Why Is Primary Care Like the Weather?

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Overview

A. If doctors matter so much, why are they so often marginalized?
B. What's the supply of doctors? Need for doctors?
C. Why is primary care like the weather? Or like climate change?
   - Problems – causes – possible remedies

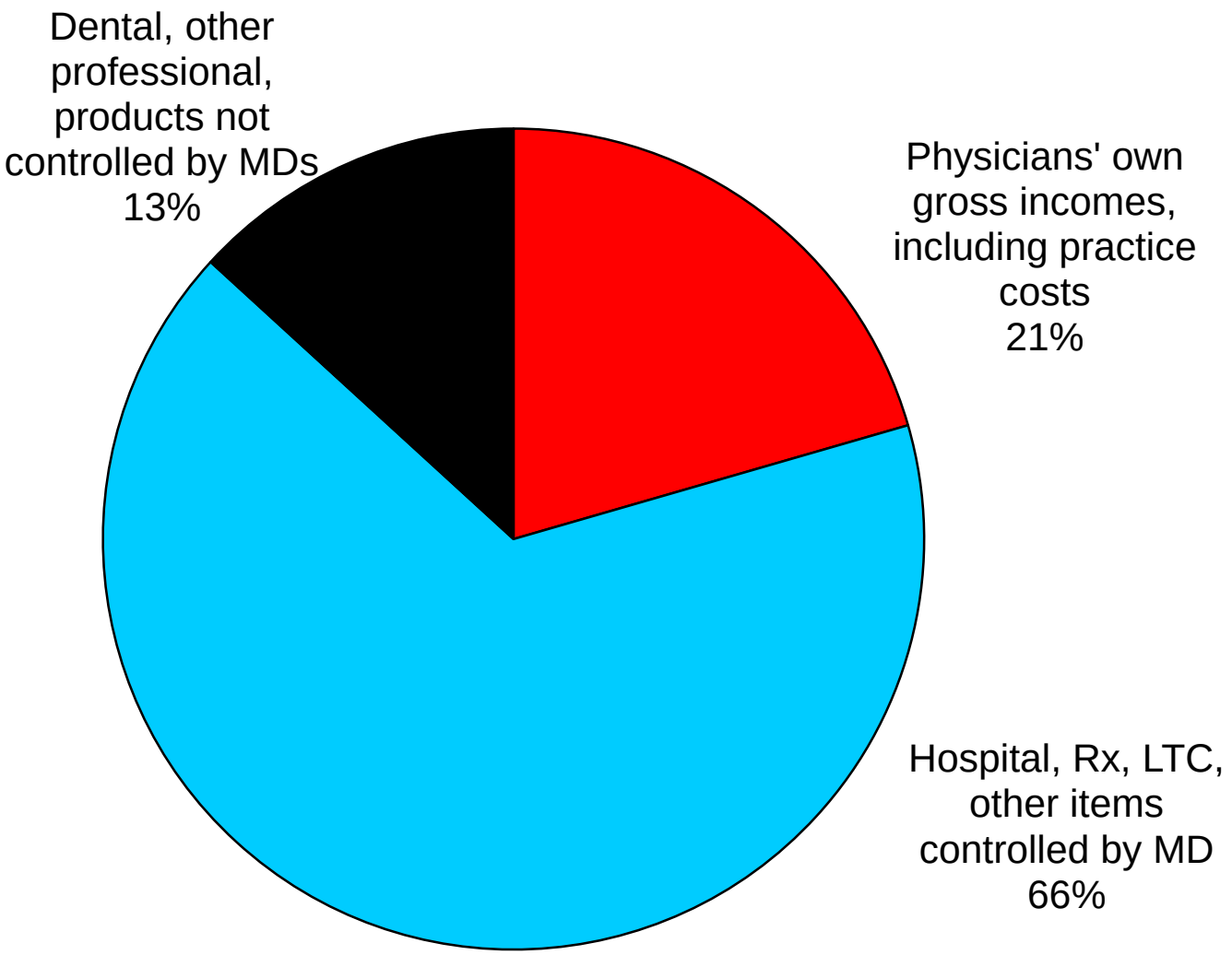
A. If doctors matter so much, why are they so often marginalized?

Doctors essential to assuring access to appropriate care and to containing cost

Doctors' individual clinical decisions commit and control overwhelming share of health $

- Can ACA's access expansions work if doctors can't or won't give care?
- Can any cost control work if doctors oppose?
  - Could game new incentives if unsympathetic
  - Could urge patients to overthrow controls

PHYSICIANS RECEIVE OR CONTROL 87% OF U.S. PERSONAL HEALTH SPENDING



Little coordination between access expansions and doctor configuration

- U.S. efforts to expand access focus on financing expanded access
  - Financing fights exhaust political oxygen
- None left to address the 3 elements of doctor configuration
  - How many physicians to train?
  - In what specialties?
  - Practicing where?

Cost control efforts are rarely negotiated or coordinated with doctors

- Why not?
  - Doctors aren't well-organized
  - Lack mechanisms for consultation and trust-building
- Consequently, cost controls often
  1. Squeezed doctors
     - Blue Shield or Medicaid fee cuts
     - Higher patient out-of-pocket costs
  2. Manipulated doctors
     - Must join multiple HMOs—or your patients won't be covered
     - Buy costly EHR or suffer financial penalties
  3. Ignored doctors

= Some of the reasons few cost controls have worked

Accidents, not intentions? But still very consequential

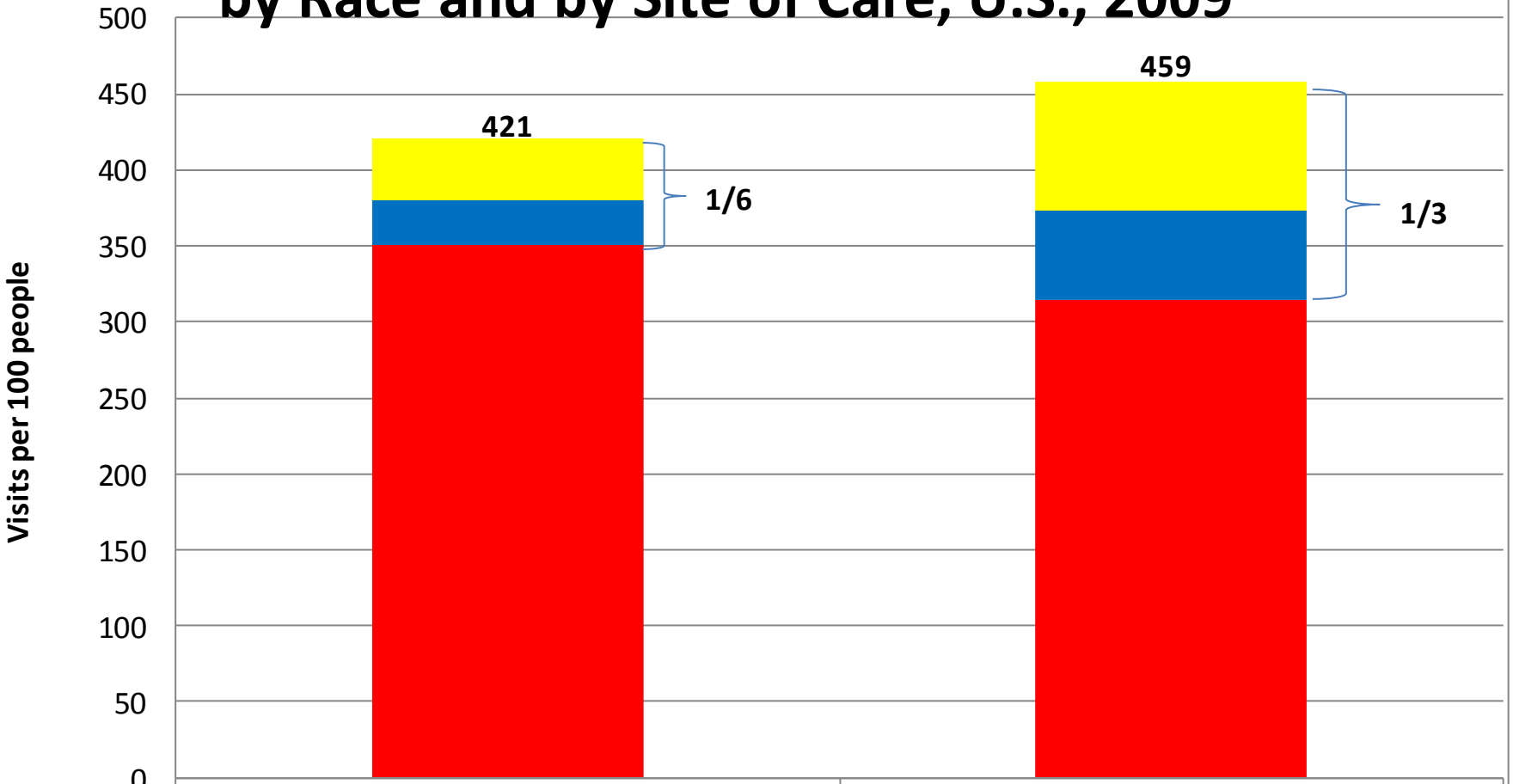
- In recent years, physicians consolidate, or sell practices to hospitals
  - EHR burden?
  - Complex billing environment?
  - Low incomes, weak leverage with private payers?
- For many years, many doctors haven't accepted Medicaid owing to low fees
  - State role in setting Medicaid prices
  - Inability to move to single price for all payers

