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How to Save Primary Care

By Ken Terry
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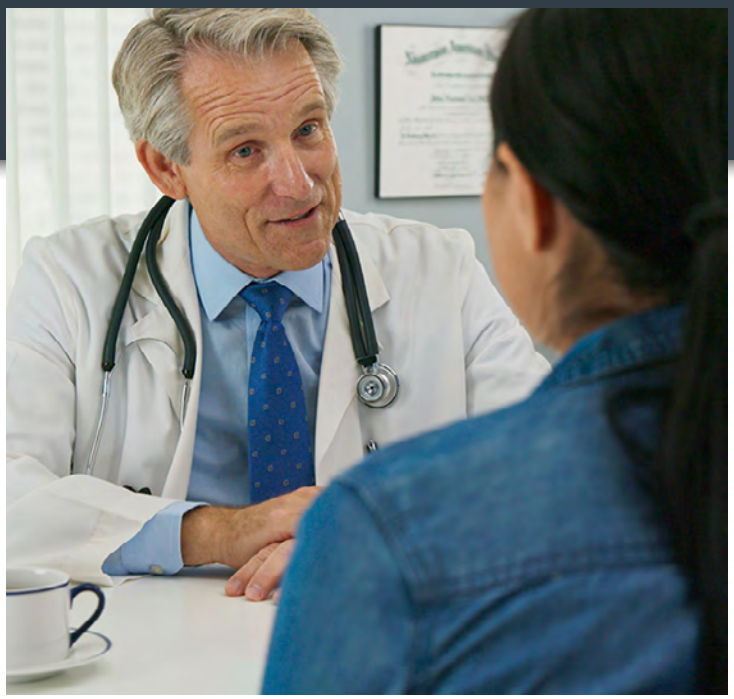


Primary care is declining rapidly, threatening the stability of our healthcare system. Even though less than 5% of health spending goes to primary care, [1] the rest of the system could not function without it. Primary care is also our hope for the future. If we want to build a new system that is universal, comprehensive, high-quality and affordable, we must take better care of primary care physicians.

According to a 2024 opinion piece in the Journal of the American Medical Association (JAMA), "Primary care plays a foundational role in an efficient, high-quality health system. It is the only element of the healthcare delivery system in which an increased supply is associated with better population health and a reduction in inequitable outcomes. Studies find that continuity in primary care reduces mortality, healthcare expenditures and hospitalizations." [2]

Yet, nearly a third of the U.S. population lacks access to primary care. [3] Despite the increasing number of nonphysician clinicians, it will become ever harder for patients to find a primary care physician (PCP) as more family doctors, general internists and pediatricians retire and as fewer trainees go into the field. Population health will suffer, and cost growth will accelerate. As a result, patients will have worse access to poorer care at a higher cost.

Many reasons have been cited for the woes of primary care, including relatively modest incomes and the low prestige of the field compared to other specialties. But we should also look at the rapid shift of physicians from private practice to employment over the past decade — the same time period in which PCPs' portion of the workforce began to drop significantly. Specialists also left private practice during this period; in fact, 82% of all practicing doctors are now employed, [4] mostly by health systems and corporations. But primary care physicians are especially low in the pecking order and are treated accordingly. In part, that's because employed PCPs are valued more for generating referrals to specialists and facilities than for their own revenues or patient relationships. [5]

If primary care physicians could somehow be freed from this corporate stranglehold — and the deadening assembly-line work

and lack of autonomy that go with it — they could reverse the decline of primary care, raise their incomes and create a healthcare system that works for everyone, including the big players. Medicare for All wouldn't do this, even if it were politically feasible, but putting PCPs in charge of basic care and letting insurers cover the rest could accomplish this goal, as I'll explain later.

Why should PCPs run basic care, including primary care and the lower levels of specialty care? Because they're the clinicians best suited to providing preventive, chronic and minor acute care, and their decisions have a big impact on downstream health and cost outcomes. In addition, giving PCPs financial and clinical responsibility for basic care would restore luster and viability to the field. Both PCPs' incomes and their prestige would benefit if they were the accountable quarterbacks of healthcare.

