The Future of Primary Care:

A Report on Primary Care Medicine in New York State

November 2006

New York Chapter
American College of Physicians
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The New York Chapter of the American College of Physicians (NYACP) is the state's largest medical specialty organization. NYACP represents 11,000 physicians practicing general and specialty internal medicine. The Chapter maintains a special focus on improving access and enhancing quality of care, promoting public health and patient safety, providing continuing medical education and promoting the use of evidence based practice guidelines.

Mission

The mission of the NYACP is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine. We share a vision with the American College of Physicians to uphold the best traditions and create opportunities for excellence in internal medicine.

Goals

- To establish and promote the highest clinical standards and ethical ideals;
- To be the foremost comprehensive education and information resource for all internists;
- To advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession and our members;
- To serve the professional needs of the membership, support healthy lives and improve the practice environment for physicians, and advance internal medicine as a career;
- To promote and conduct research to enhance the quality of practice, the education and continuing education of internists, and the attractiveness of internal medicine to physicians and the public;
- To recognize excellence and distinguished contributions to internal medicine; and
- To unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members, and our profession.

Working with medical students, residency training programs, Departments of Medicine and individual members in our 5 regions and 16 districts across New York State, the NYACP provides educational opportunities highlighting the latest clinical advances in medicine, practice management improvement and public policy initiatives that promote increased access to care.

The NYACP supports structural system changes to assure every patient has access to a health care delivery system which promotes affordable, high quality and efficient care.

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Executive Summary

Primary Care Medicine, the field of medicine practiced by primary care physicians, is critical to the provision, coordination and management of cost-effective, timely, high-quality health care. In New York, as in much of the United States, recent health care trends, health policy legislation and career choices of physicians away from primary care bode poorly for the future health care needs of its citizens. This report examines those trends, including their antecedents and consequences, and offers possible solutions for what is fast becoming a health care crisis.

As of 2003 there were 293,701 primary care physicians (PCPs) in the United States, constituting 37.3% of the physician work force, 12.7% fewer than are considered necessary for the health care needs of the population. In New York State, only 17 of 62 counties have the requisite 50% of their physicians involved in primary care, and 7 counties have more than 2000 patients per single primary care provider, a grossly inadequate ratio akin to that found in some developing nations.

While US primary care physicians average 92.4 office visits per week, an estimated 30-70% of their time is spent on non-reimbursable activity such as telephone calls, internet communication with patients and insurers, and paperwork. For this office-based work, PCPs are compensated an average of 65% of what Medical Specialists and 45% of what Surgical Specialists are compensated. In a recent poll, 63% of PCPs said they felt "the compensation doesn't make up for the hours and stress."

Over the last 20 years, the average debt of medical school graduates has increased from approximately $20,000 to approximately $120,000. Medical students, who are exposed as part of their formative education to very busy, difficult to manage PCP private practices that are able to offer little time for preventative medicine services for their patients, are becoming less willing to enter the field. Primary care residency positions continue to fill poorly. In 2006, only 56% of Internal Medicine positions were filled by US medical graduates. In Family Practice 41% of these positions were filled by US medical graduates. While the preferred method for promting PCP careers in the United States has focused on debt repayment, the amount of that repayment has not kept up with tuition increases. In its Final Report, the Commission on Health Care Facilities in the 21st Century recognizes that "primary care is an essential component of the health care delivery system" and specifically cites the need to reform the reimbursement system to encourage the provision of primary and preventive services[34].

Key Recommendations

Among the solutions available to help reverse some of these trends and provide a necessary lifeline to primary care medicine are the following:

- Reimbursement schedules for physicians delivering primary care must recognize the value of the traditional primary care office visit, the increasing needs of physicians to manage patients between visits (online or by telephone) and disease prevention and health promotion. Possible approaches include: the addition of a case-management fee, a time-scheduled fee, technological improvements, billing per time spent managing a patient's chart (outside of the office visit) or in communicating with or on behalf of patients.

- Medical schools and graduate medical education (GME) residency training programs must do more to improve the prestige and appeal of primary care medicine for their trainees and provide positive role models for current students and residents.

- Improved patient access to preventive health education opportunities, in doctors' offices or by insurance companies, could help dramatically improve health care while decreasing some of the time strains felt by physicians during office visits.