The care we get depends heavily on the caregivers we've got

Doctors and hospitals

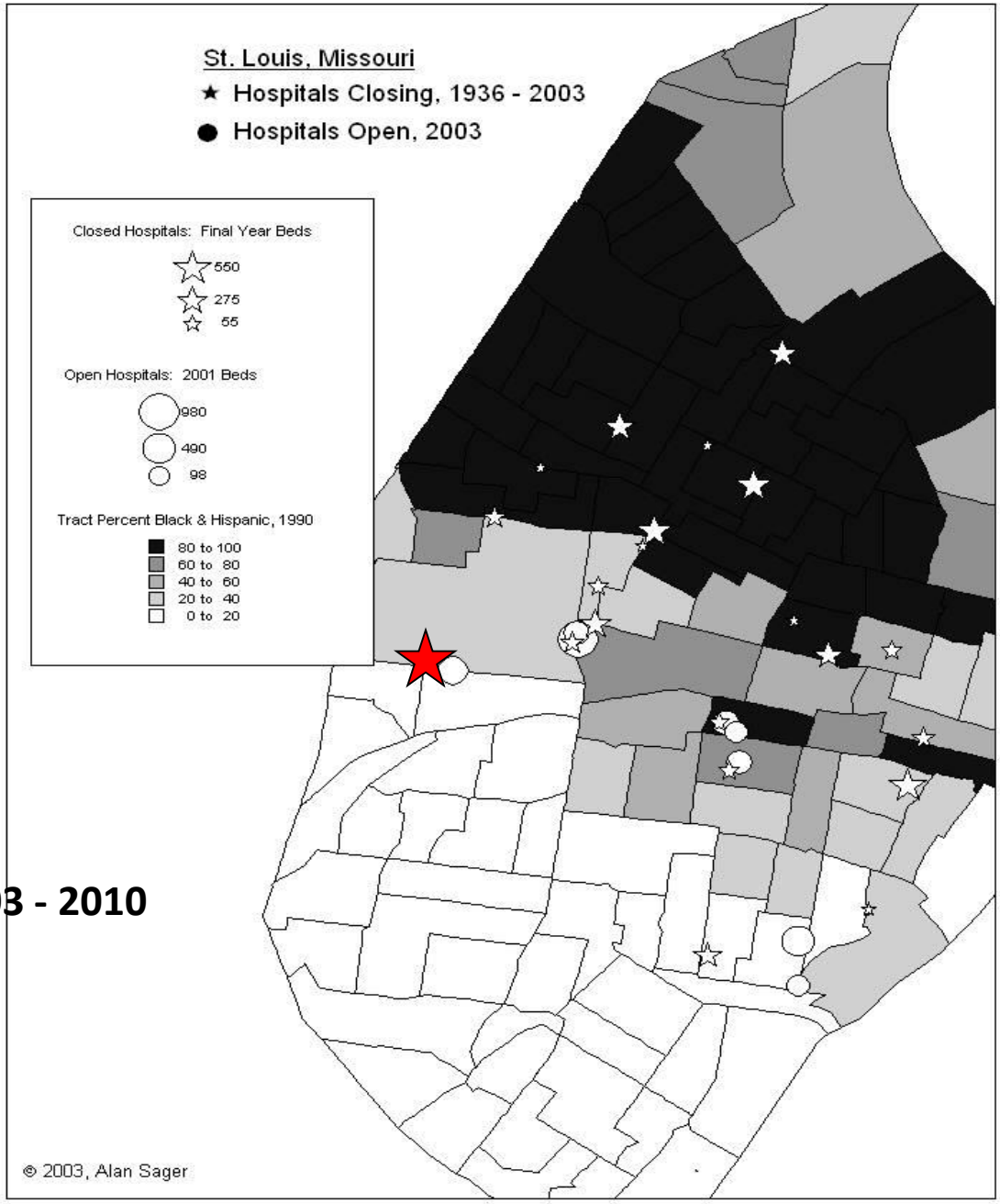
- How many?
- Located where?
- Doing what?

Physician Visits per 100 People, by Race and by Site of Care, U.S., 2009



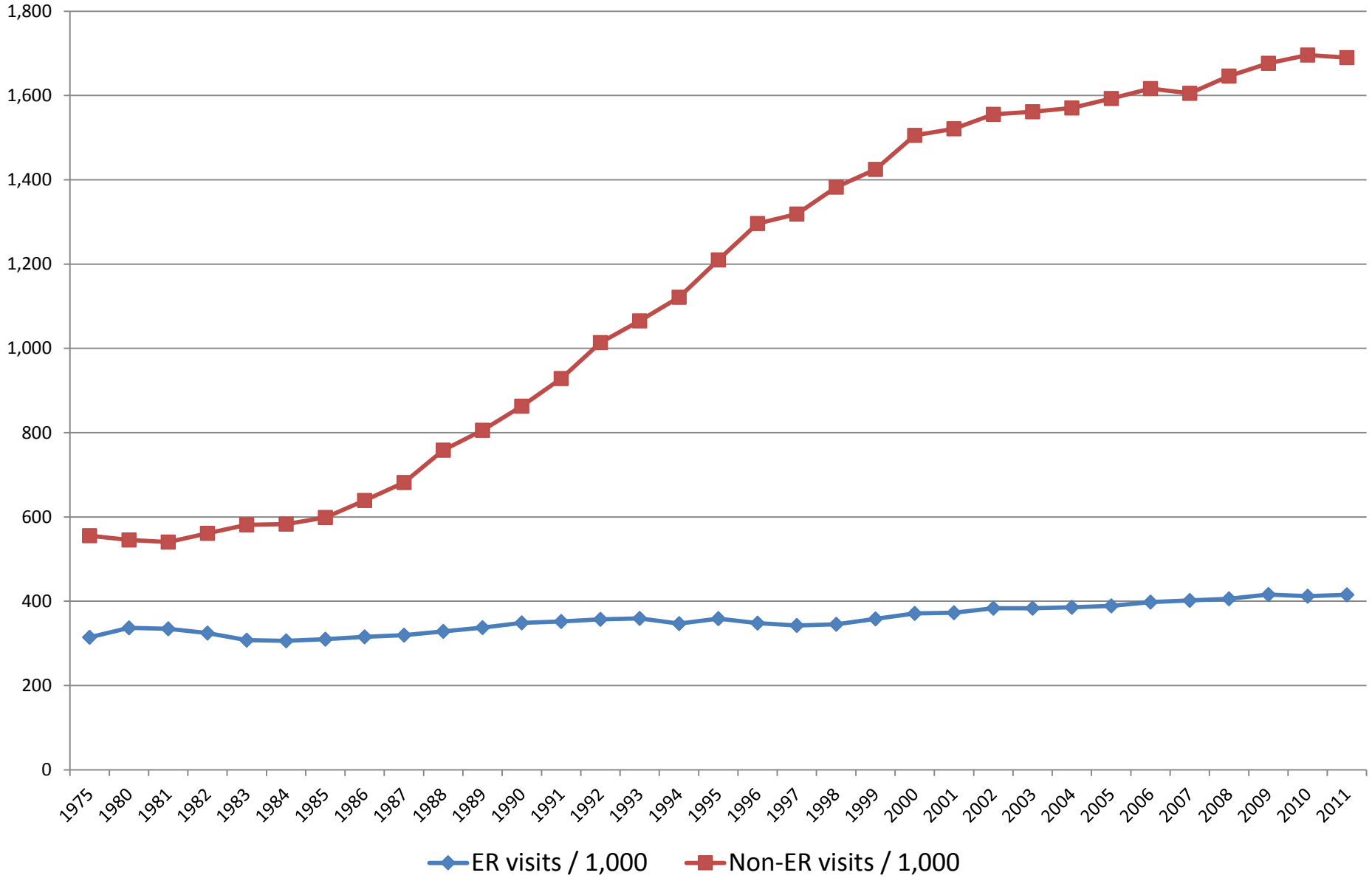
	white	black
ER	41	85
OPD	29	59
MD office	351	314

Source: *Health United States, 2011*, Table 96, age-adjusted.

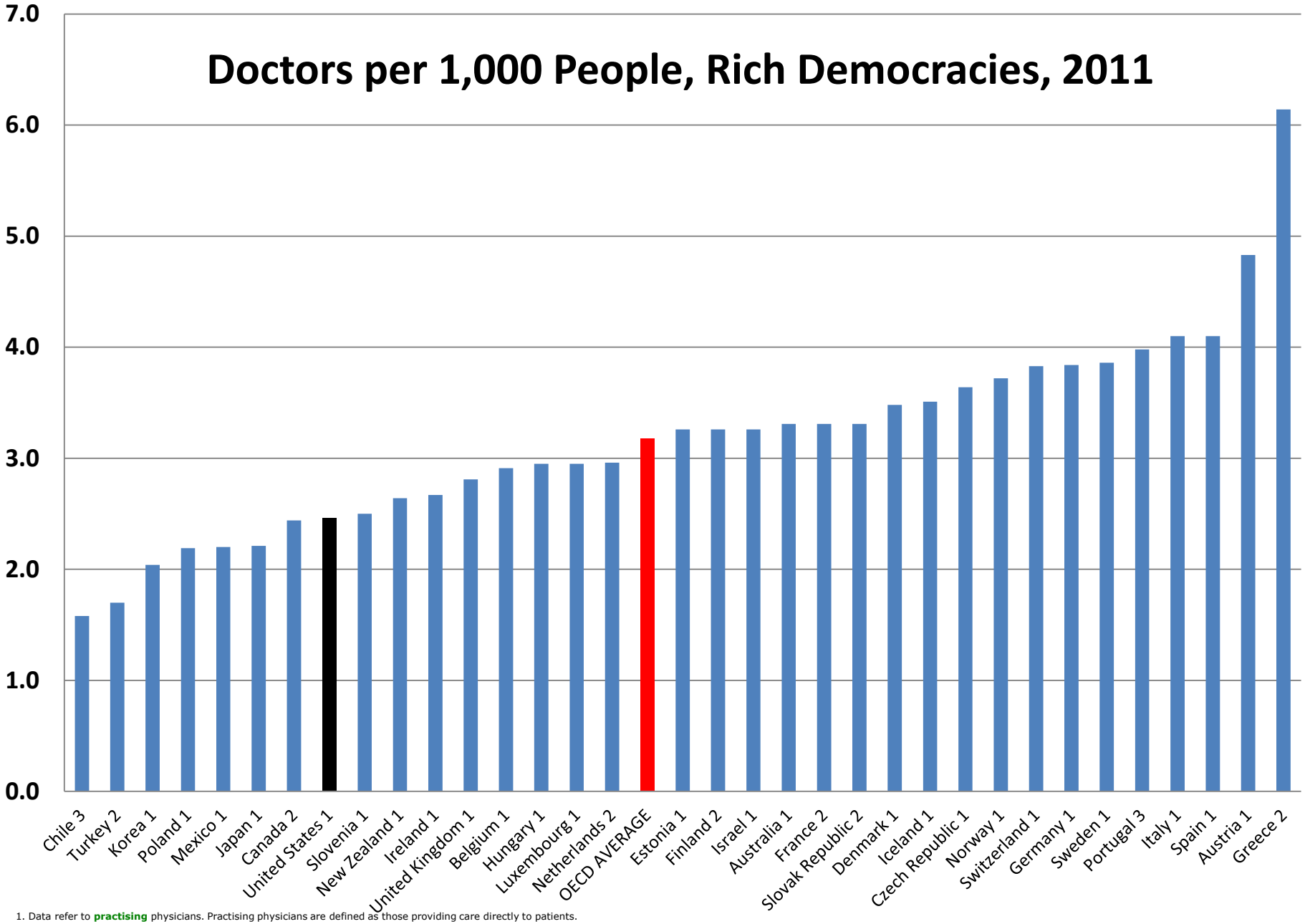


★**Closed 2003 - 2010**

ER and Non-ER OPD Visits/1,000 People, 1975 - 2011



B. Doctor supply and need



1. Data refer to **practising** physicians. Practising physicians are defined as those providing care directly to patients.
2. Data refer to **professionally active** physicians. They include practising physicians plus other physicians working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).
3. Data refer to all physicians who are **licensed to practice**.

