

Review & Commentary on Health Policy Issues for a Rural Perspective – July 1st, 2008

Surf, Turf and the Future of Primary Care

This article by Emily Friedman was first published in Hospitals & Health Networks OnLine, 6/3/08. Given the issue's importance and the clarity of this article, we are grateful to have Ms. Friedman's permission to share it here in its entirety.

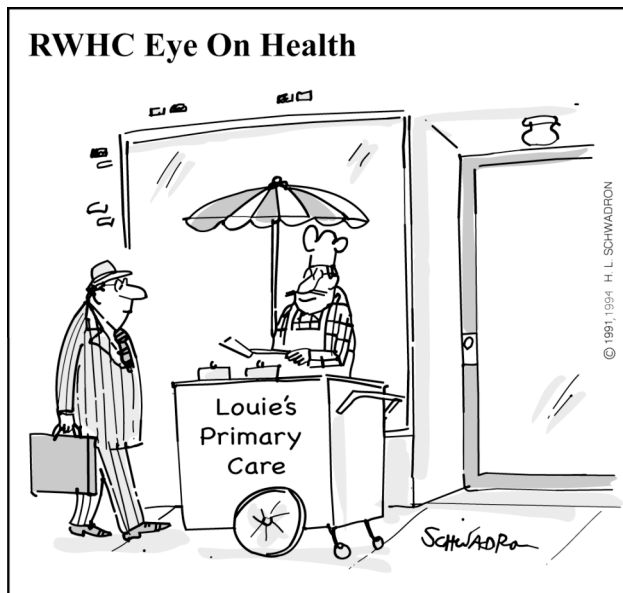
"In the 1930s, it was the bedrock of the health care system. In the 1960s, federal policy not only encouraged it, but also based much future planning on it. In the 1980s and early 1990s, managed care plans depended on it. Indeed, primary care, historically, has been the linchpin of American medicine. So why are we running out of primary care physicians?"

"It wasn't always like this. Those of us who are older remember the great role-model general physicians of the early years of television: the legendary character of Doc on *Gunsmoke*, played by Milburn Stone, and Marcus Welby, M.D., Robert Young's storied character from the series of the same name. Most of us grew up with a family physician or general practitioner providing most of our care; some of us still have one."

"In the 1960s, federal policy favored educating more physicians, especially primary care doctors, through

Title VII funding, beginning in 1963. That helped lead to family medicine being named, in 1969, the 20th formal medical specialty in this country. And in the late 1980s and early 1990s, the burgeoning managed care sector relied on the concept of primary care physicians as 'gatekeepers' to keep costs down by restricting access to specialists and expensive therapies and technologies. We all know how well that worked out, but that's for another time."

"More recently, the Bush administration announced as a goal that every county in the United States should have a community health center; these clinics, of course, offer the services of primary care physicians."



"Yet we hear the lament everywhere today: There are not enough primary care physicians, or general surgeons, or generalist geriatricians—just as the first of more than 70 million baby boomers creep toward Medicare eligibility."

"The statistics are daunting. In 1995, according to the Government Accountability Office, there were 23,800 residents in primary care programs; in 2006, despite a major increase in the U.S. population, there were 22,100. Fewer than 45 percent of primary care residencies were filled in the last year, and 56 percent of physicians beginning primary care residencies are international medical graduates who have come from other countries. Growth in the number of primary care physicians since 1995 was a meager 1.2 percent per year. The number of federally designated 'pri-

mary care shortage areas' is growing. The much-touted universal health care program in Massachusetts, which requires state residents to acquire health insurance, has produced a painful irony: There aren't enough primary care physicians to meet the pent-up demands of the newly insured, and waits for an appointment are very long—like over a year for a physical examination."

What Happened?—"So how did this come to pass? There are many reasons."

