

# The health care problem no one's talking about

While the nation focuses on expanding health coverage, growing numbers of insured Americans lack access to primary care. We've identified 8 barriers—and the means to overcome them.

**A**s the nation moves closer to a health reform bill designed to extend coverage to the vast majority of the uninsured, a key concern is being overlooked: Simply *having* health insurance—crucial as that is—is not enough. People also need *access* to care, particularly to primary care. Yet a growing body of evidence suggests that even among insured Americans, access to primary care is on the decline.

Consider the following:

- In 2005, more than 56 million Americans (nearly half of whom had some form of coverage) were “medically disenfranchised”—lacking sufficient access to primary care services. Two years later, that number had grown to 60 million.<sup>1</sup>
- In a 2006 national survey, little more than 1 in 4 adults (ages 18 to 64) said they could easily reach their doctors by phone, get after-hours care, or schedule timely office visits.<sup>2</sup>
- The number of medical school graduates in the United States choosing careers in family medicine fell from 2340 in 1997 to 1132 in 2006; during that same period, the percentage of internal medicine residents entering primary care dropped from 54% to 20%.<sup>3</sup>
- In 2008, nearly 30% of Medicare beneficiaries seeking a new primary care physician (PCP) reported difficulty finding a doctor—a 17% increase since 2006.<sup>4</sup>

## A shrinking pool of primary care physicians

Compared with other Western nations, the United States has a smaller proportion of its physician workforce engaged in primary care.<sup>5</sup> Shortages of PCPs already exist in numerous states, with Alabama, Alaska, Florida, Kansas, Mississippi, Missouri, Oregon, South Carolina, and Utah among them.<sup>1</sup> In the decade ahead, the Council on Graduate Medical Education, among other professional groups, expects the shortages to become more widespread and more severe.

■ **Recruiting PCPs is increasingly difficult**—something that comes as no surprise to physician recruiters. Merritt Hawkins, a large physician recruitment firm, reports that in 2005 the number of searches for open positions for PCPs exceeded searches for specialists for the first time.<sup>6</sup> And in 2006, nearly half of all primary care residents were contacted by recruiters more than 50 times. In a survey of physician groups that same year, 94% of respondents ranked either internists or family physicians as the most difficult to recruit.<sup>7</sup>

Nurse practitioners (NPs) and physician assistants (PAs) have been important contributors to the primary care workforce, but they, too, may soon be in shorter supply. That's especially true of PAs, given that less than one third (31%) of them are choosing careers in adult primary care.<sup>8</sup>

■ **Quality of care pays the price.** Ironi-

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**>**  
 As of 2007, some 60 million Americans were “medically disenfranchised”—that is, lacking sufficient access to primary care services.

cally, the shrinking pool of PCPs coincides with the growing recognition of the importance of the patient-centered medical home. There is increasing evidence, too, of the link between lack of access to primary care and higher mortality rates<sup>9</sup> and poorer outcomes.<sup>10</sup> Lack of access appears to have an adverse effect on health care spending, as well. While the administration searches for ways to lower the cost of care in order to pay for the expansion in coverage, directors of health plans and medical groups expect medical spending to rise as the looming PCP shortage leads to greater use of specialists and more emergency visits.<sup>11</sup>

### **A broader look at inadequate access**

The PCP shortage alone, however, is not the whole story. A number of other potent factors related to, but not the direct result of, the shortage contribute to the growing inability of insured Americans to have timely access to primary care. Chief among them are a mismatch between demand for appointments and physicians’ capacity to provide them, limited after-hours care, and organizational problems in primary care practices. We’ve identified the following barriers—and the policy changes and shifts in physician culture that are needed to overcome them.

#### **BARRIER #1**

##### **Panel size**

The average full-time primary care practitioner has an estimated panel of 2300 patients<sup>12</sup>—too many for a single physician to provide adequate patient care for, according to a recent study.<sup>13,14</sup> Some practices have excessively large panels because they’re located in areas with a shortage of primary care providers. (In an area with 25 PCPs per 100,000 population, for instance, the average panel size would be 4000.) Other practices accept too many patients in order to stay afloat financially. In either case, a situation in which the demand for appointments exceeds the available time slots impedes a patient’s ability to get timely care.

#### **BARRIER #2**

##### **Capacity**

The number of hours per week that a PCP sees

patients and the number of patients scheduled per hour determine that physician’s visit capacity. Quality of care is also at stake. Although physicians who schedule 1 patient every 10 or 15 minutes can, of course, accommodate more patients than doctors who spend 20 or 30 minutes per visit, shorter appointments have been found to adversely affect quality.<sup>15</sup>

Further complicating things is the increasing number of physicians who are opting for part-time work.<sup>16</sup> Added to the hospital and nursing home responsibilities many PCPs share, working fewer hours imposes further limits on the number of patients they can care for.

#### **BARRIER #3**

##### **Distance**

The uneven geographic distribution of PCPs makes access difficult for patients living at a distance from the nearest primary care practice, a particular problem for the homebound and those without transportation. Telemedicine could help mitigate this problem, but few primary care practices are equipped to practice “distance” medicine.