Source: http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm

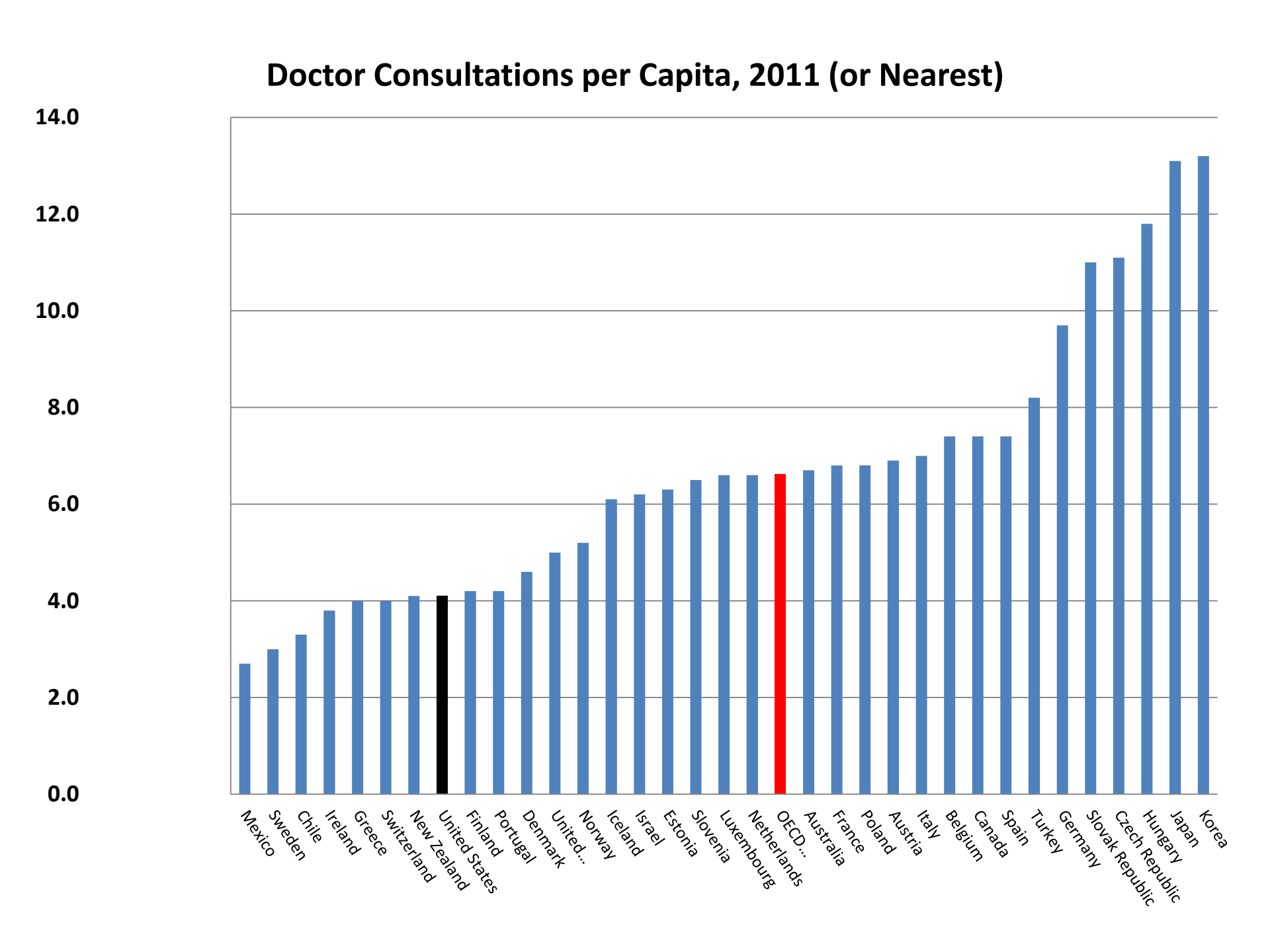
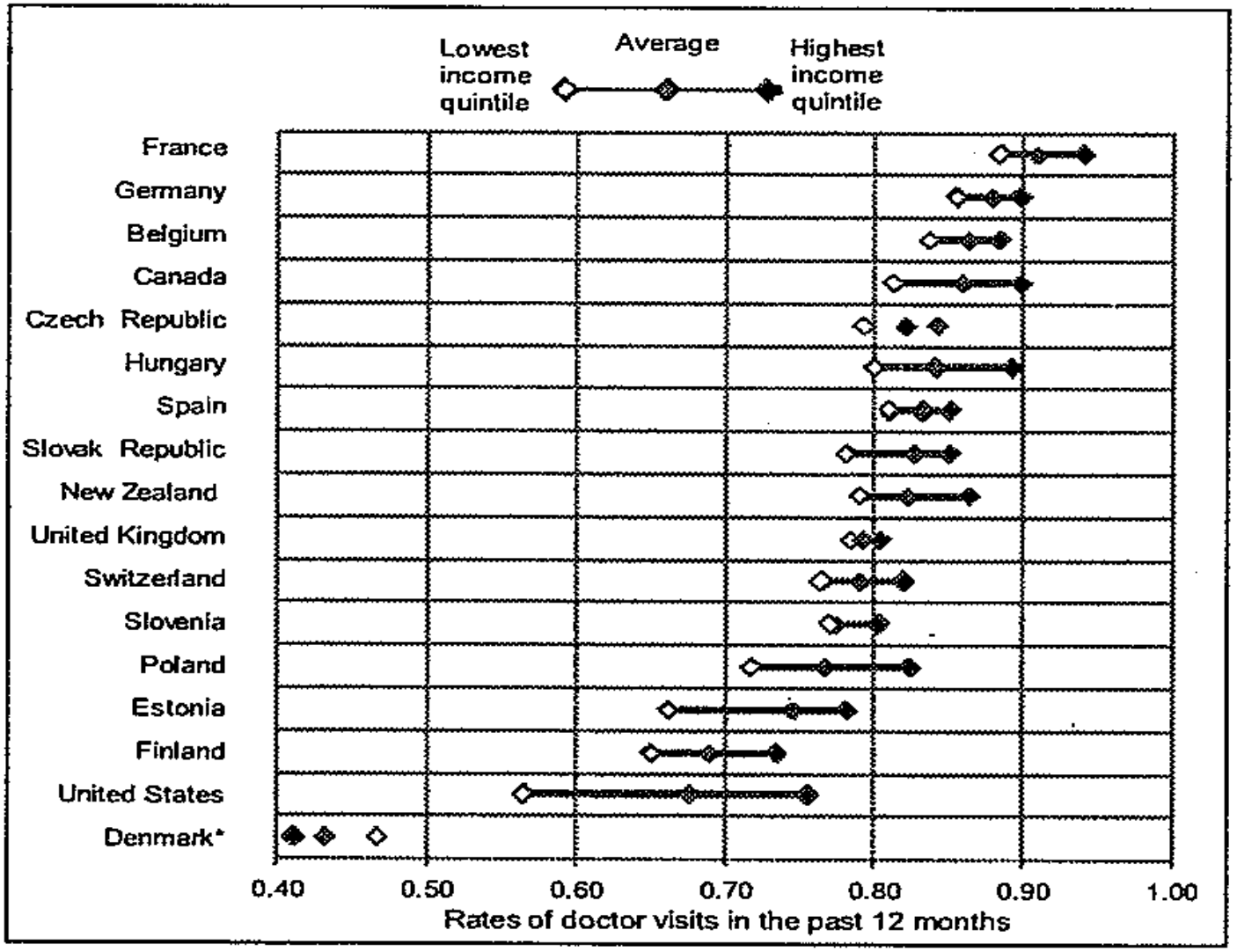

Doctor Consultations per Capita, 2011 (or Nearest)
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Mexico
Sweden
Chile
Ireland
Greece
Switzerland
New Zealand
United States
Finland
Portugal
Denmark
United...
Norway
Iceland
Israel
Estonia
Slovenia
Luxembourg
Netherlands
OECD...
Australia
France
Poland
Austria
Italy
Belgium
Canada
Spain
Turkey
Germany
Slovak Republic
Czech Republic
Hungary
Japan
Korea

Figure: Needs-adjusted Probability of a Doctor Visit in Last 12 Months, by Income Quartile, 2009 (or latest year)



Note: Denmark reports three months of data only.

Source: Marion Devaux and Michael de Looper, *Income-related Inequalities in Health Services Utilisation in 19 OECD Countries, 2008-2009,* OECD Working Papers, No. 58, 2012, p. 17.

How many doctors do we have?