- "After World War II, the number of medical specialties exploded, and the specialties were soon able to command much higher reimbursement than were primary care physicians. The difference is staggering: According to Physicians Search, among physicians who have been practicing for more than three years, the average family physician earns \$147,516; the average cardiovascular surgeon earns \$558,719; the average neurosurgeon, \$438,426. The highest-earning family practitioner earns \$197,025; the highest-earning cardiovascular surgeon, \$852,717."
- "Combine those income figures with the fact that the average medical school graduate in 2007 was carrying \$140,000 in debt, and it doesn't take a rocket scientist to figure out what most new physicians who are not independently wealthy will do."
- "All this is not aided by significant recent cuts in Title VII funding geared toward support of primary care medical education, and the Bush administration's proposal in its 2009 budget to end all Title VII funding of health professions education."
- "The medical education system must shoulder some of the blame. Students who express an interest in primary care are routinely dismissed as misguided or deluded. Tom Campbell, M.D., chairman of the department of family medicine at the University of Rochester, graduated from Harvard Medical School in 1979. He recalls, 'My classmates and I who went into family medicine all received tremendous pressure from our professors not to 'waste' a Harvard education. None of us has had any regrets.' But as a former official at Harvard Medical School told me recently, 'There are disincentives everywhere.' "

- "Among those disincentives are that it is much less likely that a primary care physician will become a medical school dean or rise to other pinnacle positions in the world of medicine. Research grants are much harder to come by, and outside income from consulting is more limited than it is for specialists."
- "Furthermore, many recent studies have shown that new physicians, more and more of whom are women, 'want a life' and are less willing to work exceedingly long hours, work at night, be on call or have a variable work schedule. Indeed, 82 percent of younger women physicians in a survey by the Association of American Medical Colleges stated that having time for family and personal life was 'very important.' Small wonder, then, that specialties like dermatology and plastic surgery are becoming much more popular among new medical school graduates: good pay, consistent hours and no life-threatening emergencies. As the percentage of women practicing primary care grows—and it is doing so, markedly, as the proportion of men in this sector decreases—these preferences will become more prevalent. The choice of specialty may well clash with the chosen lifestyle."
- "More and more patients are surfing the Internet for health care information and are finding tempting offers from all kinds of allied health professionals, from advanced-degree nurses to chiropractors to faith healers, who offer allegedly less expensive, more easily available and more 'high-touch' care, which is particularly seductive as primary care physicians are forced to spend less time with each patient to increase overall patient volume."

Rural Wisconsin Health Cooperative, begun in 1979, has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the "rural advocate of choice" for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

Tim Size, RWHC Executive Director & *EOH* Editor
880 Independence Lane, Sauk City, WI 53583

office@rwhc.com

<http://www.rwhc.com>

Email us with *subscribe* as Subject for free e-subscription.

- “Just about everyone is extremely busy these days and, being Americans, we want everything yesterday. Long waits to see a primary care physician and the Internet’s wide range of alternative offerings lead patients to do what is most convenient for them, whether that is getting a flu shot at the airport or visiting a retail clinic at Wal-Mart or Walgreens.”

Yes, But ... “So, perhaps, if it is what it is, and patients are voting with their feet, what’s the problem? There are several big ones.”

“First, even the most conservative proposals for broadening access to care are predicated on universal or near-universal access to primary care, which requires a healthy supply of physicians who can do that job. Furthermore, most proposals for improving the health care system, aside from coverage issues, emphasize coordination of care to reduce duplication of services and waste; disease management that helps patients cope with their conditions and achieve the highest possible quality of life; prevention of avoidable conditions through immunization, screening, counseling and other interventions traditionally conducted by primary care physicians; and detection of disease early in its course, so that it can be treated and, hopefully, cured before it’s too late.”

“Also, although the primary motivation for these priorities should be the health of the patient, the fact is that most of them are favored because they save money. Prenatal care of high-risk pregnant women can prevent a stay in the neonatal intensive care unit; inoculation against influenza, if everyone at risk received it (and if the flu vaccine were actually effective, which wasn’t the case in the most recent flu season, and ... don’t get me started), would save 36,000 lives annually and who knows how much money. Primary care happens to be wildly cost-effective.”