- Grants should be made available for primary care physician practices to improve their health information technology capabilities, for auxiliary staff to help provide basic services, and for educational offerings to improve the business management skills of physicians and their office managers.

- More meaningful and effective loan forgiveness and/or payback programs.

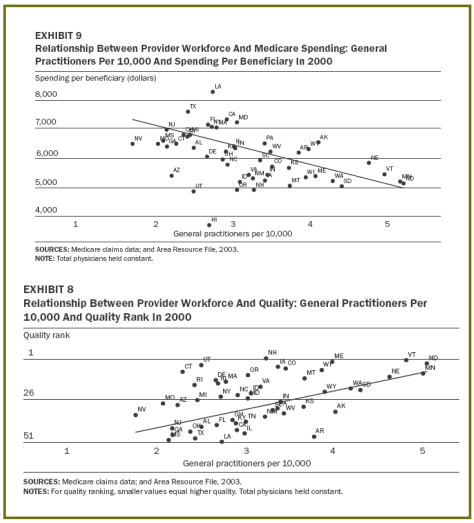
See page 13 for full list of Potential Solutions.

Introduction

Primary care physicians (PCP) are the cornerstone of a modern, high quality health care system. Their myriad roles include serving as purveyors of preventive medicine, leaders of a clinical health management team, managers of acute and chronically ill individuals, and as the primary entryway to specialized care. Primary care physicians are vital to the management of chronic diseases, providing comprehensive and coordinated long-term care for tens of millions of Americans. Studies have shown that primary care has the potential to reduce costs while maintaining quality. The early detection and treatment of chronic conditions, for instance, plays a crucial role in assuring the health and quality of life of patients and often can prevent hospitalizations and costly complications when illnesses such as diabetes mellitus and coronary artery disease are diagnosed sooner. Physicians who choose primary care medicine as a career choice cite intellectual stimulation and grateful patients as two aspects of the field they find most enjoyable[1].

The combination of these diverse functions makes primary care physicians central to the efficient and equitable distribution of health care resources. Evidence shows that an increased primary care workforce reduces overall Medicare spending per beneficiary while increasing overall quality of care[2]. (See appendix A). The forecast for primary care medicine, however, is grim[3,4,5]. Fewer qualified medical school graduates are choosing primary care medicine, while current PCPs are increasingly frustrated and dissatisfied with their career choice. According to a 2005 report by the American College of Physicians, only 20% of third year internal medicine residents planned to pursue careers in general internal medicine, compared to 54% in 1998. A 2005 survey of internal medicine physicians who received board certification in the 1990's found that 21% who were practicing general internal medicine had left internal medicine practice entirely, compared with only 5% of subspecialty internists.

With its relatively large number of medical schools and teaching hospitals and its many centers of excellence in biomedical research and specialty care, New York is often looked upon as a bellwether for the rest of the nation. The state's 14 public and private medical schools currently enroll approximately 8,000 medical students, a number that constitutes more than 10% of the national enrollment of medical students. More than 14,000 residents are in training in New York, comprising 15% of the nation's graduate medical education workforce. By economies of scale, what happens with the delivery of primary care in New York is likely to reflect and predict what happens in other regions of the United States. Solutions pursued in New York offer opportunities for other states and the rest of the nation to follow. This report focuses on the current obstacles preventing the development of an adequate cadre of qualified physicians for the primary care needs of New York State, and will offer short and long-term solutions to rectify what is fast becoming a crisis in health care.



Appendix A

What It Means To Be A Primary Care Physician

A primary care physician is formally defined as a physician who coordinates and provides primary care services in the specialties of Family Practice, General Internal Medicine, and General Pediatrics[5]. Primary Care Obstetrics and Gynecology is often included in this definition, however, their services are generally divided between specialty and subspecialty care. For the purposes of this report, they have only been included when it has been possible to ascertain whether the services they provide are truly inclusive of primary care.

As of 2003 there were 293,701 primary care physicians in the United States, constituting 37.3% of the total physician work force[6]. By specialty, the total physician work force includes 13.9% who are Internal Medicine physicians, 11.6% who are Family Practice physicians, 7% who are Pediatricians and 4.8% who are Obstetrician-Gynecologists. The numbers are striking. Though the absolute number of PCPs has increased over the last several decades, as a percentage of active doctors there has been a marked decrease in the second half of the last century (from 59.1% in 1949, to 50.7% in 1960, to 43.2% in 1970)[6]. Since 1995, this percentage has remained roughly steady between 37% and 38%. It is estimated that adequate coordination of health care requires 50% of practicing physicians to be involved in primary care medicine[7]. The current percentages fall well short of this mark.

In New York State, as of 2005, there were 29,778 primary care physicians, constituting 34.6% of the workforce[8]. This percentage is subdivided among General Internal Medicine Physicians (18.9%), Pediatricians (8.4%), Family Medicine Physicians (4.6%), combined Medicine/Pediatrics Physicians (0.3%), and others (2.4%).

Most PCPs (70%) in the United States are office-based physicians[9]. By far, most of these doctors (88.1%) have a single office location where they work from 3 to 5 or more days a week (73.9%)[6]. These offices are evenly distributed among solo practice (33.7%), single-specialty group practices (38.4%) and multi-specialty group practices (28.0%). These doctors average 92.4 office visits per week, spending between 16.1 (family practice and pediatrics) and 20.0 (internal medicine) minutes with the average patient.

In addition to their office visits, PCPs in the United States performed 26.3 non-reimbursed telephone consultations, 17.0 hospital visits, and 5.7 non-reimbursed Internet consultations per week[6]. Telephone consultations were provided by primary care physicians more often than by all other specialties (See Table 1). With respect to hospital visits, PCPs visited their inpatients as often as surgeons, but nearly 50% less often than medical specialists, reflecting a reality that inpatient care of sicker patients is often coordinated by medical specialists. Most PCPs, however, coordinate the outpatient management of their sickest patients as long as possible delaying – or avoiding - hospitalization whenever possible[10]. Some primary care groups have hired a devoted "hospitalist" (typically an internal medicine physician who spends at least 25% of their time in caring for hospitalized patients – *RangelMD.com)* to manage their group's inpatients. The second notable exception is in the utilization of the internet and e-mail, in which surgeons hold a slight edge, reflective of the fact that most PCPs have remained relatively "low-tech." Many PCPs have said that their practice would most benefit in the next 5 years from the installation of electronic medical records (EMRs), and

the use of other health information technology (HIT) to coordinate prevention, prescriptions, lab results and referrals[10]. An estimated $16,000-$36,000 office installation fee[11], plus time for training and transition from current charting and ongoing maintenance have limited wider implementation of such technology, however.

Despite only 37.3% of doctors practicing primary care, 62.7% of total office visits in 2002 were to primary care providers[6]. Of these office visits, 75% were to the patient's own designated primary care provider. These office visits were primarily for acute care (41.5%), management of chronic illness (29.6%) and preventative care (23.3%). Most of these visits involved a general medical examination (60.8%), blood pressure check (60.1%), medication discussion or prescription (73.5%), diet or nutrition counseling (19.3%) and exercise counseling (12.2%), in the short time allotted. An average of 60.4% of these patients required a return to the doctor for a follow-up visit.

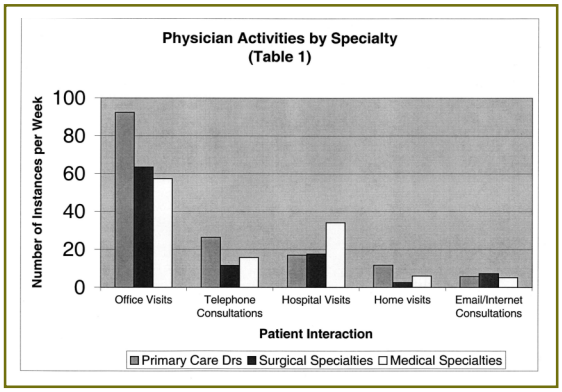


Table 1

Translated into a day-to-day routine, primary care physicians are very, very busy. Most patient encounters include, in a limited time-span: a discussion of the patient's current medical concerns; work-up of any new issues; a review of long-standing medical issues; a physical exam; a review of medication regimen; appropriate discussion of prevention, long-term health care needs and life issues. Statistical data suggest that most PCPs need to provide such care between 20 and 30 times a day to cover their practice overhead costs[10]. Between patients visits, doctors are typically shuffling through large stacks of charts on their desks (or on their computer), returning phone messages, calling patients with lab results, calling other doctors to follow-up referrals, calling insurance companies to request authorization for various diagnostic or treatment modalities, calling pharmacies or Pharmacy Benefit Managers to justify their decision-making and obtain reimbursement, finishing chart notes, checking and responding to e-mails, and scheduling professional meetings and development courses[10]. Professional journals are perused to stay current and up to date. Though receptionists and nurses often triage phone calls, most patients prefer to hear directly from their doctor and require a return phone call from the PCP for assurance. Several doctors interviewed estimated that they spend between 30% and 75% of their day on telephone calls, paperwork, and other activities that are non-reimbursable but necessary. However, some doctors express that the expectation (by insurance companies and patients themselves) of single-handedly coordinating lifestyle elements in addition to general medical issues for their patients is more frustrating than their lack of reimbursement for doing so.

PCP office-based practices nationally derive their revenue from Private Insurance (52.7%), Medicare (24.6%), Medicaid (14.3%) and other sources (8.2%). Most PCPs have either 3-10 (43.7%) or more than 10 (36.5%) managed care contracts. Essentially, most PCPs require the generation of revenue from private insurance, managed care sources, or direct fee-for-service since Medicaid and Medicare do not

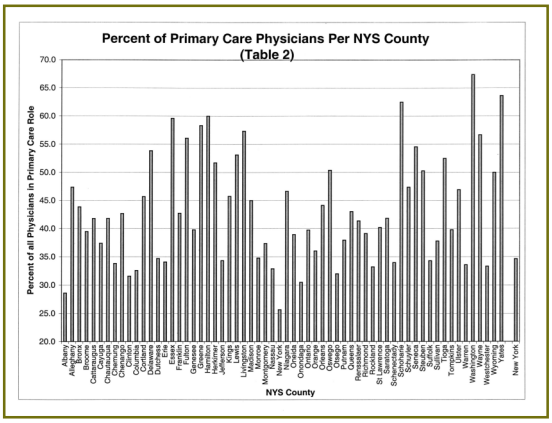


Table 2

compensate sufficiently to cover their overhead. In fact, Medicaid reimbursement for emergency department care in New York State is superior to that for outpatient primary care visits, creating a financial disincentive that works against the more efficient caregiver. This creates a serious monetary impediment for those providing primary care to the poor while simultaneously attempting to keep their "heads above water" financially. Given that 66.6% of PCPs were owners of their practices[6], many personally coordinate the distribution of this revenue towards such items as building lease and/or maintenance costs, allied professionals' salaries, office staff salaries, record keeping fees, the provision of health insurance for all employees, laboratory expenses, medical supplies and personal income, as well as medical liability insurance. When asked how private physicians acquire the business skills to negotiate their expenses, a typical answer is, "you learn as you go."

Relatively poor compensation is an impediment to growing a primary care workforce. On average PCPs (Family Practice, General Internal Medicine and Pediatrics) earn 65% of what medical specialists are compensated, and 45% of what surgical specialists are compensated[12,13]. In 2004, while specialists outside of primary care saw an 8% average pay raise, primary care physicians saw a 2.4% increase in salary[14]. This backward slide is expected to continue. Though Medicare reimbursement cuts have been held at bay for several years, cuts projected for 2007 will affect most doctors' salaries but will most heavily impact primary care physicians, decreasing what is already felt to be inadequate. As is currently projected, the Medicare system and the insurance systems that base their payment schedules by the Medicare yardstick will continue to favor episodic care over the coordinated cognitive services provided by PCPs.

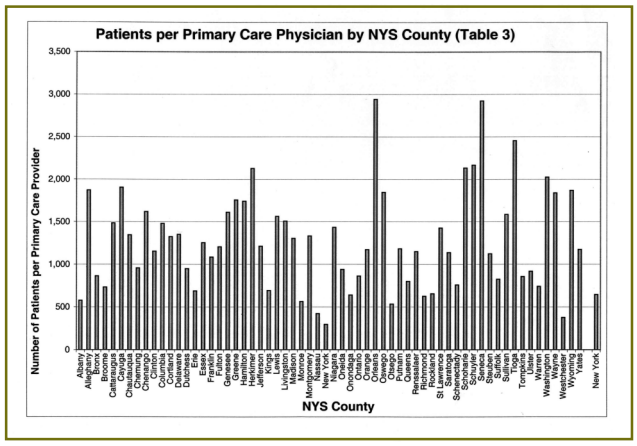


Table 3

The large workload, stresses of financially maintaining a practice, and poor reimbursements have led to significant career dissatisfaction. In a 2006 online poll of primary care physicians, published in *Medical Encounters*, 73% expressed regret that they had entered primary care[15]. Of these, 10% reported that the field "is not at all what I expected," while 63% said that "the compensation doesn't make up for the hours and stress." These figures bode poorly for the future of primary care: how do you attract new physicians to a field in which nearly three-fourths of the practitioners are unhappy in their current roles? In 2005, only 20% of third-year internal medicine residents planned to pursue careers in general internal medicine, compared to 54% in 1998. A 2005 survey of internal medicine physicians who received board certification in the late 1990s found that 21% who were practicing general internal medicine had left internal medicine practice entirely, compared with only 5% of subspecialty internists. In 2006, 19% of US medical school seniors (participating in the Match) matched to categorical IM residencies, and of the PGY-1 IM positions offered in the Match, 56.3% were filled by US seniors.

How To Become A Primary Care Physician

Becoming a primary care physician, as in becoming a physician in any other specialty in the United States, is a multi-step process:

- First, one must attend college and complete an undergraduate Bachelor's degree program that includes all the requirements needed to qualify for application to medical school.
- Next, one must complete a Medical Degree program (leading to either an M.D. or D.O. degree) at an accredited 4-year institution. The financial burden for college and medical school lies entirely with the student.
- After medical school, the new physician must undertake a three-year graduate medical education (GME) residency training program in Family Practice, Internal Medicine or Pediatrics, or a four year residency program for Obstetrics-Gynecology or a combined Medicine/Pediatrics specialty. Other specialties, such as plastic surgery and interventional cardiology, require more than four years of training after medical school. During residency, most young physicians are paid a low wage, but are guaranteed temporary immunity (deferment) from capital loan repayment.

Every step in this continuum of medical education presents a significant challenge to the development of a PCP who will remain a generalist for the entirety of his or her career.

At a basic level, even the socioeconomic status (SES) of those who have the opportunity to attend college in the United States can play a significant role in whether or not an interested individual will choose a career in primary care medicine. Studies have shown that physicians most likely to work in underserved areas tend to be those from a lower SES[16,17]. However, given the competitive nature of both undergraduate and medical school admissions, these are precisely the candidates at an academic and financial disadvantage. If accepted, these students accrue more debt during undergraduate education, which may negatively influence their willingness to take on the additional debt of medical school[18]. Students with more debt are less likely to choose lower paying careers such as primary care medicine.

Another pitfall in the development of a PCP involves the rigors of a "Pre-Med" curriculum in undergraduate college education. Emphasis on the biological and physical sciences in the Medical College Admissions Test (MCAT), as well as the traditional "weed-out" courses such as organic chemistry and calculus may ensure that an undergraduate student is capable of understanding the complexities of physiology [19,20]; however, there is no assurance that organized, social, humanistic, or business-savvy individuals will enter medicine. In recent years, medical school admissions officers have attempted to manipulate their usual "acceptance formula" to generate a more well rounded physician, including looking at age, gender, SES background, personality traits, and demonstrations of altruism such as volunteer work[7,16,20,21]. Ultimately, however, the inclusion of students with positive traits in these areas has not correlated significantly with a shift in the ultimate medical workforce or an increase in PCPs.

Medical school itself plays an incredibly significant factor in the decision to pursue primary care, however, not in the manner that most people believe. To date, much of the research on medical students and the choice of primary care has focused on debt[16,19,20,22,23,24,25]. Over the last 20 years, the average debt after medical school has increased from an average of $20K to approximately $120K[26,27].

Though debt does play an ultimate role in whether or not a new physician chooses to practice primary care medicine, numerous studies have shown that debt is not the only factor in the selection of which residency a student will pursue[16,20,23,24]. On average, medical students entering primary care have a lower debt than those entering surgery[23]. Whether this is due to a willingness to accrue more debt due to the expectation of a higher paying specialty, or due to the need to obtain a higher paying job as a result of more debt, is not definitively known. Regardless of the reason, students entering primary care seem to do so with more emphasis on lifestyle needs than on debt[21,23,24,28]: three years of residency training compared to five or more in other fields, allowing them quicker access to higher pay and the potential for more stability. The demographics of those entering primary care reflect this lifestyle component: older students, married students, women (especially in pediatrics), those wishing to return to their geographic homes more quickly, etc [6,29,30].

A more important factor in selecting a specialty for medical school students seems to be the prestige associated with the specialty[2,4,18,19,20]. Medical students rotate through each of several core specialties (e.g., Internal Medicine, Family Practice, Pediatrics, General Surgery, Obstetrics-Gynecology, Emergency Medicine, etc.) for one month or more during their final two years of medical school. Their exposure to traditional outpatient primary care medicine is, at best, limited. Several unintended messages are conveyed by such curricula. Many students, while shadowing outpatient doctors, witness what appear to be very busy, poorly coordinated practices that devote little time for the entire complement of preventative medicine services. The PCP physicians these impressionable students work with are often found to be harried, overworked, and disillusioned[2,19]. On inpatient wards in hospitals and medical centers during other rotations, students learn that there are many chronically ill patients who have been admitted, in part, because of the consequences of incomplete outpatient care or non-adherence to recommended medications and/or lifestyle changes. Compounding matters, specialty physicians are often vocal about their frustration with what they perceive as "under-competent" primary care physicians, further devaluing the latter in the eyes of the medical student.

Additionally, for students who chose to enter medicine because of its "intellectualism" or because of its constant provision of diagnostic and management challenges, the lack of potential research projects and research funding in the area of primary care medicine for overworked PCPs is seen as disheartening[19]. Though more funding is needed to research and improve overall patient flow and efficiency in primary care, this research is often allocated to public health professionals and economists rather than the primary care doctors who see patients on a day-to-day basis.

It is important to note that these factors working against the selection of a primary care medicine career are not unique to the specialties comprising primary care, and do not all play out the same way in specialty selection[31,32]. Internal medicine, for instance, is the largest medical specialty in the national resident matching program (NRMP), comprising 22% of all medical residents in the country[33]. While Internal Medicine may be seen as the more "prestigious" of the primary care specialties, as compared with Family Practice or Pediatrics, this is at the cost of nearly 2/3rds of those doctors going on to specialty training following three years of training in Internal Medicine[2]. Even with the perceived prestige, Internal Medicine is losing student interest. In 2006, while 98% of the internal medicine positions in the United States were filled, only 56% of these were filled by US medical graduates. International Medical Graduates (IMGs) filled the remaining positions[3,33].

In Pediatrics, while 96.5% of residency positions were filled, only 73% of these were filled by US medical graduates. Family practice (FP) has suffered the most of all primary care specialties[33]. In the last year, 50 fewer FP residency spots were available through the match, continuing a 5-year decline. Though 85% of the spots were filled (a slight improvement over last year), only 41% of these positions were held by US medical graduates.

Unfortunately, the choice of residency program is not the only obstacle preventing doctors from becoming primary care physicians. During residency training, all doctors are eligible to claim "financial hardship" in order to delay their medical school debt repayment until completion of their residency[26]. One projection estimated that by 2031, loan payments for attending physicians will be nearly 40% of a physician's after tax income for those who attended public schools, and 60% of their after-tax income for those who attended private medical schools[26]. A starting salary for a primary care physician currently averages between $111,000 and $118,000[9]. Between office leasing space, the purchase of new health information technologies and electronic medical records (EMRs), medical liability insurance, staffing and the incredibly steep loan repayment rates, many physicians are unable to make ends meet. Consulting firms offering to assist in the start up of an efficient practice may also charge several hundred dollars per hour. Even entering an established practice has its limits financially as it is usually standard for the newest partner to take on the toughest patients and call schedules to prove their worth and efficiency to the practice. It is no wonder then that many PCPs consider training in a specialty fellowship program (e.g., cardiology, gastroenterology, pulmonary medicine, etc.) or more lucrative careers outside of direct patient contact.

Historical Attempts At Promoting Primary Care Medicine

For many years, the preferred method for ensuring a stable supply of primary care physicians for the nation's citizens has focused on these doctors' student loan debt repayment. Federally, the National Health Service Corps and the Indian Health Services, as well as the Armed Forces, have offered financial assistance for medical students who make a year-by-year commitment to do at least 40 hours of primary care medicine in a federally-designated underserved area. New York State, in Public Health Law Article 9, has similar legislation in place though it has not been funded for some years[4]. Other methods have included the provision of financial incentives to medical schools and residency programs for increasing the number of trainees who enter and remain in primary care.

Although selected approaches showed some success in the 1990s by increasing the absolute numbers of PCPs, this number has not kept pace with the most recent physician supply projections or the needs of a growing and aging population[2]. In part, this failure may be attributable to inadequate funding of loan forgiveness programs. The dollar amount of annual forgiveness has been unable to keep pace with the rapidly increasing costs of medical education. Given the large number of factors influencing physician career choice, it is no surprise that loan forgiveness programs alone have proven to be inadequate in enticing physicians to practicing primary care.

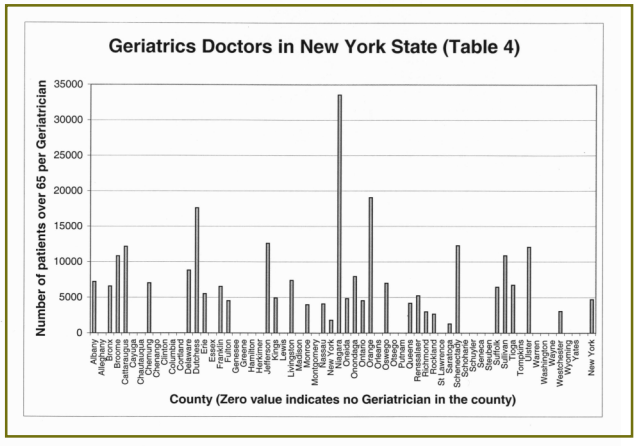
The State Of The State

While New York State remains ahead of much of the nation in producing and training primary care physicians it lags behind most of the country in the percentage of physicians actively involved practicing primary care[6,8]. In terms of overall per capita health care spending, New York is the second highest in the US, and while the state's contribution of Medicare expenditures to health care costs is 29th in the nation, the state's contribution of Medicaid ranks first. Despite allocating more dollars to Medicaid than any other state in the union, New York ranks 41st among states in terms of Medicaid reimbursement to physicians. The abundance of medical specialists and the lack of an adequate supply of primary care physicians drives patients to emergency departments and other more costly centers rather than through appropriate outpatient practices, further driving up the overall costs of health care.

Despite New York's admirable commitment to the health of its constituents, significant concerns remain. Only 17 counties of 62 in the state have the requisite 50% of their physicians involved in primary care[8]. Another 17 counties have fewer than 35% of their doctors involved in primary care. (See Table 2 on pg. 6). Additionally, 39 counties have greater than 1,000 individuals per a single primary care practitioner, and of these 7 have more than 2,000 individuals per doctor, far too many for a single physician to care for alone. (See Table 3 on pg. 7). Finally, in terms of the fastest growing segment of the population, 29 counties in New York do not have a single geriatrician (an internist or family practitioner with added specialty training in geriatrics) practicing in the county. In those that do, the ratio of geriatrician: citizen over the age of 65 ranges from 1:1287 to 1:33,581 (See Table 4). Ultimately, only a handful of counties have a sufficient percentage of their doctors involved in primary care (>50%), with enough PCPs to adequately cover their population (<1000 patients per physician) .

New York State's *Commission on Health Care Facilities in the 21st Century*, a task force established by Governor George Pataki and supported by the New York Legislature, released a comprehensive set of proposals on November 28, 2006 to improve health care delivery in the State. While the report's call to reorganize hospitals and others has garnered the most publicity and discussion, the Commission also stressed the need to strengthen primary care services. The report said New York should promote the development of primary and preventive care to generate savings which should be entirely reinvested in the health care system. It also called for investment in a primary care infrastructure, an assurance that all New Yorkers have access to a primary care "home" and the development of a robust primary care workforce[34].

Table 4



Potential Solutions

Improving the overall state of primary care in both the United States and in New York (as in the United States) will require a large effort from many different contributors, constituents, and stakeholders.

In the long term, improving the reimbursement schedules for PCPs is of prime importance[1,4,18]. While retroactive erasing of debt has done little to improve interest in the field, proactive improvement of reimbursement will ease the financial burden of those in private practice, improve morale among current PCPs, and will lend increased prestige to the field among medical students. While enhanced reimbursement for evaluation and management services by primary care physicians is urgently needed, more extensive reforms should be considered including:

A. Time-based reimbursement, as is in place in the legal profession, including time spent with patients on the phone, online, or in charting.

B. Improved reimbursement for efficient usage of EMRs, including electronic prescriptions, notes, referrals and e-mail responses to patient queries for billing purposes.