One view

Table 101. Doctors of medicine, by place of medical education and activity: United States and outlying U.S. areas, selected years 1975–2010

[Data are based on reporting by physicians]

Place of medical education and activity	1975	1985	1995	2000	2005	2007	2008	2009	2010
	Number of doctors of medicine								
Total doctors of medicine	393,742	552,716	720,325	813,770	902,053	941,304	954,224	972,376	985,375
Active doctors of medicine[1]	340,280	497,140	625,443	692,368	762,438	776,554	784,199	792,805	794,862
Place of medical education:									
U.S. medical graduates	---	392,007	481,137	527,931	571,798	580,336	586,421	591,835	595,908
International medical graduates[2]	---	105,133	144,306	164,437	190,640	196,218	197,778	200,970	198,954
Activity:									
Patient care[3,4]	287,837	431,527	564,074	631,481	718,473	732,234	740,867	749,566	752,572
Office-based practice	213,334	329,041	427,275	490,398	563,225	562,897	556,818	560,381	565,024
General and family practice	46,347	53,862	59,932	67,534	74,999	75,952	75,443	76,514	77,098
Cardiovascular diseases	5,046	9,054	13,739	16,300	17,519	17,504	17,352	17,443	17,454
Dermatology	3,442	5,325	6,859	7,969	8,795	9,038	9,066	9,192	9,272
Gastroenterology	1,696	4,135	7,300	8,515	9,742	10,042	10,119	10,293	10,466
Internal medicine	26,188	52,712	72,612	88,699	107,028	108,552	107,943	109,305	110,612
Pediatrics	12,687	22,392	33,890	42,215	51,854	52,095	51,719	52,420	53,054
Pulmonary diseases	1,166	3,035	4,964	6,095	7,321	7,490	7,535	7,677	7,846
General surgery	19,710	24,708	24,086	24,475	26,079	25,434	24,640	24,536	24,327
Obstetrics and gynecology	15,613	23,525	29,111	31,726	34,659	34,405	33,968	34,092	34,083
Ophthalmology	8,795	12,212	14,596	15,598	16,580	15,852	15,656	15,731	15,723
Orthopedic surgery	8,148	13,033	17,136	17,367	19,115	19,299	19,110	19,205	19,325
Otolaryngology	4,297	5,751	7,139	7,581	8,206	8,177	8,034	8,025	7,964
Plastic surgery	1,706	3,299	4,612	5,308	6,011	6,100	6,093	6,110	6,180
Urological surgery	5,025	7,081	7,991	8,460	8,955	8,796	8,656	8,678	8,606
Anesthesiology	8,970	15,285	23,770	27,624	31,887	31,617	31,389	31,294	31,819
Diagnostic radiology	1,978	7,735	12,751	14,622	17,618	17,327	17,197	17,100	17,503
Emergency medicine	---	---	11,700	14,541	20,173	20,036	19,965	19,978	20,654
Neurology	1,862	4,691	7,623	8,559	10,400	10,476	10,386	10,433	10,547
Pathology, anatomical/clinical	4,195	6,877	9,031	10,267	11,747	11,191	10,738	10,554	10,688
Psychiatry	12,173	18,521	23,334	24,955	27,638	27,492	26,521	26,235	25,690
Radiology	6,970	7,355	5,994	6,674	7,049	6,913	6,809	6,837	7,032
Other specialty	15,320	28,453	29,005	35,314	39,850	39,111	38,479	38,729	39,081
Hospital-based practice	74,503	102,486	136,799	141,033	155,248	169,337	184,049	189,185	187,548
Residents and interns[5]	53,527	72,159	93,650	95,125	95,391	98,688	108,073	109,065	108,142
Full-time hospital staff	20,976	30,327	43,149	45,908	59,857	70,649	75,976	80,120	79,406
Other professional activity[6]	24,252	44,046	40,290	41,556	43,965	44,320	43,332	43,239	42,290
Inactive	21,449	38,646	72,326	75,168	99,823	111,551	119,239	121,704	125,928
Not classified	26,145	13,950	20,579	45,136	39,304	52,740	50,347	57,427	64,153
Unknown address	5,868	2,980	1,977	1,098	488	459	439	440	432

Another view

- 8,940 licensed doctors in Washington, D.C.
- ~ 4,000 practice in city
- ~ 2,800 devote > 20 hours/week to patient care

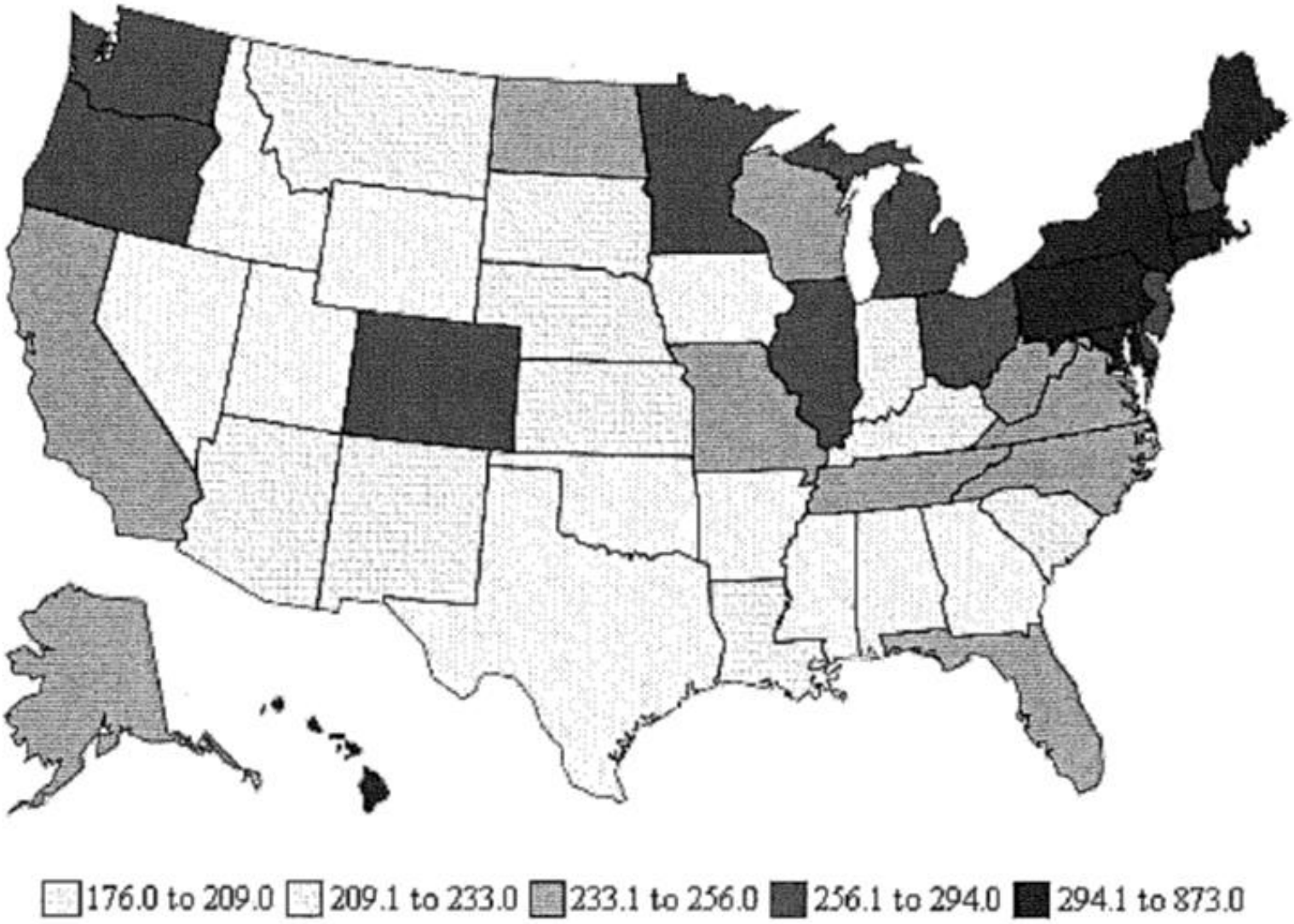
- Maybe we should be measuring number of FTE patient-care physicians
- Hard to get these data!

It isn't surprising that the best available data about doctors are not trustworthy

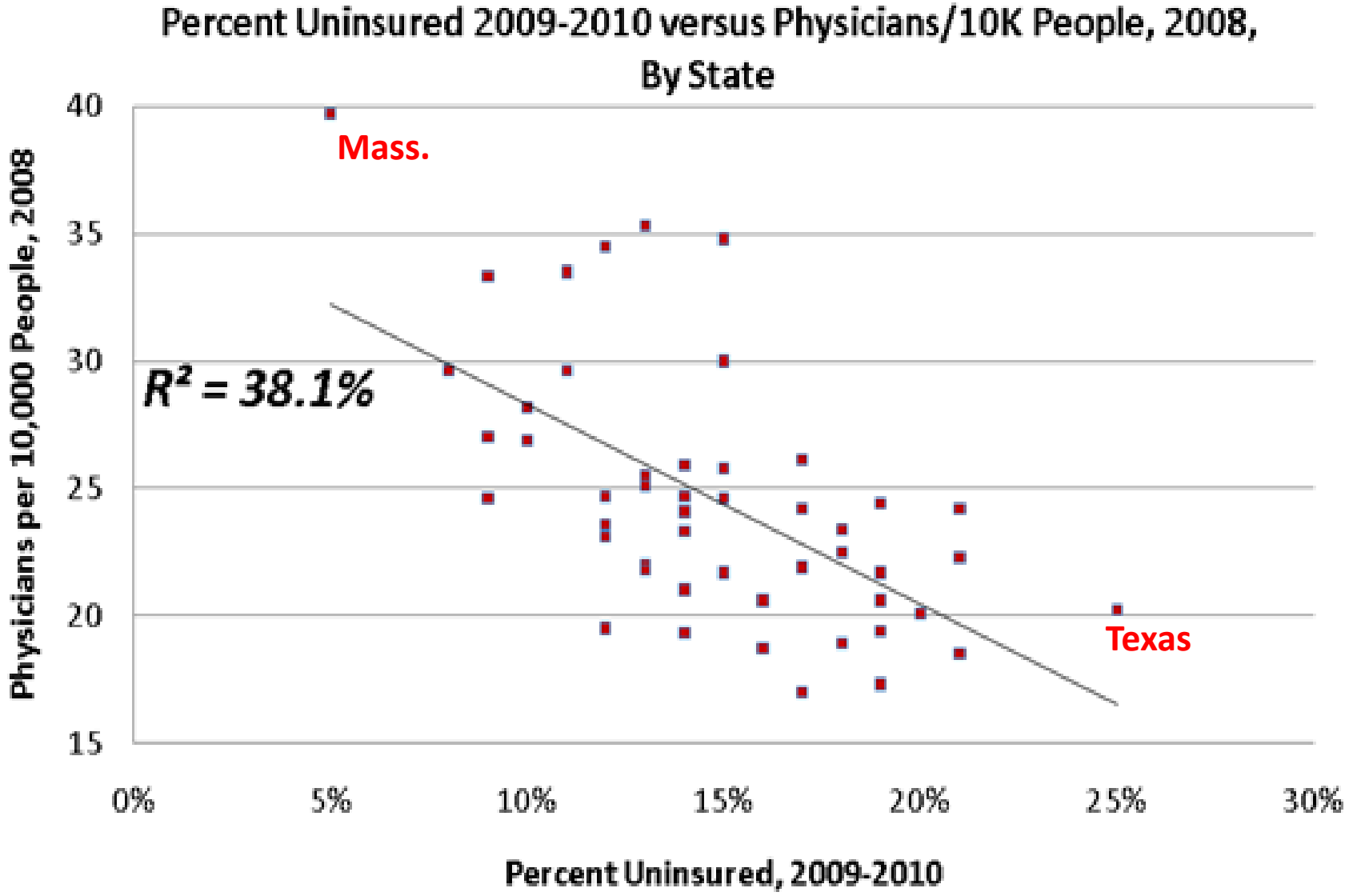
We also don't know

1. How many Americans lack health insurance?
2. How many hospital beds are actually available, set up and staffed?
   – That's the number that generates actual costs

