

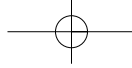
Chapter 1

The Transformation of Primary Care in the United States

Primary care is undergoing profound change in the United States. This is evident in a sicker general population, a decreasing supply of doctors to care for that population, new alternatives to the traditional primary care physician and practice, and an economic model of primary care delivery that creates dissatisfied doctors and patients. Everyone from professional associations to the government believes that money is at the root of the problem. Primary care doctors get paid much less than other doctors, and primary care services are not valued in the same way by third-party payers as specialty services.

Money is only part of the problem. Focusing only on better reimbursement or salaries, as most solutions to the primary care crisis currently do, obscures the impact of an evolving primary care workforce, the negative effects of a reduced scope of work in primary care, and poorly designed primary care training that renders the field unattractive to aspiring doctors. Indeed, the field of primary care has contributed to its own continuing demise, handing over more sophisticated work like hospital medicine to others with little but a whimper. Primary care physicians play to financial incentives that produce eight-hour work days of seeing patients in the office on a nonstop assembly line. Increasing numbers of them want a nine-to-five job and more free time on nights and weekends. At the same time, they hope for patient compliance and loyalty while acknowledging diminished expectations of their own roles as professional caretakers.

The field of primary care now proposes a solution like the “medical home” concept to provide higher reimbursements and prestige for the field. This approach involves emphasizing the patient perspective more in delivering care.



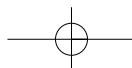
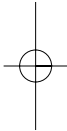
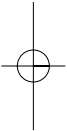
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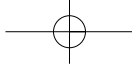
Yet, the medical home approach does not acknowledge what many medical students and residents increasingly believe about primary care, whether it is indeed true or not, that in any form the work involved is more chaotic and less intellectually stimulating than almost any other specialty, and can never match the better salaries and lifestyles afforded by specialties such as dermatology, radiology, or ophthalmology. And even when the work is perceived as interesting by would-be physicians, many of them flinch at the breadth of knowledge needed to become a competent primary care doctor, opting instead to become masters of narrow specialty areas.

It was not always this way. Up until the 1970s, generalist medicine, the forerunner of today's primary care, was held in high esteem by physicians, medical students, insurers, and the general public. Whereas contemporary television shows such as *ER*, *House*, and *Grey's Anatomy* shape our perception of the "best" and "coolest" doctors as superspecialists interacting with one another within hospital settings that are fast-paced, exciting, and attractively quirky, and where many diagnoses are made magically through the sheer brilliance and eccentricities of the physicians involved, it was an older, compassionate family physician named Marcus Welby who glorified the generalist physician's role in the 1970s.

Welby was a veteran practitioner devoted less to magic bullets and more to exploring in-depth his patients' many problems, from the physical to psychological. An admired detective in his job, mentoring younger doctors, Welby used his general medicine skills, years of experience, and ability to relate to his patients to solve a full range of clinical mysteries each and every week. The tools in his arsenal were not technology or superspecialist knowledge but common-sense approaches that involved listening to patients, taking histories, and gaining understanding of how the aspects of a patient's life fit together to drive his or her symptoms. Welby sought to know and have relationships with his patients, understand the psychosocial backdrops for their illnesses, and through this connection he had the key to successful diagnosis and treatment.

Most doctors these days are not Marcus Welby, most medical students do not wish to become Marcus Welby, and insurance companies do not pay for the qualities typified by Welby's approach to care. No longer does the wise, all-knowing primary care physician grab the attention of television viewers. Out-patient care, with its low-tech but effective tools, does not attract viewers or medical students the same way as in-your-face life and death struggles. In the early twenty-first century, taking a good family history or preventing a disease ten years before it would hit a patient does not sell to a viewing audience like an organ transplant or car wreck.





The Transformation of Primary Care

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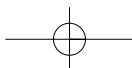
Ironically, many patients increasingly need the Welby-type practitioner and the medicine practiced by that practitioner, given their own unhealthiness and a health care system with little patience for prevention or promoting healthier lives. The primary care setting is where the vast majority of those who suffer from chronic diseases like diabetes and hypertension get their care. It is where most of us go first when something is wrong with us, or when we simply want to learn how to get healthier. Primary care doctors are the doctors we trust because we see and share with them the most.

