Primary Care Perspectives

Bringing more primary care providers to Wyoming

BY KRISTOPHER SCHAMBER, MD

It is abundantly clear that our healthcare system is costly and does not provide the type of quality, equity, or outcomes that we, or the general public, expect for that cost. Healthcare is a complex industry, and although I'm sure all readers would agree in general with free market principles, healthcare is a closed, isolated, and specialized market. Not all participants have a knowledgeable say in what, how, when, and where they are buying their healthcare "products" and services. This includes patients, and industry employees, even physicians. How many of us know what an MRI, a CBC, or a knee replacement costs?

So then, what are the cost drivers, and how do we fix them? Are costs rising because of administrative charges, pharmaceutical pricing, tort costs, technological advances, payment models, and/or arbitrary unit pricing? One facet that has received astonishingly little face time in discussion of this problem is the primary care workforce shortage. A more robust primary care workforce would strengthen our current healthcare system, improve mortality and disease rates, decrease inequity, and decrease healthcare costs for individuals and the overall health system.[1, 2, 3, 4]

There is a strong association between increased access to primary care services and decreased healthcare costs, utilization, and mortality. This is because primary care specialties place significant value on prevention, risk mitigation, health and wellness, and community health.

A numbers game

When we compare the United States to other first world countries, it is known that our health outcomes are worse, and our costs are higher. When we look at some of these countries, I believe there are two main differences: payer models and the primary care workforce. In many of these countries a higher proportion of physicians work in primary care, some even upwards of 85% or more. As of 2019, in the United States, only 38% of the physician workforce were defined as primary care specialties, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, and general practice. At this same time, Wyoming retained 79.8 active primary care physicians per 100,000 residents, the 15th lowest in the country; and 111 primary care providers per 100,000 residents (including physicians and non-physician providers), the forth lowest in the country.[5,6] Fortunately, it appears that the primary care workforce in Wyoming, and in the country, is slowly increasing, although Wyoming's rate of growth is lower than that for the rest of the country.

With fewer primary care physicians taking care of an ever-aging population, care is shifted to subspecialties who in turn see more patients, often of inappropriately low complexity, and spend less time with each patient. Less time leads to more tests, higher expense, and lower quality. The care then, by necessity, develops into a system focused on treatment, procedures, and more expensive subspecialty care, rather than value. Effectively, no patient, physician, or other provider is getting what they signed up for in the care they are receiving.

A number$ game

Compounding this disparity, the current primary care physician workforce is in jeopardy of decline because of decreased production and accelerated attrition. Fewer residents entering primary care specialties reflects the choices made by young physicians and teaching hospitals, associated with a growing income disparity between primary care physicians and other specialties.[7]

Physicians and specialties who primarily perform surgeries and procedures receive higher compensation than those who do few or no procedures. The disparity in pay is directly linking to an arbitrary assessment of value of different specialties. Payrates, and relative value units (RVUs), are set by the Centers for Medicare & Medicaid Services (CMS), and largely carried through the private sector as well. The process for setting rates and RVUs through CMS is not transparent, and has long devalued the non-procedural specialties.

When Medicare transitioned to a physician payment system based on the resource-based relative value scale (RBRVS) in 1992, the American Medical Association (AMA) developed a multispecialty RVS update committee (RUC), to provide medicine a voice in shaping Medicare relative values. In their purpose statement, the AMA noted that, "although the RUC provides recommendations, CMS makes all final decisions about what Medicare payments will be."[8]

The RUC includes representatives from most specialties, though the large majority are procedural. Prior to 2012, of the 32 seats on the committee, only six were represented by primarily non-procedural specialties. In 2012, the RUC added an additional seat for geriatrics and a rotating primary care seat, in an attempt to give primary care a stronger voice in the committee. The RUC has also made a number of changes to

the way they assess recommendations on value and payments, many of which have increased value and/or reimbursement for primary care-related services.[9]

Regarding the disparity in value and payment, I believe that procedural specialists whose training is more extensive, or who take care of more critically ill or complex patients, should be paid more than their non-procedural counterparts. How much more is not clear.

Value

When speaking of value in our system, often the focus revolves around primary care, though not in a positive way. Articles or studies looking at guideline-based or standard care for a given disease clearly show that this care is not often being provided, however typically with an accusatory tone as though primary care is simply not, as a matter of will, providing these services. The work required for guideline-based care, disregarding any special valued-based programs, is flatly not possible with our current imbalanced physician workforce. A recent study by Justin Porter, MD, and colleagues applied preventive and chronic disease care guidelines to a hypothetical 2,500 patient panel. The study concluded that primary care physicians would work 26.7 hours per day to complete the care and associated documentation. With team-based care, this number improved by over 50%, though still unmanageable at 16.6 hours per day.[10]

To remedy our system's poor value, CMS has proposed and implemented various quality metrics and value-based payment models to entice physicians, hospitals, and systems to put extra effort toward various value-based outcomes. Value-based payment models and programs certainly have an appropriate focus on outcomes, however they often distract from direct patient care. They take time and money, and in most circumstances additional employees, simply to comply with the regulatory burden of these programs.

This work disproportionately affects non-procedural specialties, particularly in primary care or hospital medicine, compounding the risk of attrition in these groups. Value-based care is an inherent enterprise within primary care, if there are enough individuals in the workforce with enough time to provide the care.

I would be remiss if I did not mention our advanced practice clinician (APC) colleagues. Generally, much of the data regarding systems costs comparing physicians and APCs suggested that the latter provide better and less expensive care. This data purported to study "complex patients," though the outcomes studied were almost exclusively diabetes-related costs and outcomes, without consideration of global complexity of care. Recent data from the Hattiesburg study has shown that primary care performed by independent APCs outside of a team-based model is actually more expensive.[11] I strongly believe a team-based workforce with PAs and NPs is integral in our endeavor to improve access, costs, and outcomes, but they cannot be seen as a replacement for physicians, or thought of as the main primary care workforce.

Unfortunately, there is no quick fix. It will take a long-term plan and political and societal shift. The AMA RUC committee has taken positive steps to increase the voice of primary care in this arena, and in recent years, reimbursement for non-procedural specialties has increased. Many hospital systems are investing significant resources into primary care infrastructure. At our state level, the WWAMI program has been very successful at bringing doctors back to the state, and a large majority remain, though less than 50% practice in primary care. I do think there is opportunity for the state, health systems, insurers, and employers to come together on primary care physician recruitment and retention and value-based models. Indeed, Gov. Mark Gordon has a keen eye on our healthcare disparities, implementing a healthcare taskforce whose aim is to identify solutions to decrease patient cost and increase access to care. It is clear that more value is being placed on primary care, and that much work still needs to be done.

Our current medical system values procedures and treatment above prevention, wellness, and health. Until this changes, our system will remain broken—costly, with poor outcomes, and decreased value.

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