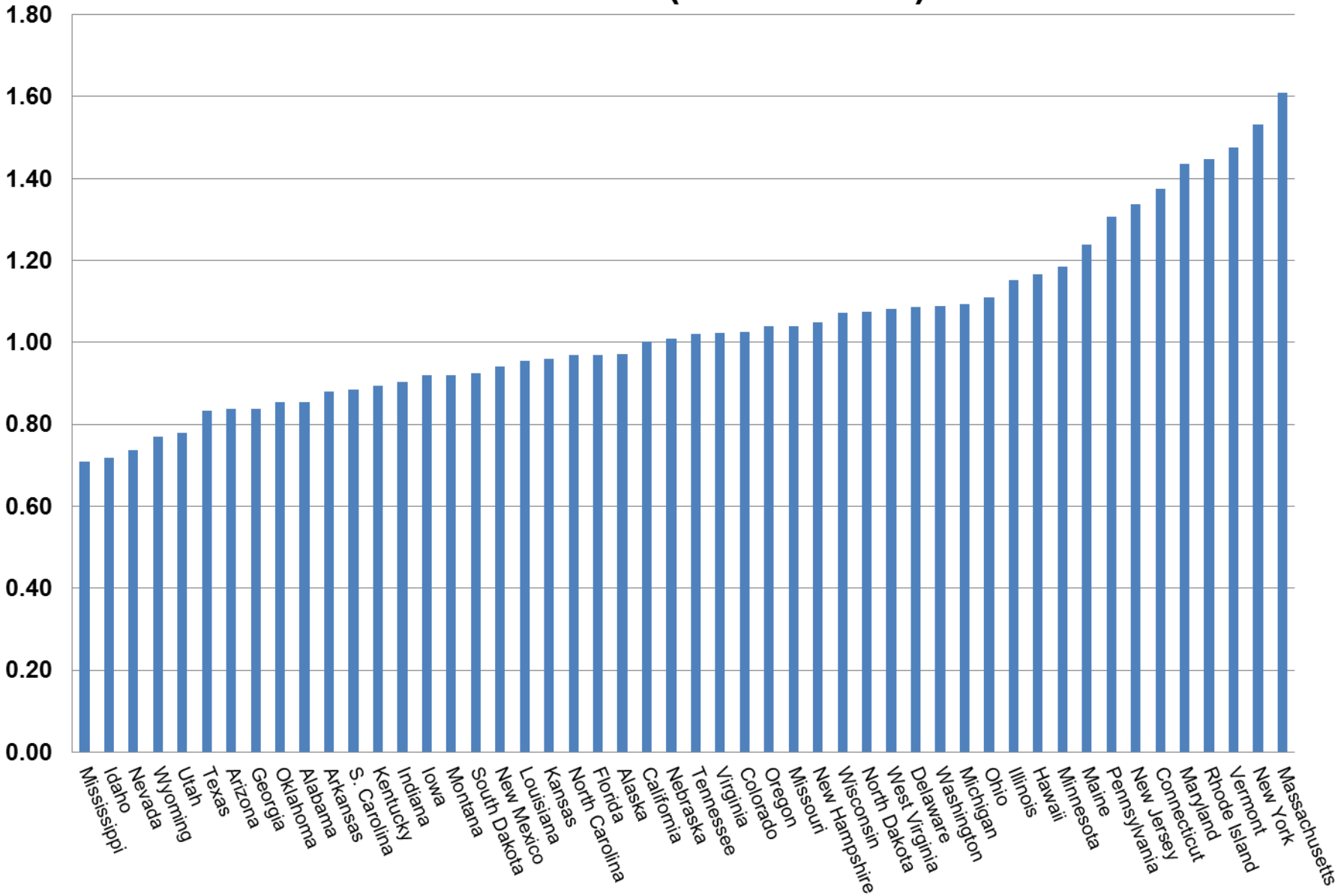
Map 1. Total Active Physicians per 100,000 Population, 2010



Source: American Association of Medical Colleges, *State Physician Workforce Data Book, 2011,* https://www.aamc.org/download/263512/data, p. 4.


Percent Uninsured 2009-2010 versus Physicians/10K People, 2008, By State
Physicians per 10,000 People, 2008
40
35
30
25
20
15
Mass.
$R^2 = 38.1\%$
Texas
0%
5%
10%
15%
20%
25%
30%
Percent Uninsured, 2009-2010

Patient Care PCPs per 1,000 People by State, 2003 – 2005 (M.D. + D.O.)



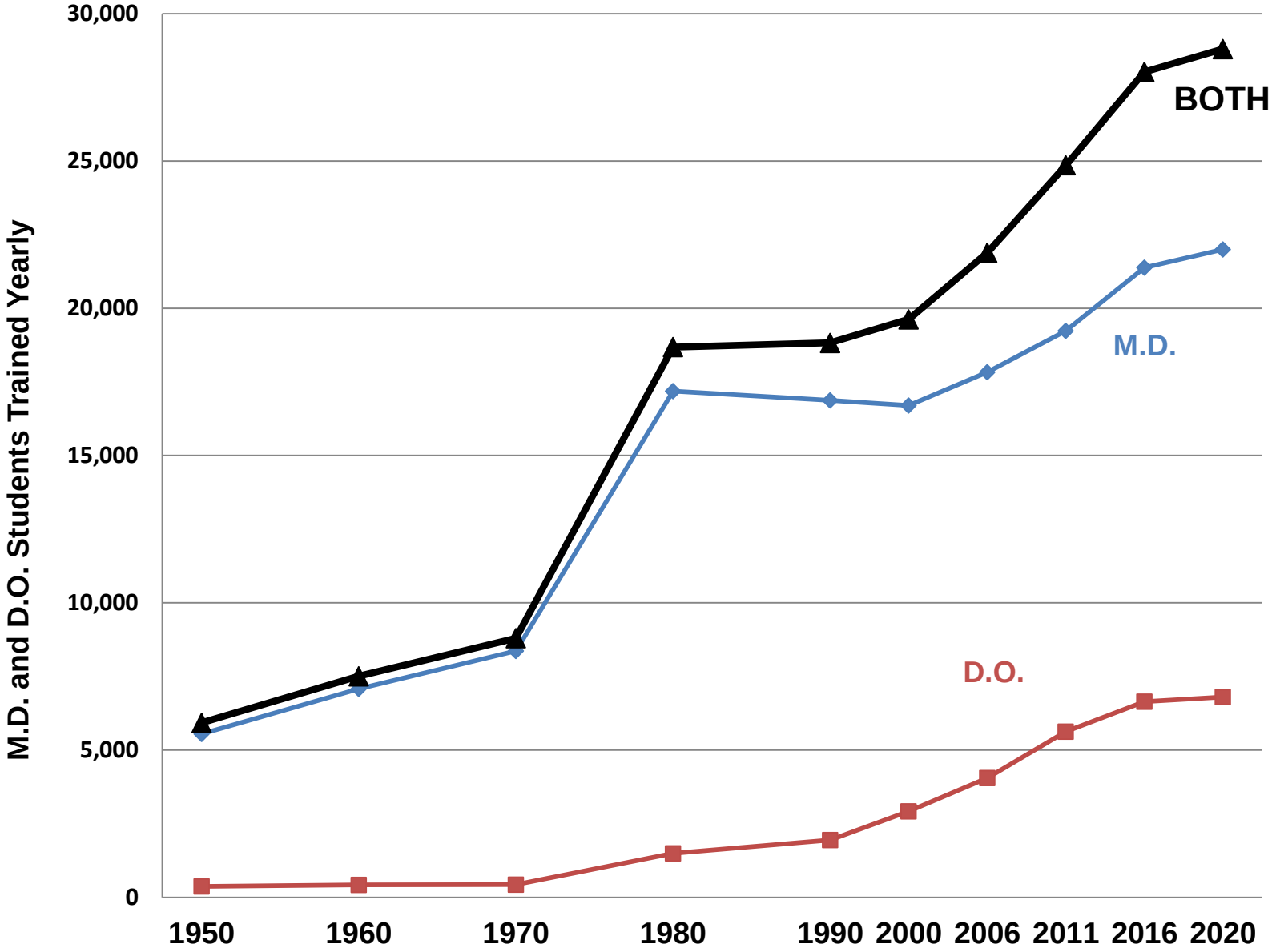
No one is accountable for U.S. physician configuration

- U.S. payers can't unite on anything
  - Legally
  - Politically
- This is unique among world's rich democracies
- Anarchy governs physician configuration
  - No functioning competitive free market
  - No competent government action

Little sustained attention to physician configuration

- How many doctors? what kinds? where?
- Sixty years of too few doctors – too many – too few – too many.
  - We've apparently never had the right number
  - Despair—we're too dumb to get it right
- Imagine that "health care market" will elicit right number of right types of doctors in right places
- Belief that training more U.S. medical school grads will push U.S. doctors into primary care