#### **BARRIER #4**

##### **Medicaid/Medicare issues**

Some primary care practices make decisions about which new patients to accept based on the kind of coverage held by the prospective patients. Medicaid patients have an especially difficult time finding a PCP—far harder than privately insured individuals. Also, in areas in which Medicare fees are below the market rates paid by private insurers, many practices limit the number of Medicare patients they accept.

The bottom line: Already stressed by the economy and low fees, some PCPs say they have little choice but to restrict the number of patients whose care costs them more than they’re paid to provide it.

#### **BARRIER #5**

##### **After-hours care**

Many patients try, unsuccessfully, to reach their PCP in the evening or on the weekend. The dearth of after-hours access has led to an

explosion of “convenience clinics” in pharmacies and shopping malls—and to overuse of the emergency department (ED). In a 2007 national survey, 67% of adults said they had difficulty getting care at night or on weekends unless they went to the ED.<sup>17</sup> In another survey, conducted in California in 2006, nearly half of those who sought care in the ED believed their condition could have been handled in a primary care setting, had it been available.<sup>18</sup>

#### **BARRIER #6**

### **Scheduling**

Many patients call their PCP's office for an appointment, only to find that the next available opening is 3 weeks away. While some groups have introduced open-access scheduling—also called same-day scheduling or advanced access—such a system can only be sustained if the demand for appointments is in balance with the practice's capacity to see patients.

Part of the problem appears to be organizational. Some physicians routinely make monthly follow-up appointments for patients with chronic conditions, such as hypertension, diabetes, or arthritis. However, the return visit interval is often based on the habits of the individual physician or provider group, rather than on the medical needs of the patients. Indeed, 1 study found that prolonging the visit interval resulted in an improvement rather than a decline in quality of care.<sup>19</sup>

#### **BARRIER #7**

### **Virtual visits**

Many chronic care and preventive care issues could be handled in brief patient encounters via telephone or e-mail. In addition to being convenient for many patients, such virtual visits would increase the practice's capacity for patients who require in-person visits.<sup>20</sup> Here, too, the problem is financial: Insurers generally do not provide reimbursement for virtual visits.

#### **BARRIER #8**

### **Troubles with team care**

At some medical groups, nonphysician providers, including registered nurses and phar-

macists, use doctor-created protocols and standing orders to address routine chronic care issues and preventive measures for individuals with certain conditions—identified via patient registries. Similarly, medical assistants and community health workers may be trained as health coaches to work with patients on behavior change and adherence to medication regimens, thus freeing up physician time.<sup>21</sup> Despite the benefits of team care, most insurers only reimburse the services of MDs, NPs and PAs, meaning that no incentives exist for primary care practices to hire other team members.

### **The solutions: Policy shifts and culture change**

What will it take to improve access to primary care and tear down these barriers? First and foremost, we believe the following policy changes are needed:

- Increase reimbursement for primary care.
- Increase loan repayment programs for medical students who establish primary care practices in areas with established shortages.
- Standardize fees paid by private insurers, Medicare, and Medicaid plans.
- Provide financial incentives for PCPs to deliver after-hours care.
- Invest in a national program aimed at helping primary care practices implement same-day scheduling, team care, and other access improvements.<sup>22</sup>
- Provide reimbursement for e-mail and telephone encounters and team care, including fees for all allied health professionals who assist PCPs in managing chronic disease and preventive care.

These reforms, if they were to truly come to pass, would ease much of the pressure on PCPs. No matter what policy changes are implemented to increase access to primary care, however, it is clear that a substantial culture change is required on the part of PCPs, as well. Physicians can begin to make changes on their own to increase patient access—expanding the interval between follow-up visits for stable patients, for instance, and reorganizing work schedules so that the practice can remain open for more hours.



**An inability to find adult primary care providers is expected to lead to greater use of specialists, more ED visits, and ultimately, increased medical spending.**

CONTINUED

It's clear that providing health insurance to the uninsured without guaranteeing access to primary care can turn a potentially positive development into widespread patient frustration. Unless Americans have greater access to primary care, we fear, the US health care sys-

tem will undergo significant change without substantial improvement. **JFP**

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**Open-access scheduling can only be sustained if the demand for appointments is in balance with the practice's capacity to see patients.**

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**1.5 CME/CE CREDITS**

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# Primary care access: The view from the trenches

by Helen Lippman, Managing Editor

When *The Journal of Family Practice* asked family physicians across the country whether access to primary care was a serious problem in their communities, the answer was a unanimous Yes. Each of the physicians we interviewed is taking steps to increase access. But all agree that the problems contributing to the growing crisis—including a shrinking pool of primary care physicians (PCPs)—are too big to be solved without a national policy shift.

"Physicians owe so much by the time they finish medical school that unless reimbursement is substantially increased, deciding on primary care will be a very difficult decision to make," says **KAROL DAVIS, MD**, a family physician (FP) at Heartland Primary Care in Kansas City, Kan.

