions. Without immediate action to reverse existing trends, there will be too few primary care physicians to meet the country's current and future needs. Costs would be lower, and lives would be saved if there were more primary care physicians.

Although the nation also needs more generalists in family practice and pediatrics, general internists provide unique skills that can meet the country's primary care needs—including training in the diagnosis and treatment of adult patients with complex medical problems, management and coordination of care, and preventive counselling.

Unfortunately, a hostile economic and regulatory practice environment is turning physicians away from primary care. The emphasis on specialization in the content and funding of medical education also contributes to the disenchantment. If policy-makers wish to rebuild primary care, it will be necessary to institute reforms that address these disincentives.

Goals and Objectives

The paper presents the following goals and objectives:

1. Fifty percent of physicians should be trained in and should practice primary care.

2. At least half of the primary care physicians should be trained as general internists.
3. Increasing the number and proportion of generalists should be the highest priority. The contributions of subspecialists in providing primary care also should be recognized.
4. Increasing primary care in underserved areas should be emphasized.

Recommendations

The recommendations that appear in the paper are summarized below. The paper provides additional details on implementing the recommendations, as well as the rationale behind them.

Changes in Medicare Payment, Coverage and Regulatory Policies

1. Primary care should be protected from budget cuts.
2. Payments for practice costs should be based on resource costs.
3. The Medicare volume performance standard (VPS) should be changed to create incentives for primary care.
4. A higher "default" floor on payments for primary care should be instituted.
5. Improvements should be made in the fee schedule's geographic adjustments.
6. Annual bonus payments for primary care services should be provided.

7. Primary care services should be protected from payment reductions caused by further refinements of the Medicare fee schedule.
8. The criteria for designation as a "health professionals shortage area" should be expanded to include additional locales.
9. Bonus payments for primary care services in designated health professionals shortage areas should be increased.
10. Medicare coverage of services provided by primary care physicians, including preventive services, should be expanded.
11. Full Medicare payments to new physicians should be restored.
12. A formal process should be created to assess the impact on primary care practices of proposed Medicare requirements prior to implementation.
13. The impact on primary care physicians of the current methods of conducting Medicare utilization review should be examined, and improvements should be made to reduce the intrusiveness of such review.
14. The impact on primary care physicians of pending documentation requirements for visit services should be examined.
15. Improvements should be made in the efficiency and effectiveness of administrative services provided to primary care physicians by Medicare.
16. A regulatory exemption from the Stark ban on self-referral should be granted

for laboratories that are shared by primary care physicians.

17. Medicare carriers should be required to divulge all utilization review criteria.
18. Improvements should be made in Medicare policies on coverage of concurrent care, pre- and postoperative consultations, and case management services.

Reforms in Other Federal Programs

1. The Occupational Safety and Health Administration (OSHA) regulations on blood-borne diseases should be modified to reduce the burden on primary care physicians.
2. All federal agencies should establish a process to assess formally the impact on primary care physicians of proposed regulations.
3. President Clinton should establish an interagency process to evaluate and moderate the cumulative impact of all regulations on primary care.
4. The Clinical Laboratory Improvement Amendments (CLIA) should be implemented in a way that does not impose an undue and unnecessary burden on primary care physicians.

Reforms in Private Insurance

All private insurers should improve payments for primary care services.

2. Private insurers should streamline administrative costs.
3. All utilization review firms should be required to meet federal standards.

4. All insurers should divulge their review criteria, involve primary care physicians in the development of such criteria, and move toward “patterns of care” review in lieu of more intrusive review methods.

Role of Health Reform in Rebuilding Primary Care

1. Health reform proposals must first “do no harm” to primary care. Proposals that will further increase payment inequities and micromanaging of primary care practices should either be rejected or modified.
2. Managed competition legislation should assure that health plans pay adequately for primary care and that they do not micromanage physician practices.
3. Market-based approaches should be emphasized over expenditure ceilings enforced by price controls. If some form of global budgets is considered, it should be in the form of negotiated goals, not absolute ceilings.
4. As an alternative to mandating uniform payment rates, payers and physicians should be required to use the resource-based relative value scale (RBRVS) to determine payments and fees, but with freedom to choose their own annual conversion factors.
5. All insurance plans should require improved coverage and a lower deductible for primary care and preventive services.
6. Internists should be represented adequately on any national or state boards that are given authority to propose bud-

gets or expenditure goals, determine benefits, establish policies on data disclosure, or recommend other health care policies.

7. Health reform should improve payments under Medicaid—or under a new program to replace Medicaid—for services by primary care physicians.
8. It is not enough for health reform proposals to “do no harm” to primary care. Instead, health reform should include comprehensive proposals—such as those presented throughout this paper—to rebuild primary care.

Reforms in Medical Education

1. Primary care training programs should receive a *substantially* larger share of Medicare graduate medical education (GME) funding.
2. A portion of the increased GME funding for primary care residencies should be provided as increased stipends to residents, with payback by those who do not go into primary care.
3. Loan forgiveness should be provided to primary care physicians.
4. Scholarships and lower interest loans should be provided for medical students who make a commitment to primary care.
5. Residents should receive greater exposure to primary care in ambulatory settings. Specific goals should be established for the percentage of training time that residents should spend in ambulatory settings, including time spent in physician offices. “Mentorship” pro-

grams should be encouraged. In addition, expanded Medicare funding should be provided for training in ambulatory and office-based settings.

6. All payers should be required to contribute a percentage of their payments for medical care to a financing pool. Payments from the pool should be distributed to training programs based on a formula that favors primary care.
7. Medical schools should be encouraged to implement proposals to increase the involvement of primary care physicians in the education of medical students, to provide students with meaningful experiences in the primary care specialties, and to expose students to primary care role models.
8. The National Health Service Corps (NHSC) should be expanded.
9. Qualified primary care physicians who are practicing in rural areas designated as health professional shortage areas should receive a tax credit for three years based on a five-year service incentive. Funds given to physicians through the NHSC loan repayment program should be tax free.

10. The National Institutes of Health and the Agency for Health Care Policy and Research should receive additional funding for research in primary care.

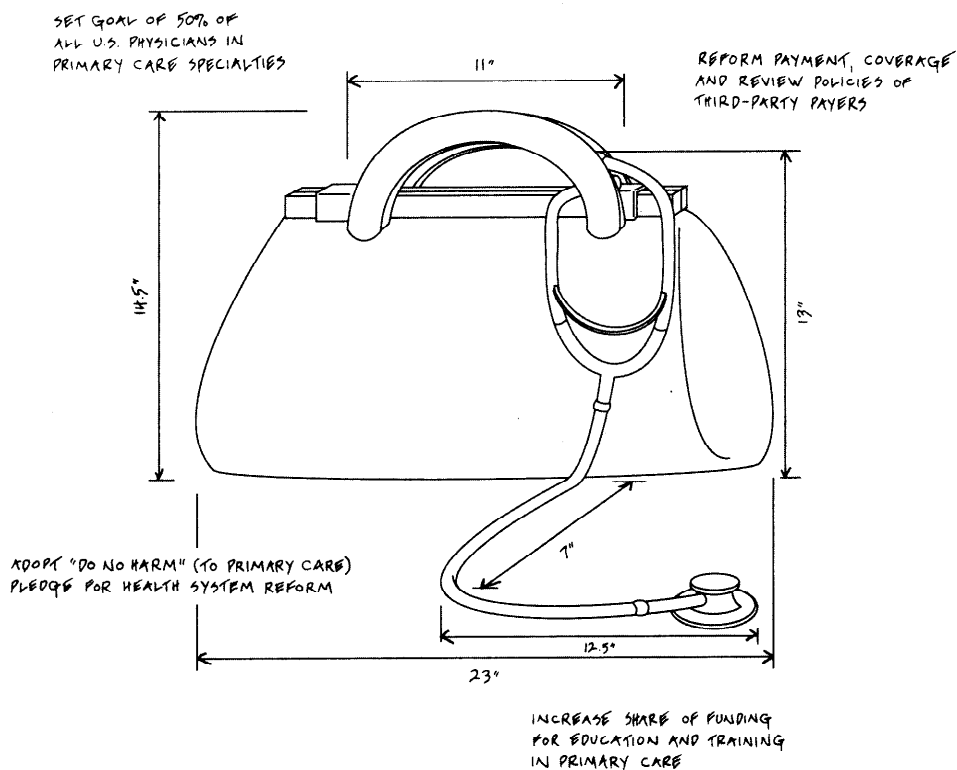
Conclusion

As Congress and President Clinton debate the future of the health care system, the problems and recommendations presented in this paper should be considered. Much of the debate so far has focused on insurance coverage, global budgets, employer mandates and market reforms. But the question of what will happen to primary care deserves just as much attention.

Rebuilding primary care is not without costs. Many of the recommendations will require either spending more or reducing payments for other services to offset the increased costs. But the costs of doing nothing are higher. Without a strong foundation of primary care, the nation cannot succeed in expanding access or controlling costs. Rebuilding primary care is not just another issue that needs to be dealt with as part of reform. Rather, it is a necessary condition for successful reform.

A BLUEPRINT FOR THE FUTURE

REBUILDING PRIMARY CARE



**Proposals of the
American Society of Internal Medicine**

“ I did not enter medicine to become wealthy. I wanted to perform a service that was honorable, respectable and needed. . . . When I ventured into solo primary care practice, I honestly believed that a physician who offered a service based on truth, honesty, integrity, ethics and patients’ wants and needs could prove to the money-grubbers in medicine that one does not have to embrace a materialistic, business attitude to be successful, and that one can maintain self-respect and dignity in the process. I am coming to the conclusion that I was wrong. Will I stay the distance? I honestly don’t know. There certainly isn’t much satisfaction left at the end of my days, except in knowing that I may have helped a patient or two. But satisfaction alone doesn’t pay the rent.

— *Excerpt from a letter from a primary care internist in Denver, Colorado, to then-Governor Bill Clinton, July 21, 1992*

[My partners and I] wonder who is going to take care of us when we retire in the way in which we have taken care of our patients over the last 29 years. If ‘they’ and the government don’t wake up and recognize the importance of primary care providers soon, health care will be even more expensive than it is, and there will

be nobody to take care of the integration of multiple-system disease. Doctors I know have little interest in staying in their present situation and undertaking those responsibilities for the amount of money they are paid, the hassle that goes with it, and the general sense of loss of prestige that has developed over the last 20 years.

— *Excerpt from a letter to ASIM from a primary care internist in Colorado Springs, Colorado, September 9, 1992*

The nation has too few generalists and too many specialists. The growing shortage of practicing generalists (i.e., family physicians, general internists and general pediatricians) will be greatly aggravated by the growing percentage of medical school graduates who plan to subspecialize. . . . A rational health care system must be based on an infrastructure consisting of a majority of generalist physicians trained to provide quality primary care and an appropriate mix of other specialists to meet health care needs.”

— *Finding Number 1, Third Report, Council of Graduate Medical Education, U.S. Department of Health and Human Services, October 1992.¹*

Introduction

If anyone doubts that this country is facing a crisis in access to primary care, he or she needs only to listen to what primary care physicians are telling us about the reality of practice today.

The American Society of Internal Medicine (ASIM) asked established primary care internists to tell us what it is like to practice primary care today. We asked young physicians in training to let us know what motivates their decisions on choice of specialty and type of practice. The comments excerpted on the facing page are just a small sample of what we heard. ASIM also reviewed the growing body of research on primary care to determine if it supported the anecdotal evidence.

All data led to the same conclusion: Unless policy-makers take immediate steps now to reverse the trend away from primary care, within a few years there simply will not be enough primary care physicians available to meet the needs of patients. Because primary care is the foundation on which the health care system rests, efforts to reform the health care system will fail unless attention is also paid to the impending crisis in access to primary care.

What Is Primary Care?

Primary care is the foundation for health reform because it is through visits to primary care physicians that patients obtain *appropriate* access to initial medical care and other services available from the health care system. The Council on Graduate Medical Education (COGME) observed that primary medical care is characterized by the following elements:

- First-contact care for persons with undifferentiated health concerns;
- Person-centered, comprehensive care that is not organ- or problem-specific;
- An orientation toward the longitudinal care of the patient; and
- Responsibility for coordination of other health services as they relate to the patient's care.

Physicians who provide primary medical care . . . are trained, practice and receive continuing education in . . . health promotion and disease prevention, assessment and evaluation of common symptoms and physical signs, management of common acute and chronic medical conditions, [and] identification and appropriate referral for other needed medical services.²

In other words, by being the initial point of contact with the health care system, primary care physicians have a critical role in determining, in consultation with their patients, what care patients will receive and how much it will cost. It is through primary care that most patients obtain the preventive services needed to keep them well. It is through primary care that decisions are made on what tests are needed and what specialists are required. It is internists and other primary care physicians who usually determine who is admitted to the hospital, for how long, and what services will be provided by the hospital. And when the ability of science to influence the course of an illness has been exhausted, it is primary care physicians who usually advise patients and their families that nothing more can, or should, be done.

Why Is Primary Care Important?