C. Case-based reimbursement, to provide a base fee for coordinating a patient's care. To improve continuity of care, and also to improve the quality of the interaction between a doctor and a patient, one variation may be to allow patients to chose any PCP they like (rather than selecting a physician from a limited list, as in a managed care arrangement) and the PCP to be reimbursed at an increasing rate for the amount of time the patient stays in their care. Patients with more chronic illnesses and more frequent visits will be categorized as more labor intensive "cases," subject to higher reimbursements.

A concept that embodies many of these approaches has been proposed by the American College of Physicians. Termed **"The Advanced Medical Home"**, such practices would provide comprehensive preventive and coordinated care centered on their patient's needs using health information technology and other practice innovations to assure high quality, accessible and efficient care[2].

In the longer term, U.S. allopathic and osteopathic medical schools and residency programs must do more to attract high quality candidates to primary care medicine, and larger amounts of funding should be given to those that are able to do so [1,2,3,18]. Some possible incentives that can be provided to increase the attractiveness of primary care include:

D. Increased funding for "primary care research" and training in academic fellowships in primary care for those who have completed residency training in Internal Medicine, Family Medicine or Pediatrics.

E. Improved hospital-practice relationships to provide positive role models to students and residents. (This must be accompanied by measures to make the practice of primary care more attractive.)

F. Improved exposure to rural medicine to ensure that a fair representation of this aspect of medicine is given to the students and residents.

G. Training programs should add training in business skills and exposure to practice management scenarios.

H. Lengthened repayment grace periods and/or lower educational loan interest rates for physicians entering primary care medicine after residency, allowing them to start up their practice before expenses become due.

I. Dramatically increase funding available for loan forgiveness and/or repayment programs for primary care doctors to accurately reflect medical school tuition costs and anticipated increases.

J. Reimburse GME residency programs more consistently for a resident's outpatient work, regardless of setting.

GME funding should be modified to remove impediments to educational innovations that encourage primary care. The current system penalizes institutions for time that residents spend outside the institution such as a private physician's office.

In the short term, improving the office efficiency of PCPs is likely to improve their career and job satisfaction rates and create more PCPs who serve as role models in the field with positive outlooks[1,18]. This can be accomplished in the following ways:

K. Grants need to be provided for new PCPs to facilitate and offset their practice start-up costs.

L. Grants need to be provided for PCPs to install and use HIT in their practices.

M. Grants or financial incentives for PCPs need to be provided to hire more allied health professionals (including nurse practitioners, physicians assistants, and/or social workers) in office practices to help assist and coordinate the provision of basic and routine medical care. This may include incentives to train community caretakers to enable home care.

N. Grants or financial incentives for PCPs need to be provided to improve their business skills, allowing them to develop novel solutions to their financial difficulties. Funding financial classes with practice consultants may help PCPs who would otherwise leave the field due to a lack of full understanding of the ways and means to manage a practice successfully.

O. Group visits need to be listed as a reimbursable activity that will enable a medical educator under PCP supervision to provide preventive care services for routine chronic diseases such as diabetes (diet management, home glucose monitoring), hypertension (teaching home blood pressure checks) or obstetric management (given by nurse practitioners).

This last option may create more open, efficient health environments and allow PCPs the opportunity to spend their office time focusing more directly on the truly ill. Though many doctors have health literature in their office, this is often insufficient to engage the patient in improving their overall long-term health. Preventative information, as is currently given, has been inadequate in terms of engaging the patients in preserving their own health[10].

Conclusion

Primary care physicians are necessary to provide basic, well-coordinated, high-quality management of each individual patient's current and potential health problems. These PCPs analyze symptoms, interpret physical exam findings and review laboratory results to discover and treat illness. They also teach patients, medical students and medical residents. They coordinate these illnesses as long as they are able, and seek the advice of expert specialists when necessary. However, in their current roles, they also do much more: personal counseling, family intervention, insurance negotiation, and general confidence building and reassurance for patients. They are both an advisor and a support system. Primary care physicians are unable to meet the expectations of all of their patients without adequate support, however. Given these findings, it is no wonder that the profession is increasingly unpopular among medical students. It is our hope that the suggestions provided in this report may help support new and existing primary care physicians and promote the field so that they may continue a role that is critical for both New York and the US health care systems.

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