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health policy in focus

Wither Primary Care?

By Michael J Pentecost, MD

The report from the American College of Physicians (ACP) didn't pull any punches.[1] Primary care is on the verge of collapse. Senior physicians are retiring or leaving the field; medical students are avoiding the discipline like the plague; health care capital is in full retreat; new technology investments are lagging. With demand for primary care services expected to skyrocket, the timing couldn't be worse. As the demographic bulge of baby boomers begins to turn 60, the ranks of Medicare patients will grow from 39 million to 72 million by 2030, then comprising nearly one fifth of the population.[1]

By 2015, the number of Americans with a chronic medical condition will swell from the current 120 million to 150 million.[1] To care for all these patients, the corps of general internists will need to expand from 106,000 in 2000 to 147,000 in 2020. On the supply side, the news is just as troubling. Over a third of American physicians are over 55 years of age and many are expected to retire in the next decade. And just when the pipeline should be increasing, it's drying up with a steep decline in interest in primary care careers among medical students.[2] The student's concerns about the field mirror those of their attendings and senior practitioners … too little respect, too much work, long hours, endless paperwork, administrative hassles … not to mention poor pay.[2] And better compensation is right where the ACP report, *The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care*, aims most of its recommendations.[1]

A couple of the proposals are novel and destined for a studied, if not chilly, reception. A couple are old-fashioned and conventional enough to make Wilbur Mills proud. One of the new initiatives is a mechanism of delivering primary care dubbed the *advanced medical home*. These certified medical practices would provide comprehensive, coordinated, preventive services with advanced technology to assure efficiency, value, quality and patient satisfaction. The other nontraditional proposal is a dramatic expansion of pay-for-performance programs that would reward physicians financially from sources such as Medicare Part A hospital funds. These resources would permit practices to invest in health information technology and data collection tools. Collectively, this money could be used by medical organizations to develop evidence-based standards and strategies to optimize chronic care.

The two more traditional ACP recommendations involve amending a couple of familiar fixtures around Washington, DC—the sustainable growth rate calculations and the resource-based relative value schedule. To better understand these issues, a brief review of Medicare history is in order.

When Medicare began in 1965, physicians were paid on the basis of their usual and customary charges—no fee schedules, no price controls, no volume limits—none of that. Predictably, spending soared at a 13% annual rate and in 1975 President Ford and Congress instituted the first limitations on physician fees, capping any increases to a rate termed the Medicare Economic Index. But with no concurrent restraints on the volume of services, annual spending grew 15% annually from 1975 to 1991, far outpacing other economic indicators.[3]

In 1992, Medicare began its first attempt to control the number and intensity of services with volume performance standards, or VPS. If volume went up, two years later fees went down proportionately. But with over a tenfold variation from year to year (0.6% to 7.5%) VPS proved too erratic and unpredictable.

Enter the Balanced Budget Bill of 1997 and the new magic bullet … the sustainable growth rate (SGR). SGR calculations are a function of three major variables: 1) the percentage change in fees for physician's services, 2) the estimated number of Medicare fee-for-service beneficiaries, and 3) changes in the ten-year cumulative gross domestic product.

The mechanism has no shortage of critics. The most common complaint is that the payment mechanism almost fiendishly uncouples cause and effect. A responsible, thrifty practitioner has absolutely no control on the other nearly half a million physicians who provide Medicare services. But if a significant number of doctors are profligate in their spending, everyone bears the burden.

The second issue that drives physicians ballistic is the addition of prescription drugs into the spending targets. Even though doctors do not sell or profit from pharmaceuticals, or control their approval or costs, drugs are included because they are "incident to" professional services.

Of course, prescription drug costs have risen much faster than other components of the national health care budget.[4,5] And as a result, the drug component of SGR increased from 3.7% to 9.8% between 1996 and 2003.[6]

Finally, the cumulative nature of SGR can and has magnified mistakes. In 1998-1999, the government overestimated the number of Medicare recipients enrolled in managed care plans, thereby underestimating the growth in gross domestic product per capita.

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Thus, SGR was incorrectly lowered which in turn reduced payments to physicians. Not only has the error never been corrected, it continues to be compounded by the ten year rolling of average gross domestic product calculations. Because of this accumulative nature, if spending targets aren't met one year (or are obviated by Congress as is frequently the case), the future cuts become even more draconian.[7] And while Congress blinked again in the recent showdown over 2006 Medicare fee cuts, few are comfortable with these nerve-wracking annual budget duels.

In defense of SGR, federal officials have a straightforward retort—it works. Simply stated, it works when nothing else has.[3] Like other primary care disciplines, the ACP, legitimately concerned about the future impact of SGR on their incomes, seeks abolition of or a dramatic change in this vehicle.

Back to Medicare history, at the same time Congress was tinkering with price and volume controls, they became aware of alleged internal inequities within the physician fee schedule, namely that procedures in surgery and radiology were overly compensated compared to cognitive services. That led to the resource-based relative value schedule (RBRVS), created in the late 1980s by William Hsiao, MD, of the Harvard School of Public Health. Implemented in 1992, the RBRVS was meant to rid the system of historical distortions and base fees on real resources expended and the actual business costs of a practice.

In the wake of these changes, primary care flourished with Medicare fee increases of 16.5% to 36% between 1991 and 1997.[8] But the good times didn't last and between 1997 and 2004, primary care compensation fell well below that of procedure-oriented specialties.[9] That retrenchment leads to the last ACP proposal—a re-examination of RBRVS methodology—all with an eye toward moving some of its components (ie, physician work units and practice expenses) to their side of the column. In an era of electronic communication, telephone consultation, distant monitoring and telemedicine, physicians argue that historical reliance on face-to-face encounters for compensation is so outdated that the entire system needs to be reworked.

So, based on these two new and two old ideas, will primary care survive? Certainly. But will the sustainability of the discipline depend on financial resources being diverted from other sources such as hospitals? Or other specialties? The lights on Capitol Hill and K Street will burn long into the night answering those questions. ❖

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A Cause That is Just

The probability that we may fail in the struggle ought not to deter us
from the support of a cause we believe to be just.

— Abraham Lincoln, 1809-1865, 16th President of the United States