Without the foundation of primary care, proposals for health reform will not succeed in expanding access and controlling costs. Expanded insurance coverage by itself will not result in expanded access, if there are too few primary care physicians around to help their patients obtain access

Unless policy-makers take immediate steps now to reverse the trend away from primary care, within a few years there simply will not be enough primary care physicians available to meet the needs of patients.

to the services that they need. Cost controls will fail, if there are too few internists and other primary care physicians—or too many of the wrong kinds of “providers”—available to *manage* the resources spent on behalf of their patients.

But even though primary care is the foundation of the health care system, it has been taken for granted and neglected for too long. As a result, the foundation is crumbling. One wouldn't add more cars and more weight to a creaky bridge with crum-

bling columns and supports. Similarly, it makes no sense to add up to 40 million more Americans (those currently without health insurance) to the health care system without reinforcing and buttressing primary care.

Why Write This Paper?

ASIM has developed this white paper in the hope of persuading policy-makers to take the steps necessary to rebuild primary care. As an organization representing one of the three major specialties—internal medicine, family practice and pediatrics—that provide primary care in this country, ASIM has long been an advocate of policies to help primary care. But it is only recently that ASIM has concluded that primary care is at a crisis point, and unless steps are taken now to rebuild it, collapse is inevitable.

This paper documents the evidence supporting the conclusion that primary care is in trouble. It examines the potential impact on primary care of the health reform options currently under consideration. It explains why only a multifaceted strategy that targets the economic, regulatory and training disincentives that discourage physicians from entering or staying with primary care will be successful in preventing collapse. And it presents 44 recommendations for rebuilding primary care and the rationale for each.

The Crisis in Primary Care

A Look at the Data

How do we know that there are not enough physicians going into primary care? Even though some may still question this basic premise, the data overwhelmingly support the conclusion that more primary care physicians are and will be needed than will be available based on current trends.

One way to look at this question is to review trends in applications for residency programs in internal medicine and other primary care training programs. According to one recent study, the limiting factor in educating an adequate number of primary care physicians is not the number of residency positions, but the declining number of applicants. In 1991, 19 percent fewer U.S. medical school graduates entered a training program in internal medicine than in 1986. The actual decline in primary care is far greater than that because many in internal medicine and pediatrics choose to enter a subspecialty. The same study reported that interest in primary care has fallen from 36 percent of graduates in 1982, to 22.5 percent in 1989, a decline of 37.5 percent.

The author concluded that these trends suggest that *fewer than 20 percent of today's graduates are planning careers in primary care*. The result is that only 34 percent of physicians describe themselves as generalists today, and less than a quarter of physicians will function as generalists in the next century if current trends continue.³ A survey of medical students conducted in 1991 by the Association of American Medical Colleges (AAMC) suggests that the trend has worsened in the past two years. *Only 14 percent of medical students surveyed in 1991 plan to deliver primary care, compared with 39 percent in 1982.*⁴

Another study noted that the proportion of physicians who practice in a primary care specialty has dwindled in recent years. In 1963, nearly half of the nation's physicians were in a primary care specialty; by 1986, only 34 percent were. An increasing proportion of physicians in the primary care specialties work in non-patient care activities, such as administration or research, or they practice as full-time members of a hospital staff. This trend, coupled with the

In 1963, nearly half of the nation's physicians were in a primary care specialty; by 1986, only 34 percent were.

diminished number of general practice physicians, has caused an overall decrease in the ratio of office-based primary care physicians to the U.S. population (a ratio of 53.1 office-based primary care physicians per 100,000 population in 1963, compared with 52.8 in 1986—a reduction of 0.3 percent).

The decrease was even more substantial in non-metropolitan areas: From 1963 to 1986, the ratio of primary care physicians in rural areas decreased from 50.7 to only 42.6 per 100,000 people, a decrease of more than 8 percent.⁵ More and more frequently, primary care is being provided by physicians who have a combined general internal medicine and subspecialty practice.

Additional evidence comes from studies that compare distribution in this country with other Western industrialized nations. Several studies have noted that approximately one-third of U.S. physicians practice primary care, compared with two-thirds in

Britain and more than half in Canada and Australia.⁶⁻⁸

Numerous expert groups that have analyzed trends in the supply and distribution of physicians have reached the conclusion that too few U.S. physicians are choosing primary care, the trend is worsening, and steps must be taken to increase the number and proportion of physicians in general internal medicine and other primary care

The evidence shows that primary care not only saves money, it also saves lives.

specialties. The Council on Graduate Medical Education (COGME), the Physician Payment Review Commission (PPRC), the Federated Council for Internal Medicine (FCIM), the AAMC, the Bureau of Health Professions of the Department of Health and Human Services (HHS) and numerous specialty societies, including ASIM, the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP), have reached this same conclusion.

Although primary care physicians treat patients of all ages, the graying of America will continue to fuel the demand for their services. This is because the elderly require far more of the health care system than other age groups, and they depend on primary care physicians to provide basic medical care and to manage and coordinate their access to the health care system.

Physicians who specialize in internal medicine will be in particular demand. Internists receive three years of training exclusively in adult medical care and currently see more Medicare patients each week than any other specialty.

According to a recent study, the most rapid increase in the 65-plus population will occur between 2010 and 2030, when the huge baby boom generation reaches age 65. By 2049, there will be about 68 million older people, or 22.2 percent of the U.S. population, compared with 12.5 percent of the population today. By the end of the 1990s, the number of people between 75 and 84 will grow nearly 70 percent, to 4.9 million. The 85-plus age group is the fastest growing in the country. By 2040, there may be close to 13 million people over the age of 85. Today, people 65 and over consume 30 percent of health care resources. By 2030, they will consume 50 percent of all health care resources.⁹

The studies cited above provide compelling evidence that the number and distribution of primary care physicians is declining. The evidence also shows that the demand for primary care services will increase, especially among the elderly. The widening gap between the need for, and the supply of, primary care physicians demonstrates the urgency of reversing the trend away from primary care. Failure to do so will mean that patients will be denied access to services that are essential to their health and well-being. It also means that the care that they receive will be far more costly.

Why Patients Benefit From More Primary Care

The crisis in primary care, however, is more than just a question of numbers. If there were no relationship between the availability of primary care physicians and benefits to the public, then policy-makers would be right to view the objective of rebuilding primary care as being of little value. Clearly, the research literature strongly supports the benefits to the public of a policy that invests in rebuilding primary care. Specifi-

cally, the evidence shows that *primary care not only saves money, it also saves lives.*

COGME has concluded that “the limited number of primary care providers in the United States intensifies the barriers to access for all Americans,” with the problem being the greatest in rural and inner-city areas. The council observed the following:

Many Americans lack access to basic primary care, which includes a comprehensive range of public health, preventive, diagnostic and rehabilitative services. The goal of these services is to prevent premature death and disability, preserve functional capacity and enhance overall quality of life. Building a health care system that ensures the availability of these services is a fundamental goal. Ensuring the right mix of health professionals to deliver these services is a prerequisite.¹⁰

In March 1992, the HHS hosted a National Conference on Primary Care that brought more than 800 participants to consider how primary care can address the health care access and financial problems facing the United States. According to the Executive Summary of the conference proceedings, “Calls for reform are being heard across the political and social spectrum. The individuals and organizations offering proposals for reform differ greatly in their views about the appropriate role of government and how health care should be financed. Nonetheless, they are increasingly looking to a restructured health care system—a *system with primary care at its center*—to solve the nation’s problems of health care cost and access. Changing the financing of health care without changing its organization, they have come to believe, will not solve the critical problems we now face.”¹¹ [Emphasis added.]

Most of the reports published to date have empirically come to the same basic conclusion: that the health of the public is related to the availability of primary care physicians. Populations and individuals who do not have access to primary care services have poorer outcomes; those with access to primary care enjoy better health. A just-published study provides convincing data to support this conclusion.

The study involved a state-by-state analysis of mortality and life expectancy compared with the number of primary care physicians. The study concluded that “a greater number of primary care doctors is associated with lower death rates and longer life spans, whereas a greater number of specialists is associated with neither.” Furthermore, “primary care was the only variable with the expected signs and highest correlations among the life chance indicators and health services resources. Primary care was most significantly correlated with [increased] life expectancy (0.54), [reduced] infant mortality (-0.41), [reduced] neonatal mortality (-0.29), and [reduced instances of] low birth-rate (-0.38).”

Dr. Leiyu Shi, the author of the study, attributed the study’s results to the fact that primary care doctors are more accessible than specialists and offer more in the way of prevention. “We know that primary care saves money,” the author commented. “What this tells us is that it also saves lives.”¹²

Cost Savings

There is considerable evidence to support the conclusion that primary care saves money. COGME found that “the cost of physician services is much greater in the United States [compared with other countries] and that patients undergo more intense medical services per visit because of

the exceptionally high proportion of non-primary care specialists in this country.”¹³

Numerous other studies have concluded similarly that costs are higher when overspecialization occurs at the expense of primary care. “More and more specialization and an increasing supply of physicians will contribute to escalating health care expenditures,”¹⁴ according to one recent study.

Similarly, another found that “the costs of the current generalist-to-specialist ratio are also great: overuse of costly procedures, inadequate access to generalists’ services and excessive medical care expenditures.” The same study notes that “the shortage of generalists, especially in the inner cities and rural areas, results in the use of emergency rooms for non-urgent care or lack of care altogether. When someone goes without care, he or she misses opportunities for prevention and early intervention, as well as case management for any complex medical problems.”¹⁵

The same phenomenon was noted by Marc L. Rivo, the director of medicine for the Bureau of Health Professions in HHS. “In many parts of the country, including large cities, there are not enough generalist physicians to provide basic access to care,” he observed in a recent interview. “So people are using emergency rooms for their care or putting off seeing a doctor.”¹⁶

The evidence is overwhelming that the availability of internists and other primary care physicians is directly related to better health status and lower costs. Therefore, even though policies to increase the number and proportion of internists and other primary care physicians will necessarily involve a greater investment of publicly funded expenditures, the long-term benefits of better health and lower costs will far outweigh the initial costs.

Primary Care and Internal Medicine

Even if there is a consensus that more primary care physicians are required, there are several questions relating to the role of each of the generalist or primary care specialties in meeting this objective. More specifically, public policy will need to address the roles of general internists, family physicians, pediatricians and internist-subspecialists in meeting the growing need for primary care services.

Family practice, pediatrics and internal medicine each should have a role. But the American Society of Internal Medicine (ASIM) also believes that internists offer unique skills that will be needed increasingly in the future. Those skills include diagnosis and treatment of adult patients with complex, multi-system problems; interpretation of sophisticated diagnostic tests; management and coordination of care; and preventive counselling. Public policy should specifically encourage the availability of internists to meet the primary care needs for a substantial portion of the population, especially the aged and people with complex, multi-system problems.

Much of the literature on the crisis in primary care, including many of the studies cited in this paper, poses the issue as being one of generalist versus specialist physicians. In some respects, however, this terminology is misleading, because internists who have completed a three-year residency in internal medicine and have gone on to deliver primary care services are considered to be "specialists" in adult medical care.

Unique Training

Specifically, internists complete at least three years of intensive postgraduate training in

a residency program, working closely with experienced, teaching internists. During this training, residents also work with many of the subspecialists of internal medicine, such as cardiologists, who specialize in problems of the heart; hematologists, who specialize in diseases of the blood; and others. Internists who complete three years of training in adult medical care and who choose not to receive further subspecialty training are often described as "general" internists or generalists, despite their training in the specialty of internal medicine.

Because internal medicine offers skills and training that will be particularly valued in the future, a policy that gives preference to other primary care specialties over internal medicine is unwise.

Other internists will complete at least two additional years of training to qualify as subspecialists in one of several branches of internal medicine, such as gastroenterology or rheumatology.

Many adults and adolescents use internists as their personal or primary care physicians for general health maintenance and the management of their overall health care. Because internists are particularly well trained in the diagnostic techniques of physical examination and interpretation of sophisticated medical tests, they are often referred to as "diagnosticians" and "medical detectives." The National Ambulatory Medical Care Survey also demonstrated that internists typically spend more time with patients, and see a greater proportion

of older and sicker patients, than other physicians who provide primary care.¹⁷

One of the reasons that internists spend more time with patients is that they place a strong emphasis on listening to patients, explaining test results, communicating a diagnosis to the patient, explaining treatment alternatives, and counselling their patients on preventive measures—such as smoking cessation and dietary changes—that can improve health and reduce illness and premature death.

Family physicians also complete three years of postgraduate training, but the training touches on several areas of medical practice: pediatrics, gynecology, internal medi-

It is possible to balance the two priorities: increasing the number and proportion of physicians who practice in primary care, and recognizing the important contributions of subspecialists.

cine, surgery, psychiatry and community medicine. Therefore, family physicians often serve as primary care physicians for all members of the family, regardless of age. By virtue of the broad scope of this specialty, a family physician's training is less intensive than that of an internist in the organ-system diseases that affect adults. Therefore, family physicians often refer patients with complicated problems to other specialists, who in many cases are internists.

Pediatricians receive three years of training exclusively in care of children and adolescents. Many pediatricians then go on to

subspecialize in other fields relating to care of children.