“And the interaction of patients—especially consumerist patients—with the health care system would benefit from a holistic approach; that is, seeing the patient as a person and not as a sum of body parts. Today’s medical hyper-specialization does not always sit well with people who want to be treated as though they are human beings, not just a wrist. A friend of mine recently saw an orthopedic surgeon for a minor condition, and was trying to explain what he thought

triggered it. ‘I think it’s stress,’ he told the specialist. ‘You mean *emotional* stress?’ the physician responded. He was used to interpreting the term *stress* as severe pressure on bones and joints. He doesn’t do *emotional* stress. Unfortunately for him, many patients have more than one condition, and someone needs to see the big picture.”

“All this argues for a robust supply of properly trained and focused primary care physicians who can serve the future in the same manner in which they served the past: acting as the first line of response, the coordinators of care, the prevention protectors and the source of oversight for an episode of disease or injury—and of the care provided.”

The Impact of the Shortage—“Unfortunately, that may not be where we are headed. The shortage of primary care physicians is accelerating—and, in some cases, spawning—trends that are not always positive.”

“For one thing, if you are in need of a bit of primary care, and your physician can’t see you for three or six months, then you will likely head to where everyone heads, sooner or later: the emergency department. Visits to EDs for nonemergency care continue to climb, putting stress on hospitals already stretched to the limit, especially as fewer specialists are willing to take call—not to mention the consequences of patients seeking primary care in the most expensive setting.”

“Also, community health centers, a major source of care for patients who are uninsured or are Medicaid beneficiaries, are having as much trouble as other providers in recruiting and maintaining primary care physicians. That spells trouble for extremely vulnerable patients.”

“For another thing, as Aristotle noted a while back, nature abhors a vacuum; if there is not enough of something that is in demand, something else will show up to fill the void. In this case, it was starting to happen, anyway, but the decreasing supply of primary care physicians is presenting a golden opportunity to allied health professionals who are more than willing to step up and do the job. Nurse practitioners, certified registered nurse anesthetists, chiropractors, homeopathic practitioners and even pharmacists are offering their services and lobbying—often successfully—for a broader scope of practice. In other cases,

they just practice independently, in violation of laws that are difficult to enforce.”

“There are signs of this everywhere. The explosion in the growth of retail clinics in big-box and drug stores, of which there were 963 in May 2008, has led analysts to predict that there will be 3,000 of them by 2011. In many cases, hospitals are partnering with or staffing these clinics, which seems to be a good thing, in that there is a straight referral path if a patient comes in with something more serious than a sore throat.”

“What’s the rub? The clinics are largely staffed by nurse practitioners. And organized medicine, which knows a turf issue when it sees one, is deeply concerned. Issues of quality, oversight and appropriate scope of practice have all been raised.”

“This, of course, runs head-on into two very tough issues: the traditional (and most unfortunate) tensions between medicine and nursing, and the always-contentious battles over what is turf and what is scope of practice.”

“The rise of the nurse practitioner (NP) has been impressive, from 30,000 in 1990 to 115,000 today. There are 250 primary care centers that are run by nurses, excluding the retail clinics. NPs may practice independently or with limited physician oversight in 43 states; they can prescribe at least some drugs in 49 states; and in many states, they can order at least some tests, diagnose conditions and refer patients to other providers. Insurer acceptance of their services (possibly because they tend to charge less than physicians) is increasing.”

