The Collapsing Primary Care Foundation: Why It Matters and What To Do About It

14th Princeton Conference

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Supply of Practicing Physicians in the US

Physicians per 100,000 Population

Source: COGME, 1996; includes active, patient care physicians not in training
Fragmented US System

Cardiologist

Chest pain

Stomach Ache

Gastroenterologist

Orthopedist

Knee ache

Pap Test

Gynecologist

Rash

Dermatologist

Patient
Patients Want and Benefit From a Primary Care Medical Home
<table>
<thead>
<tr>
<th></th>
<th>% Agree</th>
<th>% Disagree</th>
<th>% Don’t Know or Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value having one PCP</td>
<td>94</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Helpful for PCP to participate in decision to see specialist</td>
<td>89</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Grumbach. JAMA, 1999;282:261
Association of Regional Quality of Care for Acute Myocardial Infarction (AMI) and Average Number of Physicians per AMI Patient (Quartiles) with Changes in Survival and Spending, 1968-2002

**SOURCE:** Authors' calculations using Medicare claims data.

**NOTE:** Bars denote spending rise (in thousands of dollars), and lines show percentage increase in number of AMI patients surviving to one year.

Source: Skinner et al, Health Aff 2006; W6:W23-W47.
Considerable research evidence indicates that the supply of primary care physicians per capita is associated with:

- Better population health outcomes
- Better quality of care
- Lower costs

This research indicates that the supply of specialists is associated with:

- Higher costs
Primary-Care Score vs “Outcome” Indicators*

*Lower scores are better

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

Quality rank

1

26

51

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

8,000

7,000

6,000

5,000

4,000

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004
Outcomes of Patients with Specialists or Generalists as a Regular Physician

Source: Franks & Fiscella, J Fam Pract 1998;47:105. Data from 1987 NMES, adjusted for health status, insurance, and other covariates
Percentage of Office Visits According to Physician Specialty, By Primary Dx

Source: L Green, Analysis of 1996 Natl Amb Med Care Survey
The foundation of primary care is collapsing in the US
Family Medicine Residency Positions and Number Filled by U.S. Medical School Graduates

Proportions of Third-Year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists

Adult pop growth+aging
Unadjusted supply FM+GIM
Adjusted supply FM+GIM
Adjusted supply F+GIM with graduate decline

SOURCE: J Colwill, unpublished data, 2007
### Median compensation, 1995-2004, MGMA data

<table>
<thead>
<tr>
<th></th>
<th>1995</th>
<th>2004</th>
<th>10-yr increase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All primary care</strong></td>
<td>133</td>
<td>162</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Family medicine</strong></td>
<td>129</td>
<td>156</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Internal medicine</strong></td>
<td>139</td>
<td>169</td>
<td>21%</td>
</tr>
<tr>
<td><strong>All specialists</strong></td>
<td>216</td>
<td>297</td>
<td>38%</td>
</tr>
<tr>
<td><strong>Invasive cardiology</strong></td>
<td>337</td>
<td>428</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Noninvasive cardiology</strong></td>
<td>239</td>
<td>352</td>
<td>47%</td>
</tr>
<tr>
<td><strong>Dermatology</strong></td>
<td>177</td>
<td>309</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Gastroenterology</strong></td>
<td>210</td>
<td>369</td>
<td>76%</td>
</tr>
<tr>
<td><strong>Heme/Oncology</strong></td>
<td>189</td>
<td>350</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Orthopedics</strong></td>
<td>302</td>
<td>397</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td>248</td>
<td>407</td>
<td>64%</td>
</tr>
<tr>
<td><strong>Surgery, general</strong></td>
<td>217</td>
<td>283</td>
<td>30%</td>
</tr>
</tbody>
</table>
2007 Medicare payment for 30 minutes physician time

Assumes GPCI approximately 1.0
What Needs To Be Done

• Reform of physician payment policies to invest in the primary care home and reduce the physician income gap
  – Medical home care coordination payments that support EHR, expanded team personnel, etc
  – Patient registration with medical home and accountability-based payment
  – Alternatives to fee-for-service
IBM TO BACK NEW ORGANIZATION’S GOAL TO REVOLUTIONIZE HEALTHCARE IN UNITED STATES

Pledges support, resources in support of the Patient-Centered Primary Care Collaborative and its Patient-Centered Medical Home Model

ARMONK, NY, May 10, 2007 – IBM pledged today that it will dedicate its influence, technologies, services and knowledge base to help a new, emerging consortium of employers, physicians and consumer groups win its fight to revolutionize America’s ailing healthcare system. The consortium, called the Patient-Centered Primary Care Collaborative (PCPCC), is a coalition originally proposed by IBM in early 2006 dedicated to advancing a new primary-care model called the Patient-Centered Medical Home.
What Needs To Be Done

• Establish a rational, medical education financing policy
  – Change $8B+ in Medicare GME from a hospital subsidy program to a physician workforce program
  – All-payor GME models aligned with regional workforce planning assessments