These distinctions are important in plotting a strategy to rebuild primary care. There clearly will be a need for more physicians, and a greater proportion of physicians, in the specialties of internal medicine, family practice and pediatrics. Within internal medicine, it is also appropriate to create incentives for a greater proportion of internists to go into general internal medicine, rather than limit their practice to a subspecialty area. It is important to recognize, however, that internal medicine subspecialists provide a substantial proportion of primary care in practice, and their contributions to easing a shortage in primary care will continue to be needed in the future.

Therefore, it would be inappropriate to place a preference on promoting family practice over internal medicine in attempting to solve the primary care crisis, as some have suggested. Although ASIM supports many of the goals identified in the Council on Graduate Medical Education (COGME) report, we disagree with several of its recommendations, including a proposal to place a "high, short-term priority" on increasing the incentives for residents to choose family practice and osteopathic medicine over internal medicine and pediatrics.¹⁸

The council made this recommendation because of its belief that family physicians and osteopathic physicians are more likely to remain as generalists and practice in rural areas than internists. But because internal medicine offers skills and training that will be particularly valued in the future, a policy that gives preference to other primary care specialties over internal medicine is unwise. It would be better for policy-makers to change the incentives that make it difficult for many internists to remain in

primary care practice or locate in rural areas. Moreover, the *choice* of what kind of primary care or generalist physician best meets their needs should be made by individual patients, not by a governmental policy. Rather, governmental policies should encourage an adequate supply of physicians in each of the specialties who are trained to provide primary care.

Future Need for Internists

There are two factors in particular that will fuel demand for the unique skills and training of internists. One is the aging of the American population, as noted earlier. As the only specialty that is trained exclusively in the medical care of adults—including the diagnosis and treatment of diseases of the internal organs and body systems—internists are uniquely qualified to be the primary care physician of choice for many of these elderly patients.

The second factor is that redesign of the health care system is likely to result in a greater emphasis on physicians who have the skills to manage and coordinate patient care. Proposals for managed competition, for example, would encourage enrollment in health plans that will depend on a primary care physician to manage and coordinate all care provided to enrollees. Other health reform proposals also foresee a greater emphasis on *managing* and *coordinating* the total care of patients. Internists, by both training and experience, are well suited for this role.

As one internist from Salem, Virginia, wrote, "I personally became a general internist because I felt an internist, more than any other physician, was able to take complete care of adult patients in both an outpatient and inpatient setting. I felt that a good general internist could diagnose and treat

most illnesses and could direct care and use of subspecialists as they were meant to be used—for specific questions and not for total evaluation of problems."

Many health maintenance organizations (HMOs) and other managed care plans reportedly have emphasized recruitment of internists because of their belief that internists are especially qualified to manage and coordinate the care of enrolled patients.

Public Policy Directions

For these reasons, ASIM firmly believes that public policy should do the following:

- **Encourage an increased total number and proportion of internists, family physicians and pediatricians.**
- **Recognize that the choice of primary care physician will depend on individual patients' needs and preferences.** For individuals who prefer to obtain care from a single physician who can take care of the entire family, regardless of age, the choice is likely to be a family physician. For others who place greater value on obtaining their personal care from a physician who is trained intensively and exclusively in the care of adults, the choice is likely to be a general internist. And for parents who want their children to be taken care of by a physician with specialized knowledge in child care, the choice is likely to be a pediatrician.
- **Recognize that internists provide certain skills and training that will be highly valued and demanded in the future.** The growth in the number of elderly patients in particular will result in increased demand for physicians who are trained exclusively in adult medical

care, and whose training and experience specifically emphasizes diagnosis and treatment of the complex medical problems typical of elderly patients. In addition, internists' skills and training as managers and coordinators of comprehensive medical care will be valued and required increasingly in the future.

- **Encourage an increase in the number of internists who are trained to provide primary care**, rather than emphasizing certain other generalist specialties over internal medicine.

Role of Internal Medicine Subspecialists

Even though there is little dispute that more general internists are needed, the role of internist-subspecialists is more controversial. Some would argue that the goal of increasing the number and proportion of primary care physicians, including general internists, is in direct conflict with the objectives of internist-subspecialists.

As an organization that represents *all* internists, both those trained as generalists and subspecialists, ASIM recognizes the potential conflict that could arise within the specialty of internal medicine. We believe, however, that it is possible to balance the two priorities: increasing the number and proportion of physicians who practice in primary care, and recognizing the important contributions of subspecialists.

Many subspecialists in internal medicine provide a mix of primary and subspecialist care to their patients. It is not uncommon, for example, for an endocrinologist—an internist who receives additional subspecialty training in the diagnosis and treatment of the glandular internal regulatory system—to act both as a consultant and as a primary care physician.

The role of subspecialists in meeting the primary care needs of the public must be recognized, because—under even the most ambitious proposals—it will take decades to generate enough generalists to meet the primary care needs of the country. Although there is some data to suggest that subspecialists provide primary care services at a higher cost than generalists, the practical reality is that there will be a continuing need in the foreseeable future for subspecialists who are also trained to provide primary care.

Public Policy Priorities

It is logical, then, for public policy to do the following:

- **Place the highest priority on increasing the incentives for physicians to train in internal medicine and to remain in primary care.** This would include addressing the economic factors that make remaining in general internal medicine a financially unattractive option. Many internists who complete the three-year program in general internal medicine intending to enter and remain in primary care find later that they cannot afford to stay in practice unless they subspecialize.

One young internist from El Paso, Texas, explained the problems as follows:

I am an American Board of Internal Medicine-certified military doctor—former general internist—now completing a second residency in nuclear medicine, one year after completing my internal medicine residency. I entered internal medicine because it fascinated me: It was diverse, dynamic, almost unmanageable—a real challenge with attention to detail that fulfilled me. My heart brought me to

internal medicine, but it was costly, as a father of four children. Now, after maximum deferments (as I couldn't hope to make repayments on a resident's salary) my repayment total is \$144,000, to begin in the summer of 1993. Plain and simple, I couldn't afford to stay in medicine. But even your more typical medical graduate is between \$60,000-\$100,000 in debt, so I don't think they can either. I still enjoy [general] medicine and dabble in it . . . but nuclear medicine offered the most lucrative pathway an internist can take in the military, so I took it [even though] it isn't exactly what I want.

- **Recognize that subspecialists in internal medicine will continue to have a substantial role in meeting the nation's primary care needs.** For subspecialists who now provide primary care, emphasis should be placed on assuring that economic factors don't force them to limit their practices to their own subspecialty area, thus exacerbating the shortage of physicians who are able to provide primary care services.

As one internist who provides both endocrinology and general internal medicine in Oklahoma City wrote:

I initially became an internist because I enjoyed working with people and practicing preventive care. I subspecialized in endocrinology in part because it was so difficult to do comprehensive general internal medicine well. I have, however, continued to practice general internal medicine on the majority of my patients until very recently. Because of the time required to practice comprehensive health care and the financial considerations put upon us by Medicare and Medicaid, I have recently begun to limit my practice only to endocrinology. . . .

- **Recognize that there will continue to be a need for internists who practice primarily in internal medicine subspecialties.** Although encouraging a greater proportion of generalists who are committed to primary care is an appropriate and necessary goal, the need for and contributions of subspecialists must also be acknowledged.

Why Are Physicians Not Choosing Primary Care?

Before the right solutions can be implemented to ease or avert a crisis in primary care, a few key questions must be addressed: Why are physicians in training increasingly turning toward fields other than primary care, and why are a growing number of established physicians getting out of primary care?

The comments from internists and the research literature point to two answers. One is that both physicians in training and established physicians believe that the economic and regulatory environment in which they must practice is stacked against primary care physicians. The other is that training programs have emphasized specialization rather than primary care.

The Environmental Factor

When physicians are asked about the environment in which primary care physicians are expected to practice there is extraordinary agreement that low and inequitable pay and the “hassle factor” are the most important factors driving physicians away from primary care. Here is a sampling of recent comments from practicing internists:

At the time I became an internist there were no significant bureaucratic hassles, and monetary considerations were not the reason that I chose internal medicine. The environment today is that of increasing red tape and hassles for us in the form of paperwork. At the same time, we are finding incredible inequities involving the reimbursement system, where many of my subspecialty colleagues and other physicians . . . work fewer hours and receive reimbursement two to four times more than what we receive. I still enjoy internal medicine, but I am becoming increas-

ingly disturbed by the government’s lack of a common-sense approach to the problem. In our . . . large multispecialty clinic, we are virtually unable to attract qualified general internists. We are understaffed, and several of us are having to start limiting our Medicare patient population.

— *Letter from a general internist in Salem, Virginia*

What I like about primary care practice today continues to be the personal relationship with patients and the opportunity to improve their quality of life. What I do not like is that much of the care I provide is not reimbursed. . . . If the government wants physicians to choose to practice in primary care specialties, the payment schedule should be adjusted to compensate primary care physicians appropriately for their work.

— *Letter from a general internist in Omaha, Nebraska*

In my judgment, the major reason for physicians to be entering subspecialties and [performing] surgical procedures rather than primary care is simply the problem of inadequate reimbursement. Obviously, the answer to improve the balance of primary care is to increase the payments for services for this group.

— *Letter from an internist in Sylacauga, Alabama*

I was motivated to go into primary care because I found it fascinating and I felt I would enjoy dealing with entire

families. From my conversations with fellow residents in training, [I believe] their reasons for going into subspecialties were mainly financial. . . . I still like primary care for the reasons above. What I don't like is the payment system that continues to reward specialists and seems to penalize primary care, whereby we must struggle to meet our overhead expenses. . . . We need a real resource-based relative value scale that will reward the primary care physician. The present system is a big joke—one that internists are not laughing about.

— *Letter from a general internist in Boca Raton, Florida*

It is fairly obvious to me what now motivates students and residents to choose internal medicine or any other specialty. It is both a positive factor in finding a well compensated specialty and a negative factor in avoiding practice areas in which they have been told . . . that there is an increasing amount of government regulation and paper work, less appreciation for effort produced, and certainly less compensation for a higher workload and longer hours. . . . I personally know of three internists who have quit primary care within the last two years. . . . I also know of others who are attempting to limit the number of Medicare patients they see.

— *Letter from a general internist in Louisville, Kentucky*

What can the government do to aid the primary care internist? For starters, decrease the number of major regulations put on the office staff. . . . Improve reimbursement and consider allowing

funding for telephone calls. . . . Do some kind of publicity campaign showing appreciation and concern for the primary care physician. The current governmental attitude toward physicians seems to be that we are all [out] to cheat the system.

— *Letter from a general internist in Chattanooga, Tennessee*

I mostly enjoy the practice of general internal medicine. I do so because of the diverse mix of problems and because of the close personal relationships that develop with patients. Many aspects of practice are frustrating. Clearly the greatest of these are the burdens of dealing with insurers, regulators and others who require our time but have no conception of the cumulative impact nor of the overhead costs that their demands engender.

— *Letter from a general internist in New Haven, Connecticut*

Primary care medicine gives me the satisfaction of having *ongoing* patient contact. But what I hate most about medicine today is the feeling of constantly being threatened and pushed around. 'Use this code by such and such a date or else!' 'Complete this form and return it by such and such a date or else!' 'Answer the peer review organization's request immediately or else!' 'Send a copy of the entire chart (for free, of course) or else!' And the most threatening and stressful . . . are the lawyers—the constant threat of malpractice suits.

— *Letter from an internist in Gaithersburg, Maryland*

Low Pay, Long Hours, More Hassles

Unfortunately, the preceding sentiments are not uncommon. They appear in virtually all communications with primary care physicians. And physicians in training quickly learn that primary care means less pay, more hassles and longer hours.