**STANLEY KOZAKOWSKI, MD**, director of the Hunterdon Medical Center Family Medicine Residency in Flemington, NJ, echoes Davis's concern. "We need to address the inequities between the earnings of primary care and non-primary care physicians," he says, adding that by some accounts, what's needed is an increase in PCP salaries in the order of 60%.

But money is neither the sole problem, nor the sole solution. An advocate of the patient-centered medical home, Kozakowski would end the "hamster wheel model" of practice—in which PCPs squeeze more and more patients into shorter and shorter time slots, but can never catch up. To enable FPs to partner with and coordinate care for their patients, he maintains, "We need to redesign our system to support an advanced primary care model." In the model he envisions, a PCP's panel might be closer to 1000 than 2300.

That's in sharp contrast to the 3300-patient panel of **DAVID SWITZER, MD**. An FP with Page Healthcare Associates in rural Luray, Va, Switzer has spent the last 12 years in this community, a designated primary care shortage area. "As the population ages and fewer doctors go into primary care," he says, "the problem is only going to get worse."

## Improving access, 1 practice at a time

While Switzer agrees that "as a society, we need to figure out ways to make it more attractive for physicians to enter primary care disciplines," he also believes—as do the other FPs we spoke to—that increasing access is the responsibility of individual physicians, too.

With that in mind, his rural practice added 1 full-time and 1 half-time physician a year ago. That increased access in terms of "warm bodies," Switzer notes, "but we were hampered by space constraints because we had no additional exam rooms." The solution? The practice instituted staggered schedules, which resulted in opening up earlier in the morning and remaining open a little later in the day.

To further improve access, Switzer and his colleagues implemented an open-access scheduling system. "That has certainly made us more accessible than the conventional scheduling system we previously used," he acknowledges. "But when you're limited in terms of capacity, as we are, open access can only go so far."

If Switzer is not counting on health care reform to fix the PCP access problem, he is hopeful that the recent affiliation of his employer, Page Memorial Hospital, with a larger regional health system will make the group



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needs to be done to  
improve access to  
primary care?**

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more attractive to recruits over the next year or 2. “We now have access to capital to expand the office space, which will help increase our capacity,” he says. Equally helpful is the hospital’s new “convenient care” clinic, adjacent to the emergency department (ED), where patients can go for after-hours care at primary care—not ED—prices.

Heartland Primary Care in Kansas City runs its own urgent care clinic, which is open until 8 pm during the week and until 2 pm on Saturdays and Sundays. Although Davis rotates with several other physicians and nurse practitioners (NPs) in the practice (she works 1 evening a week and 1 weekend a month), after-hours care outside of the hospital is not the norm in their area.

“We routinely see patients at the clinic who have their own PCP, but their doctors close their doors at the end of the day and tell them if they’re sick to go to the ED or to our urgent care clinic,” Davis says. Those who choose the clinic, according to Davis, fare considerably better, in terms of convenience as well as costs: “We’ve gotten the wait down to a point where it’s usually less than 20 minutes,” she says. “At the ED down the street, I’m told, patients can wait as long as 3 hours.”

Davis has taken additional steps to improve patient access. After having a closed panel for 2 years, she hired an NP to help her work down the backlog and see more patients. Now she’s able to accommodate 2 new patients every workday. “I love meeting new people and would like to accept more new patients,” says Davis. But her panel size—now at 2700—is approaching the point where she may have to close it again.

While some FPs are frustrated by the focus of reform efforts, Davis sees the proposed legislation as an important first step. Another step in the right direction would be to institute reimbursement for electronic patient interactions, she adds, such as those supported by the patient portal Heartland is about to launch. Another key step: Require public and private health plans alike to pay higher fees for after-hours care.

“Plumbers get paid extra for working on Sundays,” Davis points out. “Why shouldn’t we?”

**KATE ROWLAND, MD**, an FP at Advocate Illinois Masonic Family Medicine Residency in Chicago, says that the residency clinic where she works has taken another step toward increasing access: The group has instituted formal walk-in hours. Between 8 and 10 am, established patients with acute care needs can come in without an appointment and be guaranteed that they’ll be seen by noon.

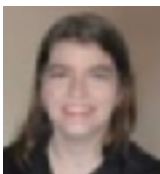
The new approach—a modified version of same-day scheduling—has been tremendously successful, she says, and relieved a good deal of pressure. Still, “We see some 3000 patients per month, and have just gotten busier and busier.”

### What else can be done?

Rowland favors taking small steps, 1 at a time: extending clinic hours (it is now open until 7 pm 2 evenings a week and from 8 am until noon on Saturdays); reallocating physician duties, as needed; and establishing classes for patients with similar issues, such as asthma and diabetes, among other innovations.

She maintains, however, that the US health system is devoted to curing disease and prolonging life rather than on keeping the population healthy. A major refocus is needed for lasting change to occur, Rowland says. But will governmental policy changes and physician culture shift in the right direction?

“Medicine is incredibly stagnant,” the 31-year-old Rowland says. “I wonder whether we’ll still have the same chaotic system when I’m ready to retire.” **JFP**



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