M.D. and D.O. Students Trained Yearly, 1950 - 2020



Results may surprise

- PCMH and its MD/DO/NP/PA/RN/SW++ teams may reduce even today's low pressure to train PCPs
- At same time, more USMGs, without lots more residencies, could displace IMGs from residencies
  - Hospitals are free to choose which residencies to offer
    - **Prefer specialists – to meet hospitals' patients' care needs**
  - Hospitals may try to convert some unfilled PCP residencies to specialist/procedure-performing
- For that reason, and also because IMGs had been much likelier to fill PCP residencies,
- Result could be fewer PCPs trained yearly
- And **lots more specialists**—needed or not

ANARCHY

= no functioning market + no competent government

a. <u>Free market fantasies</u>

– Failure to satisfy market's 6 requirements in health care

– Some assert that market justifies low PCP incomes

- **But why no movement to market-clearing PCP income?**

"Market-clearing PCP income" = how much need PCPs be paid to attract the number of PCPs we want, where we want them, at the level of competence we seek

b. No competent government action, either

- Weak political pressure to boost PCP supply
  - Formula-driven RBRVS can't generate fair PCP incomes
  - Specialists outnumber PCPs and out-gun them politically
- Cap on Medicare-financed residencies didn't cap residents
- Implementing dozens of ACA provisions + SGR impasse take attention from PCP shortage
- ACA's higher fees for PCPs are good start, but temporary
  - Medicare 10% bonus much too little, $700M/year * 5 years
  - Medicaid offers $11B in 2 years, but very hard + slow to implement → how much have doctors actually received?
- Debt, deficit, hollowed economy, cost of SGR fix, and endemic political fights probably mean few new $s for PCPs

Don’t just stand there

- Without either
  - Functioning market or competent government
  - Political commitments to cover all + cut cost
- Wide reliance on gimmicks
  - EHR “meaningful use”
  - Boost patient out-of-pocket payments, “underinsure”
  - Disease management “don’t call us; we’ll call you”
  - Behave better = “no blame, but it’s your fault”
  - Reverse financial incentives, “reward value, not volume”

C. Why is primary care — like the weather? —like climate change?

U.S. – OECD PCPs/1,000 People

	U.S.	OECD – 30-nation median
Practicing physicians/ 1,000 people	2.4	3.3
Share in primary care	1/3	1/2
PCPs / 1,000 people	**0.8**	**1.6**

Source: OECD, Frequently Requested Health Data, October 2012, http://www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm; Health United States, 2011; and various estimates of PCP share in other nations.

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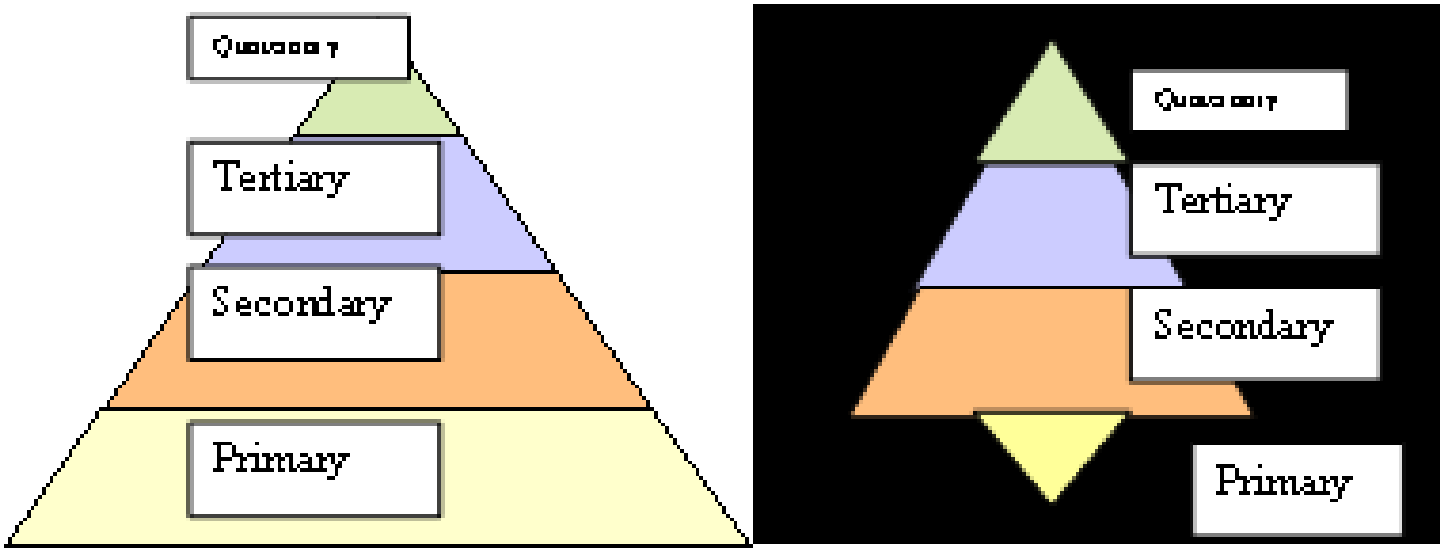
Share in primary care	1/3	1/2
PCPs / 1,000 people	**0.8**	**1.6**
→ Non-PCPs/1,000 people	**1.6**	**1.6**

Source: OECD, Frequently Requested Health Data, October 2012, http://www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm; Health United States, 2011; and various estimates of PCP share in other nations.

The inverted primary care pyramid

Chart X: the traditional health care pyramid, resting on a broad and solid primary care base.

Chart Y: Today's inverted primary care pyramid, in which growing pressure and disruption are imposed on primary care doctors by health care delivery and financing.



U.S. PCPs

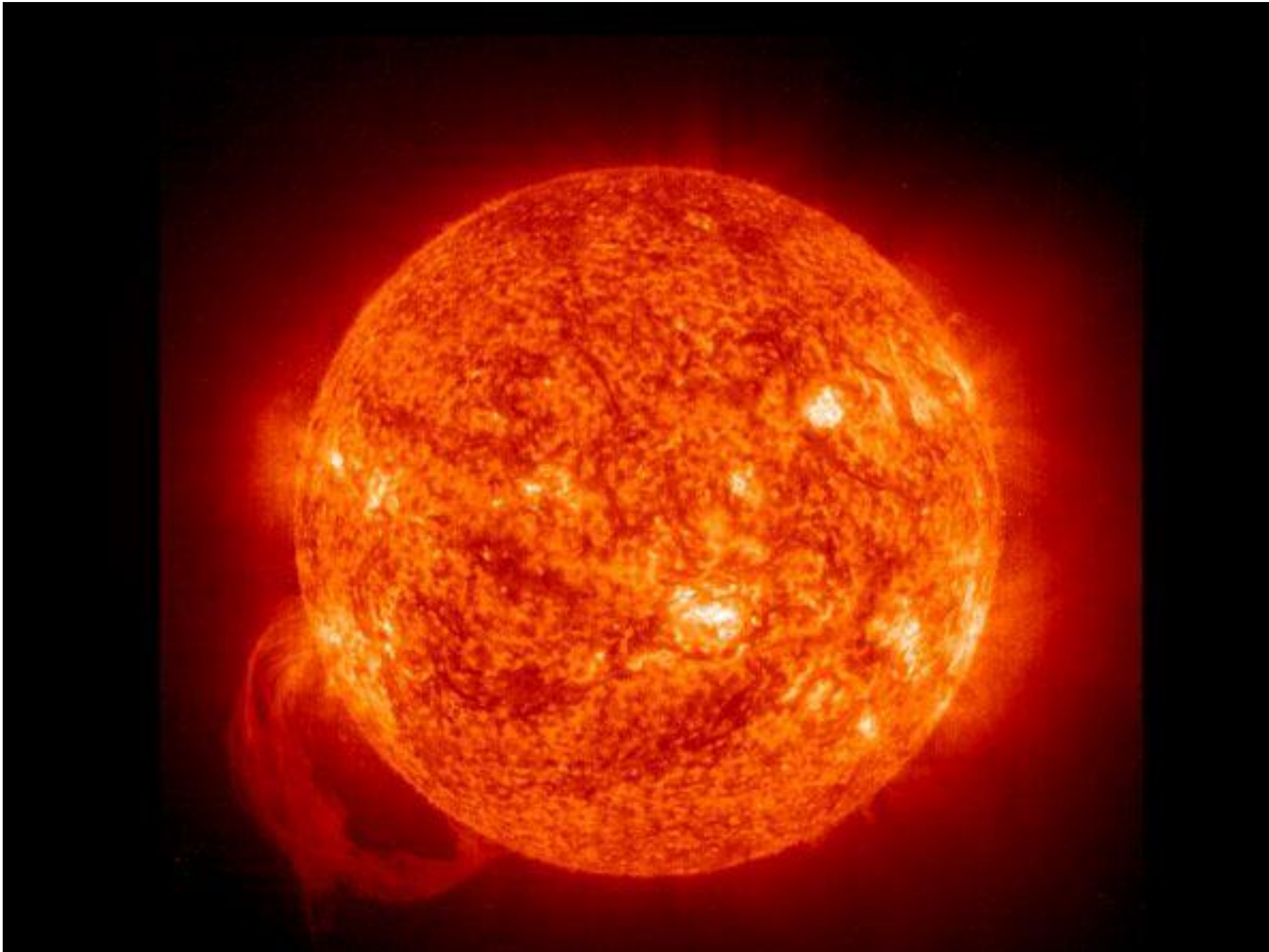
- Is there a shortage (a problem)?
- If so, what are its causes?
- What remedies are possible?
  - Which would be effective?
  - How much would they cost?
  - Which are politically feasible?
  - Would any have dangerous by-products?

Which remedies would be both effective and politically feasible?