But the evidence is not simply anecdotal. A large body of research supports the view that concerns over low pay and excessive "micromanagement" (hassles) are turning physicians away from primary care. In preparation for this paper, the American Society of Internal Medicine (ASIM) reviewed the recent literature on the reasons behind the undersupply of primary care physicians. At least 15 articles identified

A large body of research supports the view that concerns over low pay and excessive micromanagement (hassles) are turning physicians away from primary care.

low pay, disparities in earnings between primary care physicians and specialists, hassles and high debts as major factors that are motivating physicians to specialize. Key findings are summarized below:

- The average net income earned by physicians in each specialty is highly correlated with the number of applications per residency position and the number of positions filled by U.S. medical school graduates through the National Residency Matching Program. A study concluded that government and third parties have a central role in making primary care more attractive through reforming reimbursement, reducing bureaucratic

hassles and supporting primary education. *The single most important financial incentive to enter primary care will exist when the income from primary care equals that from procedure-oriented care.*¹⁹

- Forty-one percent of internal medicine residents who were surveyed in 1987 reported that their debt had influenced either training or career decisions. The study concluded that the average educational debt of graduating senior medical students is increasing, that a majority of house officers are repaying their growing debt with salaries that probably will remain constant or even decrease in real dollars over the next several years, and that as debt and repayment mount, *so will the pressure to earn more money.*²⁰
- Physicians are encouraged to choose specialties and practice locations that are favored by governmental reimbursements. Also, the income gap between primary care and non-primary care specialties has been growing. Between 1977 and 1988, the average income of both primary care and rural physicians did not increase as fast as the average income of all physicians.²¹
- Satisfaction of physicians with their careers is an essential element in determining the supply of services, the availability of providers and the outcome of care. Approximately 40 percent of surveyed internists reported that if they had to repeat their decision to enter internal medicine, they would instead choose another medical specialty or select a non-medical career. Another 21 percent were undecided. Only 39 percent were sure that they would repeat their decision. Furthermore, two-thirds of subspecialists, but only half of generalists, were satisfied with their incomes. The least satisfying element of practice was the lack of control

internists have over the way they practice medicine. The authors concluded that an essential element of any plan for universal health insurance, regardless of the source of funding, is satisfaction of providers.²²

Another article that also reported on a survey of internists' views of the future of their specialty found that "there is a pervasive feeling of frustration and demoralization, a feeling that may affect recruitment of new physicians to internal medicine and cause early retirement of practicing physicians." The study concluded that "perceptions of the increased paperwork, the financial reimbursement systems and the regulatory environment all contribute to . . . negativism. If withdrawal from practice combines with the inability to attract medical students into the field, it is not difficult to construct a scenario in which physicians in practice will become difficult to find."²³

- Primary care physicians earn significantly lower income than other physicians. In 1987, the median annual income for primary care internists, family and general practitioners, and pediatricians was less than \$75,000. In contrast, all but one of the non-primary specialties earned above \$75,000 yearly.²⁴ Expressed in terms of income growth, the primary care specialties of general internal medicine and family and general practice experienced percentage gains from 1983 to 1988 that were only one-quarter as large as the average gains in income of non-primary care physicians.²⁵

Another study similarly found that there has been a tremendous widening of income spread among specialties—such as surgery and radiology—that have intensive use of procedures, and those—such as psychiatry and family medicine—that

do not. For internal medicine, there is a wide gap in the income-generating potential between those subspecialties with ready access to a catheter or endoscope and those that lack unique technology.²⁶

- Increasing bureaucracy has demoralized many physicians. Internists feel the hassle factor even more. Internists have extensive dealings with Medicare. Unlike surgeons, who may spend several hours in the operating room with one patient, internists may have to complete paperwork for many patients seen during a comparable period of time.²⁷

The reports from physicians and the research literature all lead to one unescapable conclusion: Inequitably low payments and excessive hassles are the leading causes of physician disenchantment with primary care. To succeed, a strategy to rebuild primary care *must* improve payments for primary care services and reduce the hassle factor. Proposals that concentrate *only* on changes in medical education will fail.

The Training Environment

Although the economic and regulatory environment appear to be the principal reasons that primary care practice is viewed with increasing negativism by medical students and residents, problems in the funding and content of medical education also play a role.

One problem is that primary care training programs are far too oriented toward problems encountered in the hospital setting, rather than the kinds of problems typically encountered in an office-based, primary care practice. A second problem is that there has been a decline in the prestige of primary care programs, a related lack of positive role models or a lack of institutional support for those role models who are present.

Although many department heads espouse a view that primary care is good for the country, they often do not place the same emphasis on primary care in their own programs. As a result, even when there are positive role models available in a teaching institution, there typically is a lack of institutional support for them.

A third problem is that Medicare graduate medical education (GME) funding has encouraged the growth of specialty and subspecialty training programs at the expense of primary care. And finally, physicians have been encouraged to seek more lucrative specialties due to the combination of growing indebtedness incurred during training, low residency stipends and lower incomes for primary care physicians compared with specialists.

A general internist from New Haven, Connecticut, described the problem this way:

Our present-day training programs do not offer all that they could to prepare generalists for practice. Internal medicine training programs are much too hospital-oriented for the nature of primary care in 1992. For one thing, the patient mix in the hospital is all wrong. There is too much emphasis on intensive care, AIDS, on care at the margins of life. Moreover, young physicians have no role models in tertiary care centers to encourage the pursuit of a generalist's career. Also, many of the skills that are needed in primary care are not well taught . . . [and] little is done to introduce trainees to the requirements of running a business. Finally, primary care in general has an image problem that is probably deserved. Students see that by entering a procedural specialty or subspecialty they can work shorter and more pre-

dictable hours, master a smaller body of medical knowledge, make more money, and have greater prestige among colleagues and the public. The choice is easy, and most vote with their feet: The proportion choosing primary care is declining.

Others echoed these views. Another general internist from Chattanooga, Tennessee, wrote, "Today, medical students and residents will often see the internist dedicated to older patients with chronically ill conditions that are terminal or uncontrol-

What is required is a multifaceted approach that targets the economic, regulatory and training factors that discourage primary care.

lable. In addition, many residents are trained in inner-city programs and get a very skewed view of the primary care patient mix."

The research literature supports these conclusions. One study found that "90 percent of those entering internal medicine made that decision during medical school. . . . Today's declining interest in general internal medicine . . . and the increasing role of the subspecialties may reflect the dominant role of subspecialization in these departments."²⁸ A survey of medical students found that the five most important characteristics pushing students away from general internal medicine are feelings about taking care of chronically ill patients, the type of patients they would see as internists, the level of satisfaction among medical residents, their own feelings about treating alcoholic or drug abusing patients, and the degree of stress among medical students.²⁹

A task force of the Association of American Medical Colleges (AAMC) concluded, "Medical schools should ensure that students have adequate opportunities to encounter role models among faculty in the generalist specialties," noting that "the paucity of generalist faculty, particularly at the more senior levels, to function as role models in most medical schools in this country, in comparison to the general availability of . . . subspecialty faculty to fulfill this function, is an oft-cited reason for the declining interest in generalist careers among medical students."³⁰

Current methods of federal funding for medical education and training also have acted as financial disincentives for primary care training programs. The Council on Graduate Medical Education (COGME) noted that GME programs are predominantly sponsored by and based in teaching hospitals. The major source of revenue for hospital-based GME programs is payment to hospitals for patient care services. The faculty is also financed primarily by payments for patient care services. COGME noted that this creates several disincentives for primary care programs. Among those are the following:

- Most funding for GME is provided through payments for hospital inpatient services. Thus it is difficult for ambulatory facilities—other than those owned and operated by hospitals—to secure financing for the additional costs of operating in the presence of a teaching program.
- At the same time, higher reimbursements are made to faculty as well as practicing physicians in specialties that emphasize procedural services and inpatient care. Because payments to faculty are an important component of financing faculty

and departments, those departments with more highly reimbursed faculty are at a relative advantage in program financing.³¹

Finally, many of the studies concluded that high indebtedness is a significant factor affecting choice of specialty. Therefore, policies to encourage primary care should include low-interest loans or loan forgiveness with payback requirements, and increased stipends for residents who commit to primary care.³²⁻³⁶

A Multifaceted Approach

A comprehensive strategy to rebuild primary care, therefore, must include measures to increase the prestige of general internal medicine in medical schools, recruit positive generalist role models to medical school faculties, and expose medical students and residents to the types of patients who are typical of office-based, primary care practice. In addition, the strategy must shift education from a hospital orientation to office-based and other ambulatory settings, re-examine the content of curriculum to assure that students and residents obtain the skills required to practice primary care, reform GME funding to shift the incentives to primary care instead of subspecialty programs, and include specific measures to reduce the debt of physicians who make a commitment to practice in general internal medicine and other primary care specialties. As long as the economic and regulatory environment is unremittingly hostile to primary care, however, changes in medical education alone will not avert a crisis. What is required is a multifaceted approach that targets the economic, regulatory and training factors that discourage primary care.

Goals and Objectives

The American Society of Internal Medicine (ASIM) proposes the following specific goals and objectives, followed by detailed and comprehensive recommendations to improve the economic, regulatory and training environment so that internal medicine and other primary care specialties are no longer disadvantaged:

- 1.** As recommended by the Council on Graduate Medical Education (COGME),³⁷ the United States should move toward a system in which 50 percent of physicians:
 - Complete a three-year training program in internal medicine, family practice or pediatrics; and
 - Enter and remain in primary care or generalist practices.
- 2.** Because the unique skills provided by internists will be required increasingly in the future, public policy should specifically encourage an increase in the number of physicians who are trained in internal medicine and who enter and practice in primary care. Therefore, ASIM believes that at least half of the physicians who provide primary care should be trained and practice as general internists.
- 3.** Increasing the number and proportion of physicians trained as generalists should receive the highest priority. Because it will take decades to produce enough generalists to meet the needs of the country, physicians who provide combined generalist and subspecialty practice will continue to have an important role for the foreseeable future. Policies therefore should be designed to:
 - Address the economic factors that encourage general internists to subspecialize rather than remain in primary care;
 - Alleviate the economic pressure on internists who now provide a combined primary care and subspecialty practice to begin to limit their practice only to their subspecialty area; and
 - Provide additional training in primary care to those who deliver combined primary care and subspecialty services.
- 4.** Particular emphasis should be placed on increasing the number of internists and other primary care physicians who practice in rural, inner-city and underserved areas.

Recommendations for Improving The Practice Environment for Primary Care

The following recommendations are designed to alleviate the economic and regulatory factors encountered in practice that are driving both established physicians and physicians in training from primary care to specialties.

The recommendations for the practice environment are grouped into four areas:

- Reforms in Medicare payment, coverage and regulatory policies (page 30);
- Reforms in the regulatory policies of other federal programs (page 38);
- Reforms in the payment, coverage and review policies of private insurers (page 40); and
- The impact of health reform on the practice environment of primary care (page 43).

The recommendations under the first three groupings can be implemented on an incremental basis even in the absence of comprehensive health reform. The remaining recommendations include specific proposals for rebuilding primary care that probably can be accomplished only as part of comprehensive reform. This section will also discuss the impact of various proposals on primary care.

Recommendations for Improving the Practice Environment of Primary Care - I

Reforms in Medicare Payment, Coverage And Regulatory Policies

In recent years, there has been a growing recognition of Medicare's contribution to overspecialization.

As part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Congress mandated a new fee schedule that was intended to increase payments for primary care. By basing payments on a resource-based relative value scale (RBRVS)—as adjusted to reflect differences in costs of delivering services between regions—the new payment schedule was expected to shift payments toward visits and other evaluation and management (E/M) services by primary care physicians, and toward rural and other underserved areas.

Despite these efforts, Medicare continues to pay far more for surgery and other technological services than for visits and other services by primary care physicians.

The ability of the new fee schedule to improve payments for primary care, as originally intended, has been undermined by cuts in the Medicare budget, lower limits on what physicians may charge patients, a method of estimating practice expenses that is biased toward surgical procedures at the expense of primary care, separate volume standards that in 1993 resulted in a higher update for surgery than for primary care, inaccuracies in the geographic adjustment factors, and certain assumptions and policy decisions that were made by the Bush administration in determining the transition payments and conversion factor for the new fee schedule. The result is that most inter-

nists and other primary care physicians have found little or no improvement from the fee schedule.

With regard to the hassle factor, the Department of Health and Human Services (HHS) has made a concerted effort to reduce some of the more onerous regulatory burdens on primary care physicians. But despite these efforts to reduce red tape, internists continue to report that the administrative hassles of dealing with Medicare are a major source of ongoing frustration.

Changing Medicare policies to reward primary care is important for several reasons. The program is a major source of revenue for many internists and family physicians, so low Medicare payments are one of the major reasons that primary care is paid much less than other fields of practice. Second, Medicare payment policies are often "copied" by other insurers. Third, many policy-makers are looking at the Medicare fee schedule as a possible model to be exported to other payers as part of health reform.

Consequently, ASIM believes that it is essential to correct those flaws in the Medicare fee schedule that undermine the original intent of helping primary care.

Recommendations

1. If Medicare payments to physicians are cut to reduce the deficit or to obtain funding for health reform, payments to primary care physicians should be protected.

As part of its economic plan to reduce the federal deficit, the Clinton administration has proposed deep cuts in Medicare payments to physicians. ASIM is encouraged, however, by the administration's decision to exempt some primary care services—specifically office, nursing home and home visits. Instead, those primary care visit services will receive the full inflation update called for by current law. This is the first time in three years that the update for primary care will keep pace with rising overhead costs.

The president also proposed to obtain additional savings from procedures—such as many surgical procedures—for which practice costs are overpaid. Because the practice expenses of primary care visits and other E/M services are currently underpaid by Medicare, those services presumably will be spared further reductions. ASIM agrees that additional across-the-board cuts would have a disproportionately greater adverse impact on primary care, which already is underpaid.

As some groups raise objections to other Medicare cuts, the higher update for primary care that the president proposes could be at risk of being reduced. Congress may decide to reject some cuts and make up the lost savings by lowering the primary care update. ASIM urges the administration and Congress to stand firm in opposing any reduction in payments for primary care services.

Protecting primary care from the proposed cuts is a step in the right direction. But more will need to be done.

2. Congress should enact legislation to require the practice-cost component of the Medicare fee schedule to be based on resource costs—as recommended by the Phy-

sician Payment Review Commission (PPRC)—not on historical charges.

Payments under the Medicare fee schedule are determined in part by a relative value scale that assigns values to each physician service based on the work, overhead and liability costs associated with the service. The work relative values are based on an RBRVS that measures the time and intensity of each service. Although the RBRVS has resulted in a higher value being placed

Medicare continues to pay far more for surgery and other technological services than for visits and other services by primary care physicians.

on the work associated with primary care services compared with technological services, the overhead and liability costs continue to be based on historical charges. The result is that the practice costs of surgical procedures are inflated compared with primary care.

The PPRC believes that if the practice expenses were based on resource costs, payments for primary care and other E/M services would increase substantially. In its upcoming 1993 report to Congress, the PPRC will recommend legislation to mandate that practice costs be based on resource costs, not historical charges.

As part of its deficit-reduction plan, the Clinton administration also proposes to begin implementation of a resource-based methodology for determining payments for practice expenses. It appears, however, that the administration at least initially proposes only to lower practice cost payments for overpriced procedures, without increas-

ing them for undervalued primary care visits and other E/M services.

ASIM believes that the practice expense payments for visit services also should be increased, and the president's proposal should be modified to allow for such improvements. If necessary to maintain the anticipated savings, the reduction in the practice expense payments for overpriced procedures could be accelerated to allow for increases in undervalued primary care visits.

- 3. Congress should amend the law to change the method for determining the Medicare volume performance standard (VPS) to preclude preferential updates for surgical procedures to the detriment of primary care. ASIM specifically supports the PPRC's recommendation that either a single VPS be required, or a separate but higher VPS be provided for visits and other evaluation and management (E/M) services.**

Current law requires that the secretary of Health and Human Services propose two VPSs, one for surgery and one for all non-surgical services, including primary care.

In 1992, the secretary reported that surgery met its VPS, while expenditures for nonsurgery exceeded the VPS. Consequently, the secretary recommended a higher update for surgery. Because Congress did not modify this recommendation, on January 1, 1993, surgery received an update of 3.1 percent, compared with only 0.8 percent for primary care and other non-surgical services. As a result, payments for primary care were increased by less than the rate of inflation, thereby widening the gap in compensation between surgery and primary care.

Analysis of expenditures showed that surgery met its VPS because of inaccuracies in HHS assumptions in calculating the surgery VPS, rather than because surgeons did a better job of controlling volume. Furthermore, because the higher update for surgery was granted in the form of a higher conversion factor for surgery, the result is that surgery will permanently have a higher dollar multiplier (conversion factor) than primary care services.

ASIM believes that Congress must act to assure that surgery does not receive higher updates in the future. Even though President Clinton has proposed that in 1994 primary care services receive the full increase required under current law, the continuation of a separate VPS for surgical and non-surgical services may in later years result in surgery receiving a higher update than primary care, as occurred in 1993.

The president's economic plan also includes a proposal to lower the "default" VPS for both surgery and nonsurgery. ASIM instead recommends that if separate VPSs are to be maintained, a separate and higher VPS should be provided for primary care and other visit services, even if that requires a greater reduction in the VPS for all other services to maintain the intended savings.

Further, Congress should reverse the permanent increase in the conversion factor for surgery by retroactively providing for the 1993 increase to be treated as a one-time bonus payment, rather than an increase in the conversion factor. Congress also should specify a higher, minimum update for primary care.

- 4. Congress should amend the law to provide for a higher "default" floor on payments for primary care services.**

Current law provides for an update each year of the fee schedule, based on actual expenditures compared with the applicable VPS for the service. Congress has the authority to set the update on an annual basis, or to allow the update to go into effect by default. If expenditures exceed the VPS, current law provides for a floor—a minimum update—in the event that the update is determined by the default formula specified in the statute.

ASIM believes that there should be a separate and higher default for primary care services, such as office visits, nursing home visits and home visits. This would provide a higher floor on how much the update for primary care services could be reduced if the VPS were exceeded. Without a higher default update, payments for primary care are at risk of continuing to be far less than increases in the costs of providing those services, causing primary care physicians to fall further and further behind.

5. Congress should require the secretary of HHS to make improvements in the accuracy of the geographic adjustment factor for the fee schedule.

Congress intended the geographic adjustment factor to limit variations in Medicare payments in different regions only to measurable differences in the relative costs of providing services. Unfortunately, the use of inaccurate and out-of-date data has resulted in drastic reductions in payments to physicians in many parts of the country, including payments to primary care physicians.

ASIM supports enactment of S. 242, the Medicare Geographic Data Accuracy Act of 1993, introduced by Sen. David Pryor (D-Ark.), which would require HHS to use current, accurate and regularly updated

data when computing the geographic adjustment factor. A similar provision is included in H.R. 21, introduced by Rep. Dan Rostenkowski (D-Ill).

6. Congress should provide annual bonus payments for primary care services.

Even though the new Medicare fee schedule may result in modest improvements in payments for primary care services, surgical and other technological procedures will continue to be paid far more, even if improvements are made in the practice cost component and the geographic adjustment factor. Consequently, ASIM believes that further improvements in payments for primary care will be needed to make it a financially viable choice for physicians. ASIM recommends that Congress enact annual bonus payments for primary care, in addition to the annual update for those services.

7. Primary care services should be protected from payment reductions that may occur due to further refinements of the Medicare fee schedule. Specifically, HHS should set a floor on total relative values and payments for E/M services, so that primary care is protected from any budget neutrality reductions that are made to offset new or increased relative values for procedural services. If necessary, Congress should amend the budget neutrality requirements of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) to provide for such a floor.

OBRA '89 mandated that any refinements in relative values may not increase or decrease expenditures. Consequently, when relative values are added for new or revised services, or when HHS agrees to increase relative values for existing procedures, it must offset the higher costs by lowering payments for other services. In 1993, rela-

tive values were reduced by 2.8 percent across the board to offset increases that were made in hundreds of relative values, most of which were for surgical procedures.

Each year, codes for hundreds of new or revised procedures are added to the Medicare system. By comparison, very few new codes for E/M services are added each year. As a result, if HHS makes across-the-board reductions in payments for all services to offset the new relative values, then payments for E/M services by primary care physicians will be reduced each year. This will further widen the gap in payments between technological procedures and primary care.

If there were a floor on the relative values and overall payments for E/M services, then increased expenditures on procedural services could be offset with reductions for procedural services only. The reductions would not be applied to primary care services. The PPRC, in its upcoming report to Congress, will recommend that primary care services be "held harmless" from any reductions due to further refinements of the RBRVS.

- 8. Congress should require that the HHS secretary study and make recommendations on expanding the existing criteria for designation as a "health professionals shortage area" to include locales that currently do not qualify but are facing a shortage of primary care physicians. If the criteria were expanded to include additional locales, more areas would qualify for the 10 percent Medicare bonus payment for physician services in underserved areas.**

OBRA '89 provides for a 10 percent Medicare bonus payment for physician services that are provided in designated shortage areas. Because the criteria are restrictive, many areas that are experiencing shortages

of primary care physicians are currently ineligible for the bonus.

- 9. Congress should raise the bonus payments specifically for primary care services—office, nursing home and home visits—in designated health professionals shortage areas.**

The current 10 percent bonus applies to all physician services provided in shortage areas. Because there is a particular need to attract and retain primary care physicians in underserved areas, Congress should raise the bonus for primary care services only, such as by increasing the bonus to 20 percent for office, nursing home and home visits.

- 10. Congress should mandate expansion of Medicare coverage for services provided by primary care physicians, including coverage for periodic health evaluations (routine physical examinations), immunizations, colorectal cancer screening, smoking cessation counselling and other clinically effective preventive services.**

Medicare currently pays only for services that are necessary to diagnose or treat a medical condition or symptom. Preventive services are generally excluded from coverage. Because primary care physicians are the principal providers of preventive services to Medicare patients, the current exclusion disproportionately hurts primary care and denies patients access to needed services.

- 11. Congress should restore full Medicare payments to new physicians.**

OBRA '89 limits payments to new physicians in their first four years of practice. Primary care physicians who enter practice heavily in debt are disadvantaged by the existing limits, even though a few of their

primary care services—defined narrowly by law as office, nursing home and home visits—are exempt. All other services by primary care physicians—such as hospital visits, consultations and diagnostic procedures—are subject to the limits.

ASIM supports repeal of the limits on payments to all new physicians. H.R. 11, which Congress passed in 1992, included a repeal provision, but it was vetoed by President Bush. ASIM urges Congress once again to repeal the existing limits. ASIM specifically supports enactment of H.R. 21, which is the newly reintroduced version of the Medicare provisions of H.R. 11. Rep. Dan Rostenkowski (D-Ill.) is the principal sponsor of H.R. 21. If the limits are not eliminated in their entirety, ASIM recommends that the category of exempt primary care services be expanded to all E/M services that are provided mainly by primary care physicians.

- 12.** The HHS secretary should establish a formal process to assess the impact on primary care practices of proposed regulations and other administrative requirements prior to implementation. The process should include consultation with organizations representing primary care physicians in making such assessments. If necessary, Congress should mandate this change.

A formal requirement that the secretary assess the impact on primary care of proposed policies would help identify in advance those that may have an adverse impact, and allow for more cost-effective and less intrusive alternatives to be identified.

- 13.** The secretary of HHS should examine, in consultation with organizations representing primary care specialties, the impact on primary care physicians of the current methods of conducting Medicare utiliza-

tion review. HHS should report on changes it plans to implement to reduce the intrusiveness, red tape and costs of complying with utilization review without compromising program integrity. If necessary, Congress should mandate this study and report.

Overly intrusive and burdensome Medicare review requirements are one of the major factors causing physician disillusionment with primary care. These requirements also contribute to excessive overhead costs in primary care practices. Identifying alternatives that assure program integrity, but that are less costly and burdensome to primary care physicians, must be a key element of any program to revitalize primary care.

Although HHS recently has taken some steps to move toward less intrusive methods, such as “patterns of care” or “physician profiling,” most carriers continue to rely primarily on intrusive, claim-by-claim review.

- 14.** The HHS secretary should examine the impact on primary care physicians of pending documentation requirements for visit services. HHS also should develop requirements that minimize unnecessary hassles and administrative costs without opening up the Medicare program to abusive billing practices.

The Medicare program is currently developing requirements on what information must be provided by primary care physicians and others to justify the use of different codes for visit services. Such requirements are intended to assure that physicians bill at the “right” level of service that is appropriate for each patient encounter, and by doing so, help prevent inappropriate “upcoding” of services.

ASIM supports the goal of assuring that physicians use the visit codes properly. It is essential, however, that the requirements for documentation not be so burdensome that they would substantially increase the overhead costs of primary care physicians.

- 15.** Congress should provide sufficient funding, and the HHS secretary should require measures to improve the efficiency and effectiveness of services provided to physicians by Medicare and its local carriers. Such requirements would include the establishment of 800 numbers for calls to carriers, a prohibition against limits on the number of inquiries per call or letter, improvements in the training of carrier staff, and other improvements identified in the Gary Committee report to the secretary.

One of the chief frustrations encountered by physicians in dealing with Medicare is poor service by the carriers who administer the program. In recent years, many carriers have eliminated or reduced professional relations departments. In large part, this is due to chronic under-funding of Medicare carrier operations. Although all physicians experience service problems with Medicare, the problems are particularly pronounced for primary care physicians because they typically have more dealings with Medicare than do other physicians.

In 1992, at the request of then-HHS Secretary Louis Sullivan, MD, the Health Care Financing Administration's (HCFA) Senior Medical Adviser Nancy Gary, MD, chaired a committee that included representatives from the physician community. The report issued by the committee provides many sound proposals for improvement in Medicare relations with physicians.³⁸ Several of the report's recommendations, however, still have not been implemented.

As a starting point, HHS should proceed with implementing the recommendations of the committee. A copy of the committee's recommendations, and ASIM's evaluation of them, is available from ASIM upon request.

- 16.** The HHS secretary should provide a regulatory exemption from the Stark ban on self-referral for clinical laboratories that are shared by physicians, most of whom are primary care physicians. If necessary, Congress should enact legislation to provide for such an exemption.

Many primary care physicians have joined together to own and operate a shared clinical laboratory for their patients, even though the physicians involved in the arrangement are in separate practices.

HHS is currently drafting final regulations to implement the Stark ban on self-referral, which generally prohibits referral of Medicare patients to entities in which a physician has a financial interest. Although the Stark law provides authority for the secretary to exempt arrangements that do not pose a risk of program abuse, HHS may be leaning toward including shared labs under the ban on self-referral.

If shared labs are included in the self-referral ban, this will have a substantial adverse economic and regulatory impact on primary care physicians and on patient access to laboratory services. The only way for many primary care physicians to afford to operate a lab for their own patients is to pool resources to operate a jointly owned, shared lab. Such labs provide no greater opportunity for abuse than group practice labs, which are explicitly exempted under the Stark law.

H.R. 11, which was passed by Congress last year and vetoed by President Bush, included an explicit provision to exempt shared laboratories that met certain criteria to preclude abuse. This provision has been reintroduced as part of H.R. 21. If HHS does not provide for an exemption for shared labs under existing regulatory authority, prompt enactment of legislation to provide for such an exemption will be required.

17. Medicare carriers should be required to divulge to physicians all utilization review criteria.

Medicare currently allows carriers to keep the criteria for evaluating the medical necessity of physician services secret from physicians. The inability to know the rules by which they are being evaluated is one of the main frustrations that primary care physicians encounter in dealing with Medicare. Furthermore, the risk that patients will be denied payment for appropriate, needed services is greater when the criteria for making payment determinations are kept secret. Often, the criteria are arbitrary, unscientific or obsolete.