“The pharmaceutical companies are already hip to what’s going on: Current television ads for a widely prescribed drug suggest, ‘Ask your prescriber [not ‘your physician’] about Ambien.’ ”

Beyond that, as *The Wall Street Journal* recently observed, a new nursing specialty is arising: the doctor of nursing practice, who will have more education and training than an NP and who will, according to Mary

Mundinger, dean of the Columbia University School of Nursing, be trained to ‘have more focus than doctors on coordinating care among many specialists and health care settings.’ ”

RWHC Seeks an Associate Director of Advocacy

Applicants are encouraged to submit their resume to RWHC c/o Monica Seiler at mseiler@rwhc.com no later than the end of August. Those individuals who will be invited for an interview will be contacted in September or October. The position description is available at <http://www.rwhc.com/>

are worried that they may have to go back to school to protect their hard-won turf. And observers of the field wonder who, exactly, is going to set the standards and enforce the rules.”

“So the combination of the devaluing and resultant shortage of primary care physicians, the urge for greater scope of practice on the part of allied health professionals, the lure of lower-cost care, and turf battles everywhere have produced a bit of a stew. The question is, what are the real issues here?”

Some Key Issues—“Although turf is critical to the professions, and Internet surfing for health care options has become a way of life for many people, neither of these is a life-or-death matter. However, lurking under all the rhetoric are some real questions.”

“First, is the shortage of primary care physicians an issue of a true shortfall, or simply a maldistribution? This question has been a mainstay of health workforce discussions for at least 30 years, and no one has an answer, other than to note that the ratio of physicians to population varies wildly across this country. If the physician-to-population ratio varies as much as the studies say it does, couldn’t we just rearrange the physicians to match population need? In a word, no.”

“Physicians, like anyone else, are free to practice where they wish, and if they choose to practice in wealthy suburbs and prestigious medical centers rather than small towns in the Plains, no one is going to force them to do otherwise. There are programs that provide incentives for new physicians to practice in underserved areas, but they are not all that well-funded, and the disincentives are mighty.”

“Second, although the turf issues cloud the discussion to a high degree, questions about appropriate scope of practice are valid. When podiatrists sought to perform surgery above the ankle, other specialties had a fit, but in reality, the debate was fueled by a mixture of turf concerns and legitimate issues of competence. In Arizona recently, the state senate banned the performance of abortions by NPs, but it was not clear whether the motivation was scope of practice or anti-abortion sentiment.”

“With the retail clinic trend firmly in place, one wonders how many more services will be provided in those settings in the future, and whether those providing them will be properly trained.”

“Years ago, at a Canadian health care conference at which I was speaking, a physician who practiced in rural Newfoundland—and you don’t get much more rural than that—said flatly, ‘Listen, 90 percent of what I do can be done by any competent nurse.’ The issue, of course, is the other 10 percent—and the question of competence.”

“A third concern is just how many practitioners want a piece of the health care pie in the form of independent practice and direct reimbursement. In a famous 1981 essay, the great health economist Uwe Reinhardt warned of hordes of practitioners all trying to get to the health care feeding trough; it is a warning we should take seriously. Some practitioners are perfectly able to provide primary care, as the Newfoundland physician noted; others are not. I am not excited by the prospect of chiropractors performing brain surgery or acupuncturists doing colostomies any more than I am by properly trained, competent practitioners being barred from providing primary care because a professional lobby is protecting its turf while patients go begging for care.”

“Fourth, there is the minor matter of how referral arrangements would work in a nation where the dangers

of self-referral don’t seem to bother the authorities, and where the rules of oversight have not been written for referrals by and among allied health professionals.”

“Fifth, there has not been a great deal of discussion about the immigration of health care professionals—primarily physicians and nurses—from Third World countries to ours. There was a major debate in a British medical journal recently about whether the recruiting (which is active and aggressive) of physicians and nurses from sub-Saharan Africa was a socially responsible practice, and some of the questions, I think, were valid. For example, thousands of physicians in the Philippines have retrained as nurses (now, *there’s* a concept!) and emigrated to the United

