Point of View

A Time for Real "Change" In Primary Care

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The election of a new President brings with it an expectation of verdant approaches to many societal issues including health care. For "Change" to be more than a political sound bite, the new administration will need vision and courage to provide a better health care system for this country. Part of that vision will need to be a vibrant primary care workforce.

The United States has one of the most advanced systems for clean water and toxic waste disposal, food and medication quality and safety requirements, availability of vaccines and advanced medical/surgical expertise and technology in the world. Yet this country also ranks among the lowest for developed countries in primary care functions (prevention of infant mortality, obesity, vaccination rates, chronic disease management and others), lowest in health care outcomes and highest in cost.[1]

Paradoxically, our system of medical education attracts some of the best and brightest to medicine, educates them well in its medical schools and provides unparalleled training in its post graduate programs. Our research institutions, private industry and universities have given us exciting new therapies and technologies.

Despite these advances, we still have forty-five million people without health insurance, a crumbling access and supply of primary care and a system we cannot afford. Health insurance premiums increased 114% between 1999 and 2007, while workers' earnings increased by 27%. Health care spending in the United States is 16% of the Gross Domestic Product and increasing yearly - 6% higher than any other developed country.[2]

The path to high quality and affordable health care can only be forged with a vibrant primary care workforce. Countries with strong primary care have higher quality with lower costs to society (New Zealand, Australia, Great Britain, Canada, Sweden, Germany, Japan and others).[2] National studies demonstrate decreased death from cancer, heart disease and stroke in states with higher ratios of primary care physicians to population. One example of the power in preventive/primary care is the reduced rate of hospitalization (avoidance of 5 million admissions to hospitals in a year) with a cost savings of 26.5 billion dollars per year.[10]

Various factors have contributed to the dearth of primary care.

The Problem

A widening gap between supply and demand for primary care:

As the population ages, statisticians project a 20-27% (35,000-44,000 physicians) shortfall in primary care within the next fifteen years—a deficit exacerbated by an uneven geographic distribution.

Census estimates are that the US population will grow to 349 million by 2025 and the population above age 65 years will increase by 73%. Primary care physicians provide 52% percent of all office visits. This segment of the population also uses a majority of health care services resulting in a 29 percent increase in workload for adult care.[3]

The decline in interest in primary care:

The peak in interest in primary care occurred in 1998, when 9,348 residents entered practice. Since then, there has been a decrease to 1995 levels of new primary care physicians. During this period the US population has grown by 12%.

Today's status is the end result of a process which began with the priorities of medical schools and students entering the profession. In the 1980s and 90s there was an appreciable shift by medical schools to support primary care and recruit interested student. The result was a short-lived increase in students entering these residency programs. Since 1998 there has been a steady decrease in interest, with only 2% of medical students now thinking about a career in general internal medicine.[15] Some of the decline is attributable to an increasing desire for sub-specialization with 62% of general internal medicine graduates entering specialties.[4,5,6]

The culture of physician training and preferences

The cultural training ground for future physicians, a priori, does not foster an interest in primary care. The clinical curriculum is primarily tertiary care-centered for third and fourth year medical students. This environment is also the setting for post graduate education. Though this institutional structure has been in place for close to 100 years, the allure of the subspecialties has developed over the past twenty five years. Many of the mentors during training are sub-specialists, the cases are often complex and require sub-specialty care with procedural and surgical solutions to medical problems that seem on the surface to lend more professional satisfaction.

Further, studies have shown a trend in medical students of prioritizing a balance between work, leisure time and a controllable lifestyle. Primary care is viewed as less able to satisfy these preferences.[7]

Income disparities

Income disparities and levels of educational debt are partially responsible for the decline in primary care. Numerous studies demonstrate a two-to-threefold difference in compensation between primary care and any procedural medical subspecialty or non-internal medicine-based specialty. Further, the income gap is widening. In the past decade there has been a 20% change in net income in primary care and a 30 to 75% increase in net income in non primary care medicine.[8,9]

The Solution

Recognition by the general public, legislators and policy makers of the value of a strong primary care workforce. Primary care can be a powerful driver for controlling costs and maintaining a high quality health care system through the following measures: