Primary Care and Health Care Reform: The Next 100 Days

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A clear consensus has emerged among Washington policymakers and the American public that the health care system is in urgent need of reform. The heavy emphasis on health care during the presidential campaign increases the probability that significant changes will occur during this administration. While no clear mandate for a specific proposal has gained ascendancy, all solutions reflect a common awareness of the challenge to increase the equity and value that Americans obtain for their considerable health expenditures.

It is important to note that no executive or legislative proposals for reform have addressed primary care with any specificity. Implicit in any significant reform of the health care system, however, is an expansion of primary care activities. When the United States last enacted significant health care reforms (ie, the introduction of Medicare and Medicaid), the expanded need for primary care services was accompanied by the establishment and expansion of training programs for nurse practitioners and physician assistants, the establishment of a family practice specialty, and the rediscovery of general internal medicine and pediatrics.[1] The experience of developed nations that guarantee universal access for a substantially lower per capita cost than the United States argues strongly that an emphasis on primary care will be a prerequisite to affordable health care. To this end, there is growing recognition of the relevance of physician specialty distribution to efforts to contain costs and increase access.[2]

Implications for Primary Care Practice

Virtually all health care reform legislation introduced in the last Congress addressed the financing of health care and offered few specifics on the delivery of health care services. The long-awaited changes in physician reimbursement promised by implementation of the resource-based relative value scale (RBRVS) have not been as favorable to primary care physicians as initially promised. The restructuring of physician reimbursement by specialty and, moreover, by service delivered is likely to be an incremental process with multiple modifications and revisions before a payment system that addresses historical inequities is adopted.[3] Whether other payers are likely to follow the lead of the Medicare program in reimbursing physicians according to an RBRVS schedule is less clear at this time.

Organizational changes in the delivery of health care services occupy a central role in the health care reform debate. Most reform proposals call for increased use of managed care plans, in which a primary care provider functions as the entry point to a coordinated system of medical care. Studies showing that primary care physicians use fewer resources[4] and may protect patients from inappropriate specialty services[5] have suggested societal benefits that might accrue from a health care system that uses primary care providers as "gatekeepers." It remains to be seen whether this will enhance or diminish the prestige of primary care providers.

In some countries, most notably England, the role of the primary care physician as a gatekeeper has led to a correspondingly larger role in resource allocation and decision making. An increased emphasis on managed care could result in a larger constituency demanding an increased emphasis on resources for primary care training. On the other hand, many physicians may find the prospect of increased "management" (eg, justifying straightforward clinical services to insurance clerks) far from reassuring.

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An increased emphasis on clinical prevention is suggested by the explicit inclusion in many legislative proposals of financing for preventive services. In addition, certain proposals waive copayments and deductibles in an effort to enhance the use of these services. There is evidence to suggest that more generous coverage of clinical preventive services will result in increased utilization.[6,7] Depending on how RBRVS and other payment mechanisms weight cognitive work relative to procedures, primary care providers may find additional economic incentives to provide these services personally, or with the assistance of midlevel practitioners.

Clinical preventive services, as well as an array of traditional medical services, will be under increased pressure to demonstrate improvements in patient outcome associated with their use. Though in its infancy, profiling of ambulatory care practices and providers by outcomes of care achieved may well become a benchmark of accountability and a measure of quality in any reform of the current health care system.

Implications for Primary Care Education

Of significant concern to policymakers, given the expanded role for primary care providers implied by the above discussion, is the eroding provider base. Interest in primary care careers has been steadily diminishing over the past two decades and is evidenced by the low entry of new physicians into primary care postgraduate training. Influential factors include the lower income of primary care physicians relative to other specialties, the increased debt burden of students, the hospital-based nature of current clinical training, a perceived lack of prestige—particularly in academic medical centers—and a lack of role models during medical school.[8] Only two health care reform bills introduced in the last Congress include incentives to hospitals as part of a prospective global operating budget for training primary care residents. No bills as yet address incentives for medical schools or Medicare funding of graduate medical education.

Public policies of the Department of Health Human Services (DHHS) toward health care professional training have heretofore been somewhat inconsistent. There are signs, however, that this may be changing. The largest proportion of federal dollars supporting medical education comes from the Medicare payments for direct and indirect medical education costs. Although these funds are not explicitly directed toward any specialty, the mechanism of funding provides incentives to teaching hospitals to have residencies in specialties other than primary care, particularly those who provide services that receive the highest reimbursement.

Recently, discussants within the Bureau of Health Professions (Public Health Service) and the Health Care Financing Administration have begun to consider the possibility of proposed changes to increase Medicare funding for primary care residency training and extend Medicare indirect graduate medical funds to residency programs in ambulatory facilities. As of July 1, 1993, the Health Professional Student Loan Program will be targeted to medical students willing to commit to a primary care specialty. Failure to remain in primary care practice will result in severe penalties for the individual and a reduced pool of loan funds for the medical school. The recommendation by the Council on Graduate Medical Education and other influential groups that primary care physicians comprise 50% of all physicians, coupled with the emerging agreement within DHHS, is a promising indication that these proposals will eventually be realized.

Implications for Primary Care Research

Federal interest in outcomes research as well as in the development of clinical practice guidelines continues to remain strong. Some proposals specifically require the establishment of national and state health boards that would, among other activities, collect data to assess the effectiveness of medical interventions. The effects of any health care reform package on expanding access and containing overall costs will provide fertile territory for primary care and health care services researchers alike.

There is also considerable interest in research examining the relationship of primary care to the overall cost and quality of health care services. For example, Weissman et al[9] recently demonstrated that hospital admission rates for patients with pre-defined "avoidable hospital conditions," ie, conditions that "can be avoided if ambulatory care is provided in a timely and effective manner," such as asthma and congestive heart failure, are significantly higher among uninsured and Medicaid patients than among the privately insured. These results challenge researchers to determine which components of ambulatory care are most important in reducing avoidable hospital admissions, and to develop interventions that evaluate the efficacy of different models of primary care delivery.

Finally, the role of nonphysician providers (nurse practitioners, physician's assistants, clinical nurse specialists, etc) is an issue of great interest to policymakers. What are primary care services, who currently provides them, how can they best be provided, and through what mix of providers?—these are policy-relevant research

questions that will inevitably accompany any improvement in the reimbursement and prestige of primary care that follow health care reforms.

Conclusions

While it may not be immediately apparent that primary care is a central focus of the health care reform debate, any and all health care reform in the United States is inextricably linked with an expansion of primary care services. This will present enormous opportunities to primary care providers and teachers. In the short term, policies to contain costs and expand coverage will occupy the immediate agenda. In the long term, advocates for primary care will be challenged to demonstrate that primary care can deliver effective, high-quality care at reasonable cost to the broadest segment of the population. It is incumbent on the primary care community to carefully monitor the health care legislation developed in the 103rd Congress, and to prepare coherent responses to the many areas of health care reform that will have major impact on family practice. What occurs in the near future will have lasting and significant influence on the practice, education, and research aspects of primary care.

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