In theory, primary care is about treating the patient as a whole person—a living, breathing organism with a specific lifestyle, work and home environment, and biological risk profile. PCPs are the doctors trained to see us in this holistic way. While they provide a lot of low-level health care, their importance in making us feel better cannot be underestimated. They get us to accept that nothing serious is wrong when we feel ill. They are the ones who first care for our children, treat our run-of-the-mill infections, prevent future illness, help correct our lives to lessen the effects of chronic disease, and often first diagnose serious conditions. Though not trained or paid formally to do it, they are usually the first professionals who identify depression, stress, and sadness in many of our lives. In these ways, PCPs are the foot soldiers of medicine. They are the low-paid grunts defending the front lines of the health care delivery system from hordes of sicker people. They are often the last line of defense against unnecessary, expensive care and a system that divides patients into discrete parts attended to in an impersonal manner.

The Need for a Strong Primary Care System

Current, unarguable realities support the conclusion that we need a stronger primary care system staffed by doctors who are generalists, listeners, confidantes, and care coordinators. These realities include rising rates of chronic diseases such as obesity, diabetes, and heart disease; longer life spans; the greater attention now given to prevention to stabilize health care costs, deal with chronic diseases effectively, and increase the quality of life for all citizens; and a renewed focus in the United States on health care reform, in particular providing more citizens with health insurance and access to basic primary care through a medical home.

Estimates show that up to 50 percent of the U.S. population has a chronic medical condition. Fifty percent of this group has multiple chronic conditions. Two-thirds of these individuals are over the age of sixty-five. Two-thirds of all adult Americans are either overweight or obese. The prevalence of obesity over the past three decades has more than doubled among adults age twenty to



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seventy-four, from 15 to 33 percent.¹ Nineteen percent of children (age six to eleven) and 17 percent of adolescents (age twelve to nineteen) were overweight in 2003, and we can project a significant number of potentially obese adults in the near future.²

These statistics call for a strong primary care workforce. Obesity leads to greater prevalence of chronic diseases like hypertension and diabetes. It is a condition that cannot be cured with a single prescription, doctor's visit, or procedure. It requires extended consultation, monitoring, and significant adjustments in lifestyle. It requires doctors who know the patients and appreciate what is possible with respect to lifestyle, nutritional, and attitudinal adjustments. It demands proactive prevention strategies that involve physical activity, diet modifications, and in some instances, extended pharmacological or psychological interventions. More overweight and obese individuals in American society mean increased numbers of visits to primary care offices, a greater need for prevention and counseling by PCPs, and a less healthy general population that suffers from a range of illnesses simultaneously. Millions of overweight and obese children place a greater strain on the primary care pediatric system.

One third of all Americans suffer from cardiovascular disease.³ The more common forms of this disease are hypertension and coronary artery disease, conditions not immediately life threatening but requiring constant monitoring and prevention-related activities. Most nonsurgical services for hypertension and heart disease are provided by primary care, which is a cost-efficient level of care. Over seventy million outpatient visits to doctors' offices in 2004 were for patients with a primary diagnosis of cardiovascular disease.⁴ Avoiding emergent situations like stroke or heart attack, respiratory distress, and high blood pressure involves extensive involvement by a patient's PCP in medication monitoring, diet and exercise counseling, and regular testing. And heart disease does not affect only the very old. Over 60 percent of those with the disease are younger than sixty-five.⁵ This means that many people will be living with heart disease for years to come, and making visits to the primary care office.

Diabetes is the third player in the twenty-first century chronic disease troika that demands more services from the field of primary care. Ten percent of people over the age of twenty in the United States have diabetes, or close to 20 million individuals.⁶ In 2005, there were one and a half million new cases, the majority of which occurred in the relatively young forty to fifty-nine age group. Diabetes is more prevalent among individuals sixty years and older, meaning that more new cases will occur as people live longer.⁷ Over \$100 billion dollars annually gets spent on diabetes care.⁸ Diabetes is a manageable

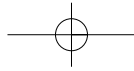
disease that with the right treatment and attention does not have to significantly lessen quality of life. Yet death rates are rising, especially for younger citizens.⁹