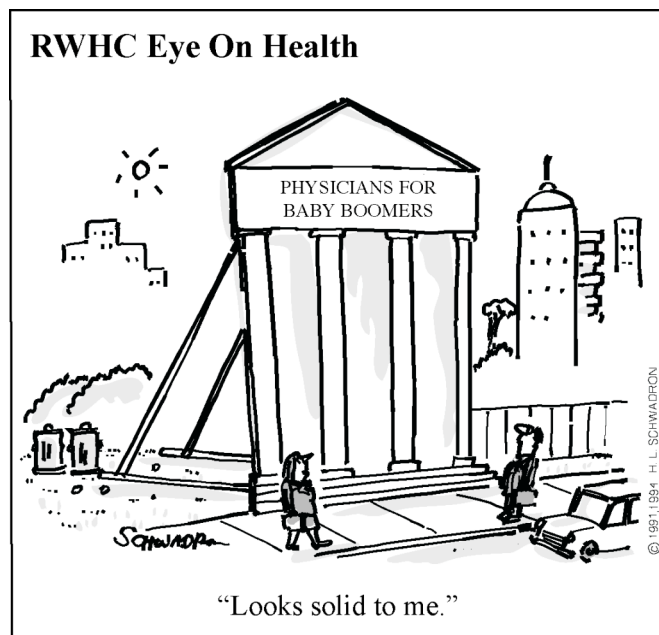
States in recent years; during the same period, three of every 10 physicians in Ghana have emigrated to First World countries, primarily the United States. Ghana has a ratio of six physicians per 100,000 people; the U.S. ratio is around 280 per 100,000.”

“Nonetheless, a bill was recently introduced in the U.S. House to expand the availability of visas for nurses who wish to emigrate here.”

“And finally, given that the United States suffers from a chronic shortage of nurses, especially in hospitals and nursing homes, the shift of nurses from traditional nursing duties to primary care practice will only exacerbate the shortage in many areas. Noted nursing workforce analyst Peter Buerhaus of Vanderbilt University last month issued a dire warning that this country will be short 285,000 nurses by 2020 and 500,000 by 2025.”

“Figures like that lead one to ask, if nurses are going to fill the gap created by the shortage of primary care physicians, who will fill the gap created by the shortage of nurses?”

What Might Be Done?—“There have been many proposals for addressing this problem, which, if you plough through all the other issues that have coa-



lesced around it, consists of how we can ensure that competent, accessible primary care will be available in the future. Among them are:"



RURAL HEALTH CAREERS
WISCONSIN

physicians who want to practice in a community health center or public health clinic will be strong-armed not to 'waste' their medical education."

- "Increase pay levels for primary care providers, especially physicians. I was recently privileged to spend two days as a resident scholar at a medical and dental school, and during one of our discussions, we got into the topic of the shortage of primary care physicians. I was running through all the challenges, and one of the professors said, 'Yes, but much of the problem would be solved if the pay was better.' He was right. If we want graduating medical students who are \$140,000 in debt to choose primary care, we must make it a financially feasible choice. Earlier this year, the Medicare Payment Advisory Commission recommended that Medicare pay primary care physicians more, and Sen. Max Baucus (D-Mont.), chairman of the Senate Finance Committee, supported the idea; the political challenge is that the money would likely come either from reduced Medicare payments to specialists or else reduced payments to Medicare managed care plans, either of which would produce a political firestorm and a likely presidential veto. But if it passed, Medicaid and private insurers might well follow suit."
 - "Another way of addressing the income issue would be debt reduction for physicians who choose to practice in primary-care shortage areas and in community health centers, public hospitals, public health and other settings where the shortage is most critical. This is already done in small programs, but putting more money into the effort would help. That idea, in turn, would lend support to continued Title VII funding for health professions education, especially for primary care. If the debt that students are carrying when they graduate can be reduced, they may be more likely to choose primary care."
 - "But some of these issues transcend money (difficult as that may be to believe). And foremost among them is that the medical school culture needs to change. As long as specialists and hyper-specialists are in control of the money, the prestige, the plum positions, the research funding and the culture, the pressure to become a specialist and not a generalist will remain strong, and young
 - "Encouraging the development of multispecialty group practices along the lines of Permanente, Mayo, Geisinger, Ochsner and others would help, because in these settings, primary care physicians are part of the team and not wallflowers waiting to be asked to dance. Historically, this practice model has demonstrated higher quality of care and greater efficiency, but what has not been highlighted so much is that the collegiality of a group practice environment can be profoundly supportive to primary care physicians."
 - "Finally, remember the late comedian Rodney Dangerfield, who just couldn't get no respect. Show respect to primary care physicians, who, despite all that they face, are the backbone of American medical care. Whatever you do in health care, make it a point to support them and encourage them and make life easier for them. Katherine Atkinson, M.D., a family physician in Massachusetts (whose waiting list, at last report, was over a year), told *The New York Times* in April, 'I never went into medicine to get rich, but I never expected to feel as disrespected as I feel. Where is the incentive for a practice like ours?' In the absence of true respect, efforts by organized medicine to protect the turf of specialties whose members have long been devalued by organized medicine are not likely to be very successful."
- About That Vacuum**—"Biology, anthropology and evolution theory teach us that there are reasons some beings survive and some do not. The dinosaurs may have met their fate because an asteroid careened into the waters off the Yucatan. The peoples of the Marquesas and Easter Island perished because outsiders killed them or took them away as slaves. Many Native Americans died because newcomers wanted their land. These are ancient patterns, played out all over the world, again and again."
- "What will happen to primary care will be the result of a cacophony of forces, some eventually coalescing, others still conflicting, that will be played out on a stage rife with professional, political, social and

cultural battles. I don't know what will happen. I do know that patients deserve access to physicians or nurses or others who will be the front-line caregivers, who will test and diagnose and protect and try to keep whatever it is from happening, and if it does happen, to keep it from getting worse. Perhaps more important than that, patients deserve someone who will marshal them through the ever-more confounding health care system, and who will, above all, see them as whole human beings."

"As for the fights among the professions, I leave the last word to the great biologist David Attenborough, who, at the end of his 1983 masterpiece book *Life on Earth*, observed matter-of-factly, 'It is more than likely that if men were to disappear from the face of the earth, for whatever reason, there is a modest, unobtrusive creature somewhere that would take our place.' "

"That creature may not be modest or unobtrusive, but it may well be providing primary care to our grandchildren."

Copyright © 2008 by Emily Friedman. All rights reserved. *Emily Friedman is an independent writer, lecturer and health policy analyst based in Chicago. She is also a regular contributor to H&HN OnLine.*"

A Rural Hospital Leads on Dental Access

Monthly, Eye On Health showcases a RWHC member story from the Wisconsin Hospital Associations' annual Community Benefits Report. Wisconsin hospitals provide over \$1.6 billion in community benefits; twice that if you include Medicare shortfalls and bad debt. This month's feature is St. Joseph's Hospital, Chippewa Falls, "Affordable dental care—a collaborative effort."

"Affordable and accessible oral health care for the elderly and low-income families in Northwest Wisconsin has just been improved thanks in part to efforts of St. Joseph's Hospital and Chippewa Falls 2010, a health community initiative sponsored by St. Joseph's Hospital, in bringing a new state-of-the-art dental facility to Chippewa Falls. The new Marshfield Clinic Chippewa Dental Center is now open, serving the thousands of people on a waiting list for affordable dental care."

"St. Joseph's Hospital became involved in the effort six years ago when reports of emergency department visits for oral health care increased. 'People were coming to the emergency department of the hospital to relieve severe tooth pain, blatantly showing us an unmet need in our community,' says Rhonda Brown, healthy communities specialist at St. Joseph's Hospital and coordinator of Chippewa Falls 2010: Achieving a Healthier Community. 'We soon discovered thousands of people were on a waiting list for affordable dental care in our community.' "

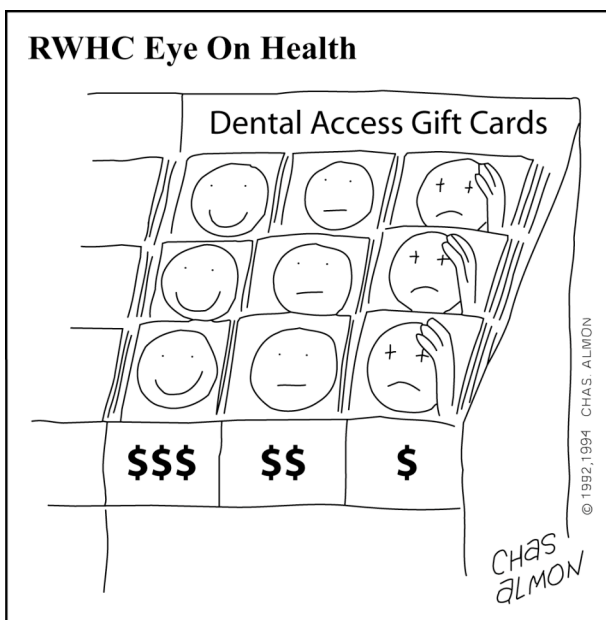
"Lead by Ray Myers, assistant administrator at St. Joseph's Hospital and Chippewa Falls 2010, the Oral Health Community Initiatives of Chippewa County was created to explore multiple options to improve access. In the meantime, St. Joseph's Hospital assisted a rural health dental clinic by providing expanded space and renovations in the former Convent."

"Several grants and collaborations paved the way to bring a federally qualified dental center to Chippewa Falls. Myers and Brown helped form the Chippewa

County Dental Foundation, Inc., a nonprofit foundation, which was able to secure funds to build a state-of-the-art dental facility, which has ten operatories and space for several dental specialists. Marshfield Clinic Health Center partnered with the group to bring the dentists, oral surgeons, staff and services to the center."

"The Chippewa County Dental Foundation, Inc. continues its work towards awareness, education and prevention of oral health issues. For more

RWHC Eye On Health



information on the Foundation, contact Rhonda Brown at 715-726-3647.”

2008 Monato Rural Essay Prize Winner

Christi Barden’s essay, “The Flu, An ER Nurse’s Perspective” has been selected to receive the 2008 Hermes Monato Essay Prize for \$1,000. Christi is enrolled in the RN to BSN Collaborative Nursing Program at UW-Madison as well as working at Divine Savior Healthcare in Portage. (Divine Savior is a RWHC Member but all entries are judged “blind.”)

The Essay Prize, established in 1993, is open to anyone who has been a student at the University of Wisconsin within the preceding year (all campuses, programs, graduate, under graduate, part-time, nondegree included.) The competition was established to honor the memory of Hermes Monato, Jr., a 1990 graduate, as well as to highlight the importance of rural health. Hermes worked at the Rural Wisconsin

Health Cooperative for only a few years but his infectious spirit and creative mind left rural health an enduring legacy. **Starting in 2009, the writer of the winning essay will receive a check for \$2,000 (up from \$1,000 in 2008) paid from a trust fund established at the University by RWHC, family and friends of Hermes.** The winning essay will be about rural health with some of the following attributes: relevant to rural communities, innovative, practical, multi-disciplinary, improves quality of care, team/relationship oriented, applicability to networking, cooperatives.

There are no specific requirements for length, format, etc.. To date, winning papers have ranged from first person essays to formal “journal ready” articles. **Please note that essays already written for a class or others purposes during the previous twelve months are also eligible for this competition.** All entries (no copies needed) must be submitted by April 15th c/o Monica Seiler, RWHC, 880 Independence Lane, Sauk City, Wisconsin 53583 with writer's name, academic program and expected date of graduation.

Space Intentionally Left Blank For Mailing