HEALTHCARE FINANCING AND DELIVERY

To enable this renaissance, the healthcare system would have to be restructured. I believe this is feasible and that the major players would accept it if it would prevent healthcare from collapsing. But this plan could succeed only if it were designed to rescue primary care.

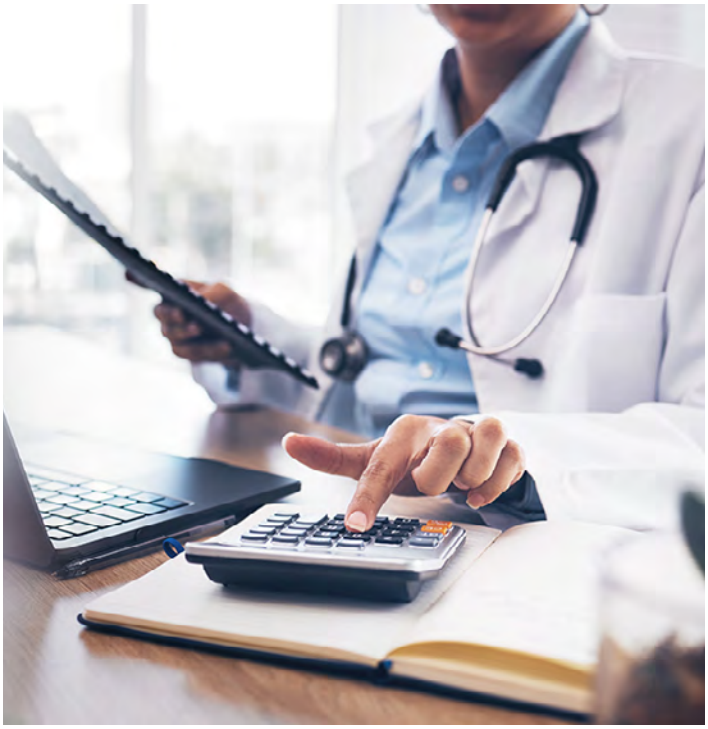
Proposals to save primary care break down to those focused on financing, care delivery or a combination of both. In a 2021 report on PCP compensation, the National Academies of Science, Engineering and Medicine (NASEM) discussed several such solutions. [6]

Within the fee-for-service (FFS) model, NASEM noted, money could be shifted from specialists to PCPs by simply revising fee schedules. NASEM recommended that, in setting Medicare's physician fee schedule, the Centers for Medicare and Medicaid Services (CMS) lessen its reliance on the advice of the American Medical Association's Relative Value Update Committee, which is dominated by specialists, and assign greater weights to primary care evaluation and management work. If this happened, NASEM said, private insurers would likely follow suit.

Alternatively, NASEM said, a hybrid model could pay PCPs fee for service for well-defined office visits and give them a care management fee or capitation payment for population health work. The combination of FFS and population-based payments would be greater than their current incomes. This approach was tested in CMS' Comprehensive Primary Care Plus (CPC+) program, which had mixed results. [8]

Another way to increase primary care revenues, NASEM noted, is to have large physician groups or accountable care organizations (ACOs) take financial risk for all or part of care delivery. These arrangements may involve global or full professional risk or may require physicians to assume a smaller amount of risk for all healthcare services. For example, many ACOs in the Medicare Shared Savings Program (MSSP) take a portion of the total risk.

Some large primary care groups have done well in the MSSP, and ACOs led by primary care doctors have out-saved all other kinds of ACOs. But overall, the MSSP ACOs have garnered only modest savings for Medicare. [7] Moreover, the MSSP's two-sided risk approach has an inherent flaw: More efficient ACOs must surpass their historical performance to achieve savings. While CMS has tinkered with this formula, it hasn't really solved the problem. [9]



Nevertheless, these experiments have shown that any successful effort to bolster primary care must involve changes in both healthcare financing and delivery. Primary care physicians need the right incentives and the requisite infrastructure to manage population health well. By keeping people healthy and helping them manage their chronic diseases, primary care groups can stay within their budgets and thrive economically.