Effective?	Politically feasible?	
	Y	N
Y	✓	
N		

Primary care is vital

- Enough PCPs in right places mean better, more accessible, and more equitable care at lower cost
  - The health care we get depends heavily on the caregivers we've got
- Bedrock of trust and competence
  - A personal relationship with a good doctor is even better than a good EHR
- Coordination and continuity
  - Especially for people who are very ill or disabled, who can destabilize very quickly
  - Primary care – the sun whose gravity keeps fragmented medical care from flying off into space



The U.S. PCP shortage is real

- International differences
- Shortage much worse in many states
- Even graver differences within states
  - Rural
  - Urban
  - Racially/ethnically

Possible causes

1. Accumulated debt
2. Primary care is hard
   - Need know breadth and depth
   - Need be comfortable with science and people
   - Few doctors seek to practice in urban and rural under-served areas
3. PCP prestige falling
   - Higher incomes for procedures lure “best” doctors?
   - Medical school faculty guidance
   - Easier to diagnose with better imaging?
   - PCPs rarely in hospital now, as hospitalists take over coordination
4. Income gap
   - Early Blue Shield plans paid doctors’ charges—high for specialists
   - Teaching hospitals created lots of residencies in specialties
   - Payers’ cost controls hit PCPs hardest in past two decades
   - Large panels, low fees, short visits = bad working conditions for PCPs

Nothing tried so far has worked well enough

a. **Pretend** growing PCP shortage isn't a problem
   - There's always the ER
   - Specialists can/do provide primary care
     - Quality of PCP and specialty care may suffer
b. **Expand** CHC capacity + enlarge NHSC + forgive some of some doctors' debts
c. **Try** RBRVS formula to re-balance cognitive/ procedural fees
d. **Ignore** the problem
e. **Suppose** that HMOs (or ACOs) require more gatekeepers → higher pay to more PCPs

Nothing tried so far has worked well enough

f. **Build** PCMH to offset PCP shortage
- NPs or PAs or teams could substitute for many PCP visits
- MD/DO = internal consultant, could make more money

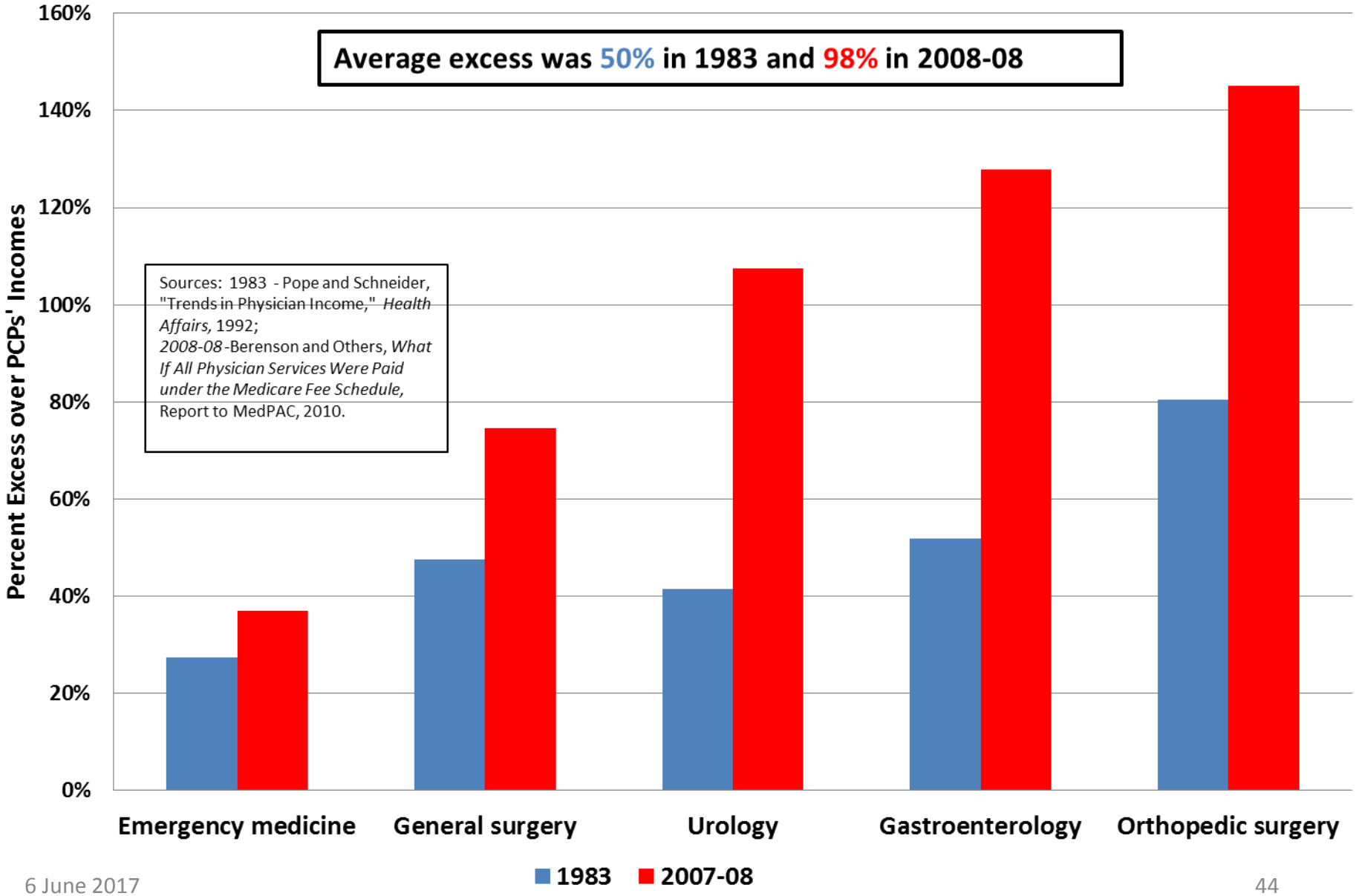
g. **Deride**: Who needs one-class PCP care?
- Walk-in clinics, in pharmacies and elsewhere
- Urgent care centers
- Free-standing ERs

h. **Talk** about it, especially when seeking new medical schools from legislatures
- But focus on overall "doctor shortage"
  - Sustain big, indiscriminate rise in U.S. graduates
- Not on what kinds of doctors are needed

Why haven't easy fixes worked?

a. Income gap
b. Prestige gap
c. Primary care is very hard work
d. Stunted empathy + rampant myths
e. Cumulative erosion of urban community hospital care in many areas (undermines local physicians)
f. Little sustained attention to physician configuration
g. No functioning market + no competent government = **?**
h. Haven't tried what works elsewhere
i. Very weak political commitment to finding solution

Five Specialties' Average Incomes - Percent Excess over PCPs' Incomes, 1983 and 2007-08



Expand CHCs + NHSC, + lower debt

- Better to light a candle than curse the darkness
- Still
  - Income matters much more than debt
  - Suppose average academic debt rises to $250K

    = 365 days' gap in before-tax income between orthopedic surgeon and PCP
  - PCP incomes so low that many PCP residencies unfilled

No debt
(The response to debt)

- Suppose medical school costs

  $50,000/year tuition + $15,000/year living expenses

  = $65K/year * 4 years = $260 K

- * about 25K MDs + DOs yearly = **$6.5 billion/year**

  = 0.21% of health spending ($6.5B/$3,100B)

- But very strategic
- Doctors don't repay their debt (payers do)
  - Doctors just write the checks
- But debt might make them very money-conscious

Hope RBRVS will re-balance fees, incomes

- Some initial success but surgeons, others worked in Congress to cut fee shift in half
  - Now, we fight about the formula instead of incomes
    - About methods instead of aims
  - Hard to win since RBRVS is zero-sum game
  - PCPs outnumbered numerically and politically
- Hospital-based proceduralists use free hospital capital
  - Use hospitals' machines, ORs, nurses to earn incomes, but don't pay for them

Prestige gap

- Medical school faculty – role model shortage
  - "You're too good for primary care"
  - One response: Teaching health center program
- Prestigious teaching hospitals train few PCPs
- Rise of hospitalists means PCPs have less contact with in-hospital physicians
- Diagnosis often believed to rest less on accumulated wisdom, history, physical exam
  - Rely more on better imaging, labs than in decades past

Is primary care hardest job in medicine?

- Need great breadth + depth of medical knowledge
- Need enjoy science + relationship
  - Do medical schools enroll enough students who like both?
- Memory, history, physical exam inform diagnosis and treatment
  - Not just imaging, labs, referrals, EHRs
- Hours of self-limiting illnesses **+** staying alert to grave, acute problems
- Rising panel size, long hours, lots of unpaid paperwork

Denigrate importance of primary care: Stunted empathy + rampant myths

- **"It's not my problem"**
  - **Not one influential American who wants a PCP lacks one, or fears future lack**
- But keep broadcasting prevention rhetoric
  - Prevention fantasies – behave better and live forever
    - "It's your fault you got sick, anyway"
- Rant against "inappropriate and costly ER use"
  - Symptom, not cause
  - Few go to ER if have a better choice
  - Fragmented care costly; Giving it in ER is no costlier

Real remedies

- “If you pay them, they will come”
  - Find and pay market-clearing price
- Improve the job
- Decide the kinds of doctors we want as PCPs and attract them
- Personal care
  - The answer to depersonalization

Cap the gap – 3 standards

Cut annual income gap between PCPs and the 5 specialties examined earlier

- Shrink gap to 50%
  = boost PCP income from $185,000 to $235,000 (27%)
  - Cost $13.8 billion annually, or 0.50% of annual health $s
- Shrink gap to 25%
  = boost PCP income to $282,000 (52%)
  - Cost $27 billion annually, or 1.0% of yearly health $s
- Pay 300K PCPs @ $300K
  - Gross cost = $90B (2.9% of annual health $s)
    - Net cost about $45B
      - About $150 / American yearly

Concierge PCP for all

Panel size = 1,000

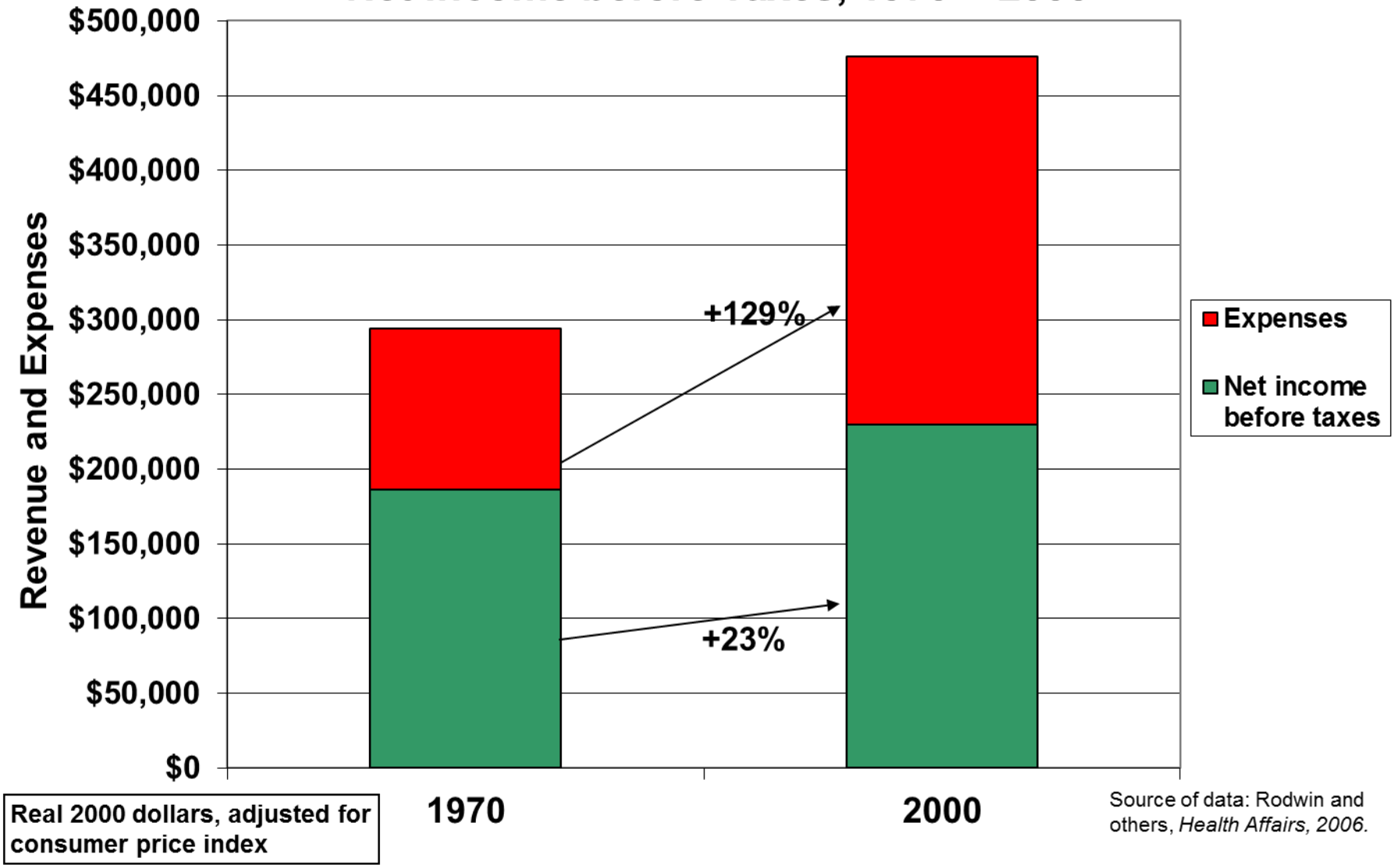
- Pay 300,000 FTE PCPs $300,000 annually
  - Could be old-fashioned alternative to team model
    - Or maybe just bigger role in team for actual PCPs
  - Time for phone calls, e-mails
  - Coordinate!
    - Visit patient in hospital; see patient post-discharge
    - Chronic care case management
  - Health education
- Over time, lure more physicians to primary care
  - Need for many more PCP residency positions
  - Divert many new USMGs from specialties
  - Reconsider med school admissions criteria

Possible sources of more money

- Why not simply cut specialists' incomes?
  - Very hard to take money away – so why try?
  - Lots of specialists have scalpels

- Key $ figure = net income (after expenses) and before taxes
  - ! Big changes in gross and net income, 1970-2000!
  - But how cut expense without simplifying payment?
  - How simplify payment without rebuilding trust?

U.S. Physician Average Gross Income, Expenses, and Net Income before Taxes, 1970 + 2000



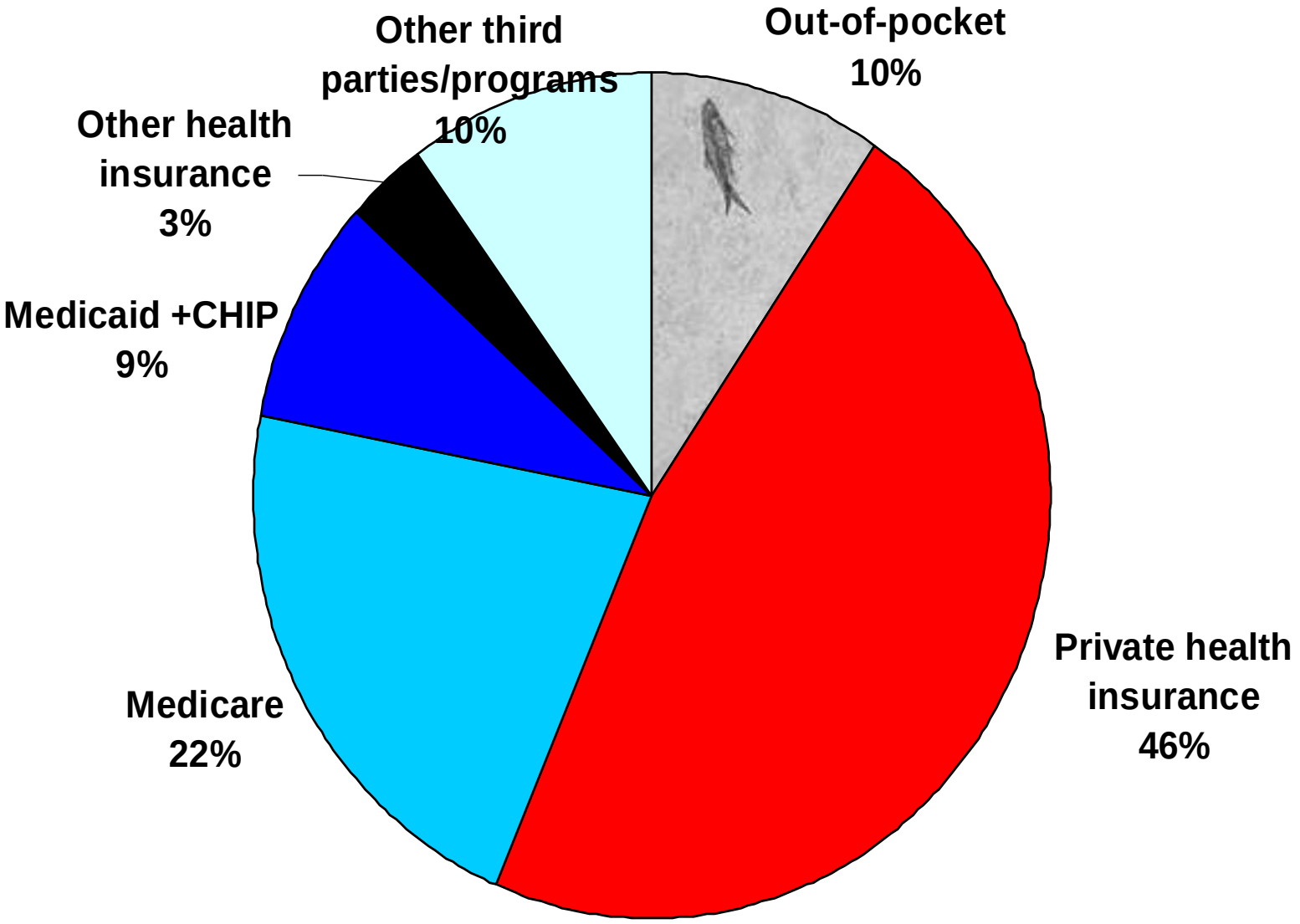
Real 2000 dollars, adjusted for consumer price index

Source of data: Rodwin and others, *Health Affairs, 2006.*

Where find money to boost PCP $ pay?

1. Imitate free market
   - All payers must pay same price for same care
   - Raise Medicaid PCP rates up to Medicare level permanently
     - Hard sell unless almost all federal $s
     - Good investment
2. Regulation: All states adopt Rhode Island health insurance commissioner's requirement
   - Private insurers direct 10% of premium revenue to PCPs
3. Sell idea that primary care ***really*** does save $
4. PCPs charge patients $150/year fee to join practice
   - * 1,000 patients = $150K/year
     = $12.50/patient/month

Sources of Revenue to Finance Physician and Clinical Spending, 2009



Channel more physicians into PC

Use residency limits + surge in U.S. medical graduates to direct greater share of doctors into primary care?

- Medicare-paid residencies capped
  - Leverage is available
    - But does anyone want to exert it?
- Will Congress try to use this leverage to induce teaching hospitals to train more PCPs?
  - If so, will teaching hospitals manipulate "PCP training" to train specialists?
- Is it worthwhile to try to train more PCP residents without narrowing PCP-specialist income gap?
  - **Many will escape to cardiology fellowships**

Weak political commitment

- Many mechanisms could be used to boost PCP incomes, supply, location where needed
- But so what?—If the political commitment to adequate PCP supply and pay is weak
- Is this inevitable?

Where do other nations find that commitment?

- When all are insured, people seek care
  - So PCPs must be available to assure access
    - And all payers pay same prices → access equity
- Long-standing caps on number of salaried hospital-based specialists and residents
  - Usually paid from hospital's capped budget
  - Remaining medical graduates will be PCPs
- Health spending capped
  - Recognition that PCPs help contain cost

How we might find that commitment?

1. PCP shortage could hit some influential people
2. ACA covers lots more people
   - Previously covered people face longer waiting times
   - And newly-covered stymied by narrow networks and high OOPs
3. If today's cost control bubbles pop loudly
   - Big out-of-pocket costs bankrupt humans
   - ACOs could go the way of HMOs
4. Lots of older people with complex needs require actual care
5. If value of good PCPs shines through
   - Coordination and continuity
   - Cost control, appropriate care
6. Craving for durable personal relation with PCP caregiver?
   - Especially if teams find it hard, costly to coordinate
   - And if EHRs remain frustrating

Will enough of today's PCPs be willing to accept PCMH's responsibilities?

1. Patient has long-term partnership with clinicians
   - Promote shared decision-making
2. Physicians and non-physicians work as team
3. Coordinate services, backed by EHR
   - Especially for chronic or preventable problems
   - Specialists' and primary care, including behavioral health
   - Community supports
4. Consider behavioral and social factors
5. Expanded hours, with on-line communication

NCQA, PCMH Fact Sheet, http://www.ncqa.org/Portals/0/Public%20Policy/2013%20PDFS/pcmh%202011%20fact%20sheet.pdf

Given primary care's value

- Why haven't we done more?
- Will we do more in the years and decades ahead?