Congress enacted legislation in 1991 that directed HHS to conduct a study on release of utilization review criteria. The results of the study have not yet been released. HHS should proceed with releasing the results of the study and issuing instructions to require that criteria be divulged to physicians and patients.

18. The secretary of HHS should examine and make improvements in Medicare policies

on coverage of concurrent care services, pre- and postoperative consultations, care plan oversight and other case management services provided by primary care physicians.

Specifically, Medicare should provide payment for medically necessary visits by primary care physicians to hospitalized patients who are also being seen by a specialist ("concurrent care"). Medicare also should pay for pre- and postoperative consultations done by primary care physicians, and for case management services.

By routinely denying payment for these important primary care services, or by requiring excessive red tape in order for these essential services to be paid, Medicare's coverage policies penalize primary care physicians. By contrast, concurrent services and pre- and postoperative consultations by specialists typically are reimbursed. Primary care physicians also spend a considerable amount of time managing, supervising and coordinating the care provided to their patients (for example, coordinating the care by nursing home personnel). Currently, they receive no payment for this service.

ASIM has recently developed a proposed new code and descriptor for "care plan oversight" to describe such services. If accepted, the code would be paid on a monthly capitation basis. HHS should move promptly to accept the new code and provide adequate coverage and payment for care plan oversight.

Recommendations for Improving the Practice Environment of Primary Care - II

Reforms in the Regulatory Policies Of Other Federal Programs

Even though Medicare has a bigger influence over the economic and regulatory environment of primary care than any other federal program, other federal agencies also contribute to the frustrations and costs of primary care practices.

The Medicaid program has a substantial adverse impact on primary care. Low payment rates and heavy paperwork requirements have discouraged primary care physicians from participating in Medicaid, contributing to significant access problems for low-income Americans. Because reforms in Medicaid are likely to be considered as part of comprehensive health reform, ASIM's recommendations on this program are presented in that section of this paper.

The Department of Labor also exerts a direct impact on the regulatory environment of primary care. For example, the department is responsible for implementing regulations on the Americans with Disabilities Act (ADA) and the Occupational Safety and Health Administration's (OSHA) standards to prevent health workers from being infected by blood-borne pathogens.

One of the chief complaints of primary care physicians is the cumulative impact of regulatory changes on their practices. Even regulations that appear to be reasonable on their own become a problem when they are implemented at the same time as other requirements and regulations. Often, individual agencies proceed with their own regulatory plans without being aware of, or concerned with, the fact that other agencies are at the same time also issuing regulations that affect primary care physicians.

For example, in 1992 alone primary care physicians were forced to comply with new payment and coverage policies to implement the new Medicare fee schedule, new codes for visit services, the Clinical Laboratory Improvement Amendments (CLIA) regulations, self-referral regulations and regulations from the Department of Labor on blood-borne diseases and ADA. The cumulative impact was highly disruptive and costly to primary care physicians.

Recommendations

- 1. The Department of Labor should re-examine the Occupational Safety and Health Administration (OSHA) regulations on blood-borne diseases and, in consultation with primary care groups, issue revised regulations that are less burdensome and more appropriate for the low level of risk typically encountered in the offices of primary care physicians.**

The OSHA regulations on transmittal of blood-borne pathogens assume a level of risk in physician offices that is similar to those encountered in hospitals, although the actual risk is much lower. The result is that the costs of complying have been much higher than is appropriate or justified to protect the health of workers in physician offices.

As part of the fiscal year 1993 appropriations for the Department of Labor, the House-Senate conference report directs OSHA to re-examine the regulations based on the lower level of risk of transmittal in physician offices. The Department of Labor

should proceed promptly and issue revised regulations, as intended by Congress.

2. All federal agencies should establish a process to assess formally the impact on primary care physicians of proposed regulations prior to implementation.

A more formal process of assessment would increase the likelihood that unnecessarily costly regulations, such as the OSHA standards, would be identified and modified prior to being mandated for primary care physicians.

3. President Clinton should establish an interagency process to evaluate the cumulative impact of all pending federal regulations on primary care prior to promulgation, with the intent of reducing the cumulative burden on primary care physicians, such as by staggering implementation.

As explained earlier, the lack of any effort to assess the cumulative impact of requirements from different agencies led to primary care physicians being required to comply with an unprecedented number of regulations in 1992. In the future, unless there is a compelling reason for immediate implementation of a regulation, requirements that affect primary care physicians should be staggered so that the cumulative impact is eased.

4. The HHS secretary should continue to implement the Clinical Laboratory Improvement Amendments (CLIA) in a way

that improves the quality of laboratory testing but that assures that the requirements affecting small, office laboratories do not impose an undue and unnecessary burden on primary care physicians.

The regulations implementing CLIA are a major source of concern for primary care physicians, who worry that the costs of compliance may be so high as to force them to close the laboratories that they operate for their patients.

When Congress enacted CLIA, it specifically intended that the regulations be appropriate for the types of testing and degree of risk of tests done in physician labs. HHS has developed a number of policies to meet this intent, such as developing realistic personnel requirements for the types of tests commonly done in office laboratories, creating a limited exemption from some of CLIA's requirements for physician-performed tests, and relying primarily on announced inspections of office labs, except when quality problems are suspected.

Some interest groups are now pressuring HHS to reverse these policies and impose more rigid requirements on office labs. ASIM strongly believes that the changes made by HHS in these areas are appropriate and necessary. Not only are more burdensome requirements unnecessary, but they also would greatly increase the economic and regulatory costs to primary care physicians with no greater benefit to the public.

Recommendations for Improving the Practice Environment of Primary Care - III

Reforms in the Payment, Coverage and Review Policies of Private Insurers

Although the policies of the federal government have had a lot to do with the hostile economic and regulatory environment of primary care, the policies of private insurers are also important factors.

Private insurers typically pay too little for primary care services and too much for technological services. They often engage in “micromanagement” of the practices of primary care physicians, thus increasing the hassles and costs associated with primary care. Coverage for preventive and other primary care services is often inadequate. And as private entities that are regulated by the states, private insurers seldom offer primary care physicians the ability and opportunity to have their concerns addressed constructively.

Consequently, reforms in the payment, coverage and review policies of private insurers are clearly necessary. ASIM hopes that private insurers will be willing to make changes voluntarily to improve the economic environment for primary care. If they fail to do so, increased regulation by the states may be required. Federal standards ultimately may need to be imposed to reverse those policies of private insurers that create a hostile environment for primary care.

Recommendations

- 1. All private insurers should revise their payment policies to provide improved payments for services provided by internists and other primary care physicians. Specifically, private insurers are encouraged to use the resource-based relative value**

scale (RBRVS) methodology to determine their payment schedules, but without applying the conversion factor or other Medicare policies that undermine the intent to improve payments for primary care.

The RBRVS, which is one element of the Medicare fee schedule, substantially increased the value of primary care—and other visit, or E/M—services compared with surgery and other technological procedures. Originally, it was estimated that general in-

Private insurers typically pay too little for primary care services and too much for technological services.

ternists and family physicians would have gained between 20 and 40 percent in increased Medicare revenue due to implementation of a fee schedule based on the RBRVS.

For the reasons discussed earlier, however, several decisions made during the implementation of the fee schedule significantly eroded the projected benefits for primary care. Most primary care physicians are reporting that they have gained little or nothing, or even have lost income, since the fee schedule began to be implemented in 1992.

Nevertheless, the RBRVS itself remains a powerful tool for private insurers to improve the economic environment for primary care, but only if it is implemented in a way that avoids the Medicare policies that

offset the expected benefits. ASIM has developed suggested guidelines on the use of the RBRVS by non-Medicare payers.

Among the suggestions are the following:

- Private payers should use their own conversion factor, not the Medicare conversion factor.
- The conversion factor should be high enough to allow for an absolute (real) increase in payments for primary care.
- No volume offset should be assumed in determining the payer's conversion factor.
- The conversion factor should be updated regularly for inflation.
- There should be no preferential update or conversion factor for surgery.
- The Medicare geographic adjustment factor should not be used.
- Practice-cost relative values for visits should be increased to bring them in line with what would occur if they were based on resource costs instead of historical charges.
- Finally, the RBRVS should not be applied in a way that is designed merely to lower payments for procedures, without increasing payments for primary care visits.³⁹

2. Private insurers should continue to join in a cooperative effort to reduce and streamline administrative costs, including the development of a uniform claims form, "smart cards" to facilitate transfer of patient information to insurers, and uniform requirements for electronic billing.

One of the factors that increases the administrative costs and hassles for primary care physicians is the lack of uniformity in the requirements of different insurers. Each insurer has its own claim forms and billing requirements.

In 1992, then-HHS Secretary Sullivan announced an agreement by HHS and private insurers to join together in an unprecedented effort to streamline the administrative costs of insurance. Uniform claims forms, smart cards and electronic billing are among the objectives that are being pursued. ASIM believes that a high priority should be assigned to continuing and intensifying this effort.

3. All utilization review firms should be required to meet certain standards to assure that their activities do not burden primary care physicians with hassles and administrative costs that are not commensurate with their benefits.

Many private insurers contract with private utilization review firms to review the medical necessity of services provided by physicians to subscribers. Many of the firms have employed highly intrusive, arbitrary and questionable review methods that are a source of frustration and costs to primary care physicians. As private entities, the review firms have lacked accountability to physicians and patients.

In response, several states have enacted legislation to require such firms to meet certain standards, including appropriate due-process requirements, to operate in the state. To avoid further regulation, the industry has reacted by developing its own accreditation standards.

ASIM believes that utilization review firms should continue to be held accountable for their review methods, and appropriate stan-

dards should be required to reduce the burdens on primary care physicians and to protect the public. To that end, ASIM has developed recommendations on the manner in which utilization review should be conducted, which are available upon request.

- 4. All insurers should divulge their utilization review standards and criteria and develop specific policies to involve physicians (especially primary care physicians) in the development of review criteria. All insurers should begin moving toward "patterns of care" review (or "profiling") and the use of professionally developed practice guidelines in lieu of more intrusive, claim-by-claim micromanaging of physician practices.**

Insurers traditionally have relied on intrusive, claim-by-claim review as the primary

means of controlling costs. Such methods have been a major reason that primary care physicians repeatedly cite micromanagement as among their chief frustrations. ASIM believes that patterns-of-care review and professionally developed practice guidelines offer the potential of reducing micromanagement while holding physicians accountable for the decisions they make on behalf of insured patients.

Such alternative methods, however, potentially could be misused by insurers if physicians were not involved from the outset in developing policies on their use. For this reason, ASIM has developed specific recommendations on profiling and the use of practice guidelines that are available upon request.

Recommendations for Improving the Practice Environment of Primary Care - IV

The Impact of Health Reform

The debate over health reform represents both a risk and an opportunity for primary care. On one hand, health reform presents a historic opportunity to incorporate measures that will reverse the decline of primary care. Done properly, comprehensive reform can provide the will and the means to improve payments and coverage for primary care, reduce micromanagement and introduce incentives for primary care into the training system.

But health reform could be implemented in a way that does harm to primary care. If, for example, health reform attempts to control costs by further reducing payments to primary care physicians and by increasing the scrutiny and micromanaging of primary care practices, then health reform will accelerate the collapse of primary care.

Ultimately, this will mean that health reform itself will fail to ensure access, because there will be no foundation of primary care to support the tens of millions of uninsured Americans who will be added to the system. In addition, those who now have access to a primary care physician will find it harder to find one in the future. And if health reform accelerates the collapse of primary care, it also will fail to lower costs because without more primary care physicians, health care expenditures ultimately will be higher.

Policy-makers are currently considering two basic approaches to controlling costs. One would rely primarily on market-based reforms, such as those advocated by proponents of managed competition. The other would impose national and state ceilings on

total expenditures, which would be enforced by controls on the prices charged by either physicians, hospitals, other providers, insurers or all of the above.

Both approaches create risk for primary care. Managed competition will force plans to compete on the basis of price and other factors. That competition, in turn, could lead competing plans to impose discounts on payments to physicians, including primary care physicians, and to exert more control—micromanaging—of the physicians' practices. Expenditure ceilings enforced by price controls, however, could cut payments to primary care physicians in order to keep spending within the ceiling.

ASIM has developed the following recommendations to assure that health reform does not accelerate the decline in primary care, but instead includes positive measures to rebuild primary care.

Recommendations

- 1. Health reform proposals must first "do no harm" to primary care. Therefore all health reform proposals must be critically assessed to determine the potential impact on primary care. Proposals that will further increase payment inequities and micromanaging of primary care practices either should be rejected or modified to prevent further damage to primary care.**

Ideally, health reform should include measures to strengthen primary care. But at the very least, health reform must not make things worse.

Expenditure ceilings that are enforced by price controls on physicians are of particular concern. Some have proposed that national and state ceilings on expenditures be developed, and that a fee schedule be negotiated within each state. Expenditures under the fee schedule could not exceed the budget for the state. If the expenditure ceiling were exceeded, states would have

If health reform accelerates the collapse of primary care, it will also fail to lower costs because without more primary care physicians, health care expenditures ultimately will be higher.

the authority to reduce the fee schedule payments to physicians, including primary care physicians. Such an enforcement mechanism could result in continued reductions in payments to primary care physicians.