How can this type of reform occur when primary care doctors are in such short supply? In a 2022 paper in "The Annals of Family Medicine," Thomas Bodenheimer, M.D., argued that the root causes of primary care's decline include both insufficient reimbursement and overly large patient panels. Unless they work in a properly constituted care team, he said, PCPs cannot manage so many patients effectively. Bodenheimer cited some studies showing that expanded care teams can enable PCPs to see more patients and do a better job for them. [10] Along with telehealth and AI, this would go a long way to making up for the current physician shortage.

BIFURCATED INSURANCE MODEL

To buttress their primary care workforces, several states have either launched initiatives to increase the reimbursement of primary care doctors or have had legislative discussions about it. In Rhode Island, such a program increased the share of commercial insurance spending on primary care, which was 5.7% in 2008, [11] to 12.3% in 2018. [12] The increased amounts spent on primary care were offset by caps on hospital price inflation. [13]

The success of this program masks its limitations. Song, Altman, Crichlow, et al., in a recent JAMA article, point out that "state investments in primary care are often limited to populations whose health insurance is subject to state authority, including state employees, Medicaid enrollees and fully insured commercial lives.

This leaves self-insured commercial lives, Medicare beneficiaries and other populations (often totaling more than half of a state's population) untouched." [14]

The solution of Song et al. is a mechanism they call a "primary care common fund, which pools primary care spending from public and private purchasers and pays practices directly." Under the authors' proposal, insurers would still compete on specialty and other lines of business, but not on prices and benefits for primary care; instead, they would coinvest in primary care as a mutual asset. No new money would be involved, except for the uninsured; the percentage of payers' spending that goes to the common fund would vary with a state's primary care spending target. Payments and benefits would be determined by a state-administered common fund entity, except for benefits established in government programs.

Besides reducing administrative costs and enhancing patients' choice of their primary care clinician, this model would bifurcate health insurance between primary care coverage and insurance for all other types of healthcare. That is a key departure from the current system.

SUBSCRIPTION MODEL

Going a step further, I have developed a model that splits insurance between subscriptions to basic care (as described above) and a new form of "major medical insurance" that covers hospitalization, post-acute care and the more expensive types of outpatient care, such as cancer care and ambulatory surgery. Competing primary care groups of a certain size would set the subscription fees and thus control the financing of all basic care. These basic care groups would have no connection with insurance companies, which would therefore have no influence over how primary care doctors practiced.

Considering that over 80% of physicians are employed today, this idea might seem like pie in the sky. However, it is possible to restructure the current systems by using state corporate practice of medicine (CPOM) laws. Thirty-three states have such laws, [15] and more states could pass CPOM measures.

These laws have not been used to prevent health systems (except in California), insurers or private equity firms from owning practices, but they could be. Under my model, these laws would only bar the employment of primary care doctors, who would be regarded as a common good.

If health systems had to divest their primary care physicians, they'd try to get reimbursed for them; but considering how much money they're losing on these practices and how little they paid for many of them, they'd have a hard time making a legal case. Insurers, private equity firms and other corporations that own primary care practices would have to receive some compensation, but the government might pay them out over a number of years. It would be a worthwhile investment if it could save our healthcare system.

CONCLUSION

With primary care struggling and with fewer people able to afford healthcare every day, a restructuring of healthcare financing and delivery is desperately needed. The core of this revamped system must be primary care, which holds the key to improved population health, waste reduction and a compassionate approach to care.

Based on real-world examples, I believe that my model, coupled with a judicious approach to technology adoption, would slow and eventually reverse health cost growth. It would also attract more doctors to primary care and reduce the desire of many to retire early. Primary care would become more attractive after the liberation of PCPs from corporate overseers and insurance companies. No longer would any entity not engaged in the provision of healthcare be telling PCPs what to do or how much time they could spend with their patients. Their sole mission would be to provide world-class healthcare efficiently.

There is no question that a change of this magnitude would be challenging for most primary care doctors. But many physicians already participate in ACOs and/or have taken risk from Medicare Advantage plans. Given sufficient time and resources and expert advice, primary care doctors can rise to the challenge and lead the way to a new era for healthcare.

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Ken Terry is a healthcare journalist and author who has written several books on healthcare reform and value-based care. His new book, available now, is called "Beyond Medicare For All: Cracking the Code of the Healthcare Affordability Crisis" and includes a foreword by 4sight Health's David W. Johnson.