This grim statistic is despite the fact that we go to the doctor's office 27 million times a year for diabetes care alone. All those visits—and over 70,000 individuals still die from this chronic disease annually.¹⁰ PCPs are needed to help prevent diabetic complications through active preventive strategies involving nutrition and exercise, as well as monitoring of blood pressure, renal function, blood glucose, blood lipids, and eyesight. More overweight and obese children at present will cause a significant increase in the prevalence of Type II diabetes over the next twenty years in the young adult population. The fact remains: primary care is the first line of defense in managing diabetes. It is also the first line of defense in preventing diabetes in patients who have what is called impaired fasting glucose or impaired glucose tolerance, precursors to the disease and present in anywhere from 40 to 55 million Americans.¹¹

The declining health of many Americans, including those in the more affluent middle class, is not limited to conditions such as cardiovascular disease and diabetes. PCPs diagnose and treat other major diseases in large numbers as well. For example, over a quarter of adult Americans suffer from a diagnosable mental disorder in any given year.¹² Nearly half of this group will have two or more mental-health diagnoses with which to contend at a given time.¹³ Depression is the leading cause of illness in the United States for individuals age fifteen to forty-four, and affects almost 7 percent of the general population.¹⁴ It is the primary care system that often acts as the initial intake and care point for patients with mental health disorders. For some, the primary care system acts as the only point of care for treating their behavioral health problems.

Older Patients, Prevention, and Health Care Reform

Our average life expectancy is now almost seventy-eight years, a record level, ten years higher than in 1970, and as high as most other countries in the world.¹⁵ In addition, the first wave of 80 million baby boomers is reaching retirement age. Living longer produces an increased demand for all health care services, but particularly for primary care. Individuals sixty-five years of age and older tend to see their doctors two to three times more often than younger individuals.¹⁶ This group is more likely to suffer age-related chronic diseases like arthritis, and have minor complaints that involve the heart, mobility, and respiratory and digestive systems. They are more likely to need medication regimens checked regularly, as well as common clinical indicators like blood pressure and cholesterol. They also need immunizations, mammograms, prostate exams, endoscopies, and colonoscopies at higher rates than the general



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population.¹⁷ All of these procedures are done either directly or, as is the case now, coordinated by the primary care physician.

There is a growing emphasis on prevention in the United States. But to do prevention right requires that PCPs spend a lot of time with individual patients in their exam rooms. PCPs provide over 85 percent of all the preventive care visits in the United States.¹⁸ One recent study estimated that simply to comply with existing national prevention guidelines for adults and children would require seven hours out of each PCP's day.¹⁹ Seven hours for prevention alone. No PCP has seven hours available daily for preventive care. Still, this soft mandate for preventive medicine emphasizes how much PCPs are needed if our country is to lower health care costs by avoiding more acute diseases, producing healthier citizens, and increasing the quality of care in the system. There are no shortcuts when it comes to prevention.

Finally, there is health care reform. The focus currently is on providing all citizens with some form of basic health insurance, developing a stronger primary care system in the United States, and emphasizing preventive care and chronic disease management in order to limit costs and improve the quality of life for all citizens. Within this debate, the concept of the medical home has been put forth as a means by which to center the basic elements of preventive care and care coordination within the purview of the primary care physician's office.²⁰ The medical home concept has found traction within the primary care physician community and by employers interested in reducing their health care costs while still improving quality of care for their employees.

The tenets of a medical home involve not-so-new ideas related to care management, adopting a "whole person" orientation to care, convenient access to primary care doctors for patients, the use of evidence-based practices for prevention and chronic disease management, and one-to-one physician-patient relationships. There is growing recognition that only a strong primary care system will allow for proper implementation of the medical home concept. There is also acknowledgment that if more people have health insurance, the existing primary care system will not be able to handle the increased demand. Health reform makes maintaining a strong primary care system a critical policy issue. To provide people with insurance coverage and then no accessible system of basic, primary care undermines the country's effort to make people healthier.

The Decline of Generalist Medicine in the United States

Until the 1980s, few people understood the term "primary care." Proposed in the 1960s, it sought to clarify the importance and role of generalist medicine in an advancing era of technologically driven, specialty care.²¹ In its 1996 report