Similarly, proposals to require all payers to use the Medicare rates would cause substantial economic harm to primary care physicians because Medicare rates—even under the new RBRVS fee schedule—are substantially below those of private payers. According to an analysis conducted in 1992 by the PPRC, requiring all payers to use the Medicare rates could cause the average payments to physicians to drop by 35 percent.⁴⁰

Market-based approaches are not without risks. As noted earlier, managed competition proposals could fuel the growth of the types of plans most disliked by primary care physicians: those that rely on fee discounts and intrusive micromanaging to control costs. Additional layers of bureaucracy could be created, and continuity of patient care could be disrupted.

ASIM believes, however, that properly designed, market-based approaches pose less direct risk to primary care physicians than expenditure ceilings that are enforced by cuts in payments to physicians. Market-based approaches must include measures, however, to assure that the market does not cause further reductions in payments to primary care physicians and more micromanagement of their practices.

2. To assure that market-based approaches do not cause an even more unfavorable economic and regulatory environment for primary care, health reform based on managed competition should do the following:

- Assure fair payments for primary care services, such as by requiring accountable health plans (AHPs) to use the RBRVS methodology to determine payments on a fee-for-service basis, or to calculate the capitation amount or salaries if the plan is not fee-for-service. AHPs should be permitted, however, to pay for primary care at a higher rate than would be the case under the RBRVS. Since many AHPs are likely to require that all care to enrollees be managed and coordinated by primary care physicians, it is essential that the plans also provide adequate payment to primary care physicians for the required management services.
- Require all AHPs to meet standards to assure that their utilization review methods are effective, consistent and do not impose an unreasonable administrative burden on primary care physicians.
- Assure that physicians, including primary care physicians, are not precluded by anti-trust restrictions from being able to compete on a level playing field with hospitals and insurers.

- **Do not restrict qualification as an AHP only to certain types of plans, such as staff-model HMOs.** Individuals should be able to choose from a wide range of insurance and delivery options, including plans that allow patients to choose their own physicians, particularly free choice of primary care physicians.
- **Set a cap on the deductibility of contributions to health insurance at a level that creates incentives for individuals to consider the cost differences of competing plans.** However, the cap should not be set so low that it drives all but the wealthy into the cheapest plans available.

Some argue that the market alone should determine how much primary care physicians will be paid and what utilization review methods may be used by individual plans. But managed competition could reward plans that rely on fee discounts to physicians, including primary care physicians, and plans that control costs by micromanaging physician practices.

For this reason, ASIM believes that it is important to include measures that minimize harm to primary care. The recommendations outlined above are important if managed competition is to do no harm to primary care.

3. Market-based approaches should be emphasized over expenditure ceilings enforced by price controls. If some form of global budgets is considered, it should be in the form of negotiated goals, not absolute ceilings.

As discussed earlier, expenditure ceilings enforced by price controls could do great damage to the economic environment of primary care. Despite the possible risks, ASIM believes that, if designed properly, market-based approaches are preferable to

expenditure ceilings and price controls. If some form of global budgets is considered, ASIM believes that negotiated goals or targets are preferable to ceilings, because targets, if exceeded, would not automatically cause reductions in payments to primary care physicians.

4. As an alternative to mandating that all payers use the same rates, it would be preferable to require all payers and physicians to use the same RBRVS methodology to determine payments, but allow individual payers and physicians to determine their own annual conversion factors.

Use of the RBRVS methodology, but not the Medicare rates, could help improve payments for primary care. ASIM has developed a proposal, "Competitive Pricing: Informed Choices"⁴¹ that would require all payers and physicians to use the same RBRVS method, but would allow them to set their own competitive conversion factors for the RBRVS. If the conversion factors were disseminated to individuals in a community, they would be able to select a physician whose charges were competitive with the payments of the insurer.

ASIM believes that this approach would be far better for primary care physicians than mandating that all payers use the same rates, especially if the uniform rates are linked to enforceable expenditure ceilings.

5. All insurance plans should require improved coverage and a lower deductible for primary care and preventive services.

Low payments for primary care are related to the historical lack of coverage for primary care and preventive services. Routine office visits and other preventive services historically have not been covered by most insurers. In addition, high deductibles have resulted in primary care services being essentially not covered, because patients rarely

see the primary care physician often enough to meet the deductible. Further, high deductibles for primary care have acted as a disincentive for patients to obtain services from primary care physicians.

Better coverage for primary care and preventive services—and lower deductibles for those services compared with surgical and other technological services—would substantially improve the economic environment for primary care and access to those services.

- 6. Consistent with their critical importance in the health care system, internists and other primary care physicians should be adequately represented on any national or state boards that are given authority to propose budgets or expenditure goals, determine payments or benefits, establish policies on data disclosure, or recommend other policies governing the provision and payment of health care.**

Because primary care is the foundation of the health care system, it is critical that primary care physicians be adequately represented on any boards that have authority to make recommendations on the delivery and payment of medical care services. That means that internists and other primary care physicians must have more than “token” representation on such boards. They must have enough seats to have a substantial voice in the establishment of health care policy.

- 7. Health reform should improve payments under Medicaid—or a new program to replace Medicaid—for services by primary care physicians. Options to be considered include (1) requiring all states to increase payments for primary care visit services to**

a comparable level as the Medicare fee schedule; (2) increasing payments for primary care visit services to the Medicare levels only in selected, underserved geographic areas; (3) increasing payments to the Medicare rates for primary care physicians who agree to an expanded commitment to a defined Medicaid caseload; or (4) encouraging states to convert to their own Medicaid RBRVS fee schedule, as Texas Medicaid has done.

Low Medicaid payments are a major factor in discouraging primary care physicians from participating in the program. Each of these options, which are discussed in the PPRC’s 1991 report to Congress, would enhance Medicaid patients’ access to primary care services and improve the overall economic environment for primary care. ASIM recognizes that Congress may consider Medicaid reforms in the context of overall health reform. It is imperative, however, that inequitably low levels of Medicaid payments for primary care be reversed, either as part of overall reform or by enactment of separate authorizing legislation.

- 8. It is not enough for health reform proposals to “do no harm” to primary care. Instead, health reform should include comprehensive proposals—such as those presented throughout this paper—to rebuild primary care.**

ASIM believes that for health reform to really succeed, it must do more than not accelerate the decline in primary care. It must include measures to rebuild primary care. The proposals presented throughout this paper should be considered for inclusion in a comprehensive health reform package.

Recommendations for Improving The Training Environment for Primary Care

The disincentives for primary care that are present throughout the training of physicians should be addressed as part of a blueprint to rebuild primary care.

As long as the economic and regulatory environments remain hostile, however, a greater emphasis on primary care during medical education is unlikely, by itself, to succeed in persuading physicians to enter and remain in primary care. Therefore, the following recommendations should be included as part of a multifaceted, reform blueprint that also targets the disincentives that exist once a physician enters practice.

GME Funding

- 1.** Primary care training programs should receive a *substantially* larger share of Medicare graduate medical education (GME) funding. This should be accomplished in a revenue-neutral manner by increasing the weight given to residents in three-year internal medicine training programs and in other generalist programs, while reducing the weight assigned to residents in all other residency programs. The American Society of Internal Medicine (ASIM) does not, however, favor eliminating Medicare GME funding for all training programs that are longer than three years, explicitly limiting funding only to generalist programs, or paying only for a fixed number of residents in each specialty as determined by a national work-force policy.

The largest single explicit financing source for graduate medical education (GME) is Medicare. The costs of GME are recognized by Medicare under two mechanisms: direct medical education payments to hospitals for residents' stipends, faculty salaries, ad-

ministrative expenses and institutional overhead allocated to residency programs; and an indirect medical education adjustment.

Direct medical education payments are based on hospital-specific, per resident costs multiplied by the number of residents. The indirect medical adjustment was developed to compensate teaching institutions for the relatively high costs thought to be associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require the specialized services available only in teaching hospitals. In fiscal year 1991, Medicare Part A paid approximately \$1.5 billion in direct medical education payments and \$2.9 billion in indirect adjustments.

In 1992, the Bush administration proposed changing the weighting formula for determining direct medical education payments so that each primary care resident would be counted as more than one full-time equivalent (FTE) and other residents as less than one FTE. Although ASIM favors this general approach, we believe that a substantially greater differential should be considered.

For example, in allocating its own funding for GME, New York state treats residents in family practice and those in three-year internal medicine or pediatrics training programs as 1.5 FTEs. Internists and family physicians who are being trained as geriatricians, and all other pediatricians, are weighted as 1.27 FTEs. Emergency medicine, preventive medicine and obstetrics-gynecology residents are 1.1 FTEs. All other three-year residencies are 1.0 FTEs, and all other residents are 0.9 FTEs.

Although ASIM has not endorsed the exact weights used by New York, we believe that the direction of providing a substantially greater emphasis on generalist programs is the right one, and we prefer the New York method over the administration proposal that Congress considered last year.

As part of his economic plan, President Clinton also has proposed increasing the weight assigned to primary care residency programs. Details of his proposal were unavailable when this paper went to print; however, ASIM looks forward to working with the president and Congress on implementing such a plan.

ASIM does not, however, favor proposals that would establish prescribed mixes and numbers of physicians in each specialty and eliminate funding for programs that do not meet those policy goals, or proposals that would continue funding only for general internal medicine, family practice and pediatrics. Rigid quotas may not be flexible enough for the training of physicians to adapt to unforeseen needs. In addition, the government's ability to forecast accurately the future needs of the country—and to design policies to meet those needs—has not instilled a great deal of confidence in policies to regulate directly the number and types of physicians. If the work-force quota turns out to be incorrect, it will take years to undo the damage.

Primary care should not be relegated to a "last resort" role by a public policy that fills generalist slots with whomever is left after top students successfully compete for limited numbers of subspecialty training programs. Furthermore, although it is imperative that the number and proportion of primary care physicians be increased, there will continue to be a need for physicians who practice in certain subspecialties.

The aging of the population will demand a sufficient number of physicians who are trained in the complex medical problems typical of that age group, such as oncology, rheumatology, cardiology, gastroenterology and other internal medicine subspecialties. Complete elimination of funding for those subspecialty programs would risk creating a shortage of physicians who have needed skills and training.

Finally, it is critical that physicians choose primary care because *it is what they want to do*, not because it was the only field available to them after the government cut off funding for all other programs. Patients will not benefit if their physicians resent being forced to practice in a field that they otherwise would not have chosen.

ASIM believes that it is better for physicians to be exposed to what is good and rewarding about primary care so that they choose it on their own—and to make the environment better so that they aren't penalized for that choice.

Substantially increasing the weight assigned to primary care programs compared with other programs can help accomplish the goal of increasing the proportion and number of primary care physicians, without the inflexibility and coerciveness that would occur under fixed quotas. But there must also be direct financial benefits for medical students and residents who intend to practice in primary care.

Direct Financial Incentives

- 2. The secretary of HHS should require that a portion of the increased GME funding for primary care residencies be provided as increased stipends to residents, with payback requirements should the physician later decide to leave primary care.**

Residents in generalist training programs should receive higher compensation than those in other programs. One way to promote this change is to revise the Medicare GME weighting formula to benefit primary care, as discussed above. As a condition of receiving the funds, the training programs could be required to allocate a set proportion of the increased funds toward raising resident stipends.

- 3. Loan forgiveness should be provided for physicians who enter and remain in primary care practice. Under this proposal, a portion of the debt would be "forgiven" for each year the physician remained in primary care practice. If a physician at some point decided to leave primary care, the remaining debt would not be forgiven.**

A significant problem with many loan forgiveness programs is that they require medical students to sign a contract committing themselves to primary care. Because many medical students will later change their minds on specialty choice, it is difficult to obtain a commitment from them at such an early stage of their career. It also increases the possibility that the students will default on their obligation.

A better approach is to provide loan forgiveness *after* physicians establish themselves in primary care practices. Under this alternative, physicians who establish themselves in primary care could have a portion of their debt forgiven for each year that they remain in this field.

For example, if a physician had a debt of \$75,000, and \$5,000 per year was forgiven for each year that the physician practiced primary care, then the physician would have to practice primary care for at least 15 years for the debt to be totally forgiven. If the physician in this example instead decided to leave primary care and subspecialize af-

ter only five years, he or she would have had only \$25,000 of the debt forgiven, and the remaining \$50,000 would still be due to the lender.

- 4. Scholarships and lower interest loans should be provided for medical students who make a commitment to primary care. Such measures, however, probably will have less of an impact than a program of loan forgiveness that rewards physicians for each year they practice in primary care, as discussed in the preceding recommendation.**

Direct scholarships and lower interest loans for medical students are another way of providing direct financial benefit to those who are committed to primary care. Low interest loans, however, will not have as great an impact as a program of loan forgiveness. As noted above, many medical students may be unwilling to commit to primary care at such an early point in their training, even in exchange for scholarships and low-interest loans. For these reasons, ASIM believes that a program of loan forgiveness linked to the number of years in primary care practice is likely to have a greater impact.

Training in Ambulatory Settings

- 5. Residents should receive greater exposure to primary care in ambulatory settings, including physician offices, area health education centers and community health centers. Specific goals should be established for the percentage of training time that residents should spend in ambulatory settings, including time spent in physician offices. "Mentorship" programs should be encouraged. In addition, expanded Medicare funding should be provided for training in ambulatory and office-based settings.**

The mix of patients typically experienced by residents in generalist programs is heavily skewed toward patients who are older, sicker and poorer than what is typical in actual practice. This is because most of the training is in the hospital setting. Residents in these programs view primary care

Mentorship programs—in which medical students and residents are matched with practicing, primary care physicians who can show them what primary care is really like—should be encouraged.

far more negatively than if they had been exposed to a more representative mix of patients. Furthermore, they often lack some of the skills needed to take care of the kinds of patients encountered in a typical primary care, office-based practice.

By establishing specific goals for the percentage of training time that should be spent in ambulatory settings—including time spent in physician offices—and then developing plans to meet those goals, residency programs can begin to offer a more balanced, and realistic, exposure to primary care. Furthermore, mentorship programs—in which medical students and residents are matched with practicing, primary care physicians who can show them what primary care is really like—should be encouraged.

As noted earlier, however, the current methods of funding medical education themselves must be changed to break the link between GME funding and hospital inpatient services. Because most GME funding comes through Medicare Part A payments for hospital inpatient services, residency

programs are not likely to be successful in increasing exposure to ambulatory care without funding for such training.

The Physician Payment Review Commission (PPRC) is considering several options for funding training in ambulatory settings. Time spent in ambulatory care activities could be included in calculating the number of FTEs for the purposes of direct (and perhaps indirect) medical education payments.

Medicare also could place conditions on payments to health maintenance organizations (HMOs). For example, HMOs using Medicare funds could be required to meet some minimum standard for participation in GME. Alternatively, Medicare payments to HMOs could be calculated to include the costs of direct and indirect medical education only for those programs that provide training opportunities, excluding the costs for others. A more far-reaching proposal is to support GME through Part B Medicare payments.

Building on Part B payments might make it easier for training to take place not only in organized systems of care but also in physician offices. This could be done by permitting residents to bill under Part B for the personal and identifiable services they provide with assignment to a faculty practice plan, although this is not without several problems.

An alternative would be to create an add-on to Part B payments paid to teaching physicians. Increasing the clinical income of faculty (arguably) would allow the faculty to use these extra revenues to support training in sites other than the hospital. The add-on could replace all GME payments, or only that part of GME payments attributable to faculty supervision.

One flaw of the add-on is that some of the faculty plans might not use the extra revenue to support ambulatory training. Although conditions could be placed on the use of revenues generated from the add-on, it might be simpler to make direct payments to entities other than hospitals.

This alternative would pay clinics and physician offices directly from Part A. It would require that a certification or accreditation process be used to ensure that the entity adheres to minimum standards related to supervision, facilities and content. Some type of certification would assure that rotations in these sites are a valuable educational experience. From an administrative standpoint, this would be relatively simpler to implement than the Part B model, although the necessity of certifying and making payments to a potentially large number of sites would be more complicated than the current system.

At this time, ASIM has not endorsed any of these specific financing options. We look forward to reviewing the PPRC's recommendations, expected in its 1993 report to Congress. We do believe that it is imperative, however, that funding—either through Medicare Part A or B—be provided for training in ambulatory settings, including training in primary care, physician offices.

6. As part of comprehensive health reform, all payers should be required to contribute a percentage of their payments for medical care to a financing pool to support residencies that meet policy goals related to supply, specialty mix and site of training. Payments from the financing pool should be distributed based on a weighting formula that favors primary care, as discussed above in the context of Medicare GME funding.

ASIM believes that it is appropriate to spread the costs of financing GME throughout the health care system, rather than Medicare being the primary source of funding. The supply and distribution of physicians affects the availability, cost and quality of care for all Americans, so it is logical for the costs to be borne by all payers, on behalf of their insured, rather than exclusively or principally by the Medicare program.

Medical School Reforms

7. Medical schools should be encouraged to implement the recommendations of the Association of American Medical Colleges Task Force on the Generalist Physician. The task force's recommendations include proposals to increase the involvement of primary care physicians in the education of medical students, to provide students with meaningful experiences in the primary care specialties, and to expose students to positive primary care role models.

ASIM specifically supports the following task force recommendations for medical schools:

- Provide appropriate academic recognition for scholarship, teaching and role modeling among the faculty of the generalist specialties.
- Foster research opportunities in the generalist fields among faculty, students and residents.
- Require that all medical students have meaningful curricular experience in the generalist specialties.
- Appoint faculty from the generalist specialties to key administrative and planning bodies, including the admissions committees.

- Ensure that students have adequate opportunities to encounter role models among faculty in the generalist specialties.
- Enable more community-based, generalist physicians to contribute to their academic programs.
- Adjust admission criteria to increase the matriculation of qualified applicants who demonstrate genuine interest in a generalist career.
- Establish financial incentives for medical students to choose generalist careers.⁴²

Other Training Reforms

- 8.** The National Health Service Corps (NHSC) should be expanded to provide a means for primary care physicians who commit to practicing in underserved areas to be trained without excessive debt. This service should be used especially to encourage and promote minorities to train and remain in primary care.

NHSC is particularly valuable not only in providing physicians with a means for training in primary care without incurring excessive debt, but also in providing at least temporary help to underserved communities. The corps has not been very effective, however, in getting physicians to locate their practices permanently in underserved areas. Therefore, it will be necessary to change certain aspects of the economic and regulatory environment that may have a disproportionately greater adverse impact on primary care physicians in rural areas.

- 9.** Congress should enact legislation to provide qualified primary care physicians who

are practicing in rural areas that are designated as health professional shortage areas with a tax credit for three years based on a five-year service incentive. Congress should eliminate the taxable status of funds given to physicians through the NHSC Loan Repayment Program. In addition, Congress should mandate studies to determine the feasibility of extending the tax benefit to physicians and others who practice in medically underserved urban areas.

Sen. David Pryor (D-Ark.) has introduced S. 241, the Rural Primary Care Act of 1993, which is intended to complement the NHSC efforts to place physicians in underserved areas by providing a substantive tax credit to physicians who stay beyond their original commitment or rejoin the corps. Such modest tax incentives, if coupled with other changes to address the adverse economic factors associated with practice in rural areas, could be helpful in encouraging physicians to train in primary care and to remain in rural, underserved areas.

- 10.** The National Institutes of Health and the Agency for Health Care Policy and Research should receive additional funding for research in primary care, health services delivery and patient outcomes, as well as for the development of research faculty in the primary care disciplines.

This recommendation, which is included in the Council on Graduate Medical Education (COGME) report,⁴³ would help develop a critical mass of faculty in the generalist disciplines. ASIM agrees with COGME's view that this critical mass of academic faculty will assist in providing an educational environment that fosters selection of a primary care specialty.

Conclusions

Throughout this white paper, the American Society of Internal Medicine (ASIM) has documented the extent of the decline in primary care; described the importance of primary care in the health care system; presented data to support the benefits of having a greater number and proportion of primary care physicians; identified the factors that are turning physicians away from primary care; proposed goals for increasing the number and proportion of primary care physicians; and proposed far-reaching changes in Medicare, other federal programs, the policies of private insurers, and in the content and funding of medical education. All these proposals offer the hope of rebuilding primary care.

Several conclusions have been presented and documented:

- Without immediate action to reverse existing trends, there will be far too few primary care physicians available to meet the country's current and future needs.
 - The key factors turning physicians away from primary care are a hostile economic and regulatory practice environment.
 - The emphasis on specialization in the content and funding of medical education contributes to the disenchantment with primary care.
 - To reverse the decline of primary care, it will be necessary to institute reforms that address the hostile economic and regulatory environment and the disincentives that exist in the training programs.
- Changes in the policies of Medicare, other federal agencies, private payers and the educational establishment will be required to rebuild primary care.
 - Health reform has the potential to bring great improvements or harm to primary care.

As Congress and President Clinton debate the future of the health care system, ASIM urges them to consider the problems and recommendations presented in this paper. While much of the debate so far has focused on issues relating to insurance coverage, global budgets, employer mandates and market reforms, the question of what will happen to primary care deserves at least as much attention.

Rebuilding primary care isn't without its costs. The importance of reducing the federal deficit inevitably will be presented as an obstacle to reform. ASIM believes that many of the recommendations presented in this paper can be implemented in a budget-neutral manner, by reducing payments for other services that are currently paid too highly. But if additional money is needed to rebuild primary care, it will be money well invested.

After all, primary care not only saves money in the long run—it also saves lives. Without a strong foundation of primary care, the nation cannot expand access and control costs. Rebuilding primary care is not just another issue that needs to be dealt with as part of health reform. Rather, it is a necessary condition for successful reform.

Endnotes

1. Council on Graduate Medical Education (COGME), Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. "Third Report: Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century." October 1992.
2. *Ibid.*
3. Colwill, Jack. "Where Have All the Primary Care Applicants Gone?" *New England Journal of Medicine (NEJM)*, 326 (February 6, 1992): 387-393.
4. "Trend to Specialization Reversing?" *Journal of the American Medical Association, (JAMA)*, Medical News and Perspectives 268 (July 1, 1992): 11.
5. Barnett, P., and John E. Midtling. "Public Policy and the Supply of Primary Care Physicians." *JAMA, Medical News and Perspectives* 262 (November 24, 1989): 2864-2868.
6. "Growth of Physician Specialties Called a Problem." *The Washington Post*. September 2, 1992.
7. COGME, *op. cit.*
8. Colwill, *op. cit.*
9. "Meeting the Medical Needs of the Senior Boom." *Alliance for Aging Research*. April 1992.
10. COGME, *op. cit.*
11. Health Resources and Research Administration. Public Health Service. Department of Health and Human Services. "The National Primary Care Conference Executive Summary." March 1992.
12. Shi, Leiyu. "The Relationship Between Primary Care and Life Chances." *Journal of Health Care for the Poor and Underserved* 3 (Fall 1992): 321-335.
13. COGME, *op. cit.*
14. Colwill, *op. cit.*
15. Schroeder, Steven. "Physician Supply and the U.S. Medical Marketplace." *Health Affairs* (Spring 1992): 235-243.
16. Page, Leigh. "Push for Primary Care." *American Medical Association News*. August 10, 1992.
17. "The National Ambulatory Medical Care Survey." Department of Health and Human Services. 1974, 1975, 1979.
18. COGME, *op. cit.*
19. Colwill, *op. cit.*
20. Sillman, Rebecca A. "Debt, Moonlighting and Career Decisions Among Internal Medicine Residents." *Journal of Medical Education* 62 (June 1987): 463-469.
21. Barnett, *op. cit.*
22. Lewis, Charles E. "How Satisfying Is the Practice of Internal Medicine? A National Survey." *Annals of Internal Medicine* 114 (January 1, 1991): 1-5.
23. David, Alan K. and Anita Blosser. "Long Term Outcomes of Primary Care Residency Choice by Graduating Medical Students in One Medical School." *Journal of Family Practice* 31 (1990): 411-416.
24. Cohen, Alan B., *et al.* "Young Physicians and the Future of the Medical Profession." *Health Affairs* (December 1990): 138-193.
25. Pope, Gregory C., and John E. Schneider. "Trends in Physician Income." *Health Affairs* (Spring 1992): 181-193.
26. Schroeder, Steven. "Internal Medicine: A Troubled But Still Great Specialty." *The Internist: Health Policy in Practice* (July/August 1991): 8-11.
27. Kassler, Jeanne. "Internal Medicine as a Specialty Is Said To Be Losing Favor." *The New York Times*. September 16, 1990.

28. Colwill, *op. cit.*
29. Schwartz, Mark D. "Medical Student Interest in Internal Medicine: Initial Report of the Society of General Internal Medicine Interest Group Survey of Factors Influencing Career Choice in Internal Medicine." *Annals of Internal Medicine* 114 (January 1, 1991): 6-15.
30. Association of American Medical Colleges (AAMC). "Task Force on the Generalist Physician: Executive Summary." October 8, 1992.
31. COGME, *op. cit.*
32. Colwill, *op. cit.*
33. Sillman, *op. cit.*
34. "Summary of Meeting of the Federated Council for Internal Medicine [FCIM]." April 28, 1992.
35. Cohen, *op. cit.*
36. COGME, *op. cit.*
37. *Ibid.*
38. Advisory Committee on Medicare-Physician Relationships, Department of Health and Human Services. "Report to the Secretary of Health and Human Services and the Administrator of the Health Care Financing Administration." August 1992.
39. American Society of Internal Medicine (ASIM). "Guidelines on the Use of the RBRVS by Non-Medicare Payers." December 1992.
40. Physician Payment Review Commission. "Optional Payment Rates for Physicians: An Analysis of Section 402 of H.R. 3626." November 1991.
41. American Society of Internal Medicine. "Competitive Pricing, Informed Choices: Establishing Payment Rates for Physician Services Under Comprehensive Employer-Based Access Legislation." March 1992.
42. AAMC, *op. cit.*
43. COGME, *op. cit.*

For additional copies of
Rebuilding Primary Care: A Blueprint for the Future,
contact the American Society
of Internal Medicine.



2011 Pennsylvania Avenue, NW
Suite 800
Washington, DC 20006-1808
(202) 835-2746
FAX: (202) 835-0441