Primary Care: Can It Solve Employers' Health Care Dilemma?

Given primary care's association with reduced costs and better health outcomes, employers have good reason to prevent its demise.

by Martin-J. Sepulveda, Thomas Bodenheimer, and Paul Grundy

ABSTRACT: Employers are beginning to recognize that investing in the primary care foundation of the health care system may help address their problems of rising health care costs and uneven quality. Primary care faces a crisis as a growing number of U.S. medical graduates are avoiding primary care careers because of relatively low reimbursement and an unsatisfying work life. Yet a strong primary care sector has been associated with reduced health care costs and improved quality. Through the Patient-Centered Primary Care Collaborative and other efforts, some large employers are engaged in initiatives to strengthen primary care. [*Health Affairs* 27, no. 1 (2008): 151–158; 10.1377/hlthaff.27.1.151]

EMPLOYERS, AS DESCRIBED by Robert Galvin and Suzanne Delbanco, are "between a rock and a hard place."[1] The "rock" is that health care, once considered an ancillary issue for employers engaged in making cars or in providing banking services, is now recognized by employers to be central to strategic management of human capital.[2] The "hard place" is that although many employers are paying for their employees' health coverage, costs appear to be beyond their control, and quality varies from one health care provider to another.

Over the past twenty years, employers have tried a number of ways to climb out of the abyss lying between the rock and the hard place. Managed care, wellness and health promotion, free preventive care, value-based tiered networks, nurse advice lines, disease management, employee cost sharing, low-premium/high-deductible plans with health savings accounts—each of these strategies contains major flaws, and none is likely to eliminate employers' pain.[3] Yet one strategy—adopted by the health systems of virtually every developed country—is rarely discussed in the United States: investing in primary care.

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Research studies demonstrate that a strong primary care foundation to the health system can reduce costs and improve quality.[4] Yet U.S. primary care is underfunded and undervalued, which limits its effectiveness in cost and quality spheres. Employment-based health care coverage pays for more than 40 percent of total U.S. spending for personal health services.[5] With a common voice, employers have the clout to change health care priorities by demanding a strong primary care foundation. Over time, employers would reap benefits through stabilization of health care costs and increased worker productivity.

In this Commentary we address several key questions: What is primary care, and why is it experiencing hard times? What is the evidence that a strong primary care foundation can help control costs and improve quality? What can employers do to promote primary care?

What Is Primary Care?

Primary care is care provided by personal physicians—family physicians, general internists, and general pediatricians—who are responsible for the entire health of an individual or family. Working closely with these generalist physicians are nurse practitioners and physician assistants. Primary care is the patient's entry into the health care system and the medical "home" for ongoing, personalized care.[6]

Some people mistakenly believe that primary care physicians (PCPs) handle only simple things: making sure kids are immunized, treating sore throats and bladder infections, doing school and annual physicals. The truth is quite different. PCPs need a vast amount of medical knowledge because they care for patients with hundreds of conditions, including high blood pressure, heart disease, elevated cholesterol, liver disease, headache, memory loss, depression, and more. PCPs also coordinate the care of their patients throughout a confusing health care system: arranging for patients to get a magnetic resonance imaging (MRI) scan, choosing the right specialists, and helping the elderly navigate the pharmacy maze of Medicare Part D. In a recent survey, 94 percent of people wanted a personal physician who knows about their problems.[7]

The Threats To Primary Care

The U.S. health care system has never had a strong primary care foundation. Although 52 percent of visits to doctors in 2000 were to PCPs, only 35 percent of U.S. physicians practice primary care.[8] In most European nations and Canada, 50 percent of physicians provide primary care.

In 2006, the American College of Physicians, representing both PCPs and specialists, warned, "Primary care, the backbone of the nation's health care system, is at grave risk of collapse."[9] From 1997 to 2005, the number of U.S. medical school graduates entering family medicine residencies dropped by 50 percent.[10] In 1998, 54 percent of internal medicine residents planned careers in primary care rather

than specialty medicine; by 2004, only 25 percent entered primary care.[11] Over the past ten years, medical subspecialty fellowship positions have increased by 40 percent, and the number of hospitalists, many of whom are internists, has risen from 500 to 15,000. The proportion of patient care physicians in primary care has dropped from 1997 to 2005, while the proportion of specialists has increased.[12] Not only is the PCP pipeline drying up, but one study found that 21 percent of primary care internists are leaving their practices after only fifteen or twenty years.[13] Lower incomes and a stressful work life discourage medical students and young physicians from choosing primary care careers.[14]

While the influx of international medical graduates (IMGs) has mitigated these trends, the proportion of IMGs entering primary care careers declined from 2001 to 2005, with an increasing number migrating into specialty fields.[15] IMGs help serve the 20 percent of the U.S. population living in medically underserved areas, but health centers in those areas report many PCP vacancies and major challenges recruiting PCPs.[16] The percentage of patients unable to obtain a timely primary care appointment has grown rapidly over the past ten years.[17]

The income of PCPs, adjusted for inflation, dropped by 10.2 percent from 1995 to 2003, while the amount of work increased.[18] Median specialist income in 2004 was $297,000, which is 180 percent of primary care income ($162,000). Unadjusted for inflation, specialist income grew almost 4 percent per year from 1995 to 2004, while primary care income grew 2 percent per year. The income of major medical subspecialties is more than 200 percent of general internal medicine income, with gastroenterology and oncology income, $369,000 and $350,000, respectively, growing more than 7 percent per year during those years.[19] Thus, the primary care–specialty income gap is growing. A specialist spending thirty minutes performing a surgical procedure, a diagnostic test, or an imaging study is often paid three times as much as a PCP conducting a thirty-minute visit with a patient who has diabetes, heart failure, headache, or depression.[20] It is these realities that define the crisis of primary care.

Primary Care: Costs And Quality

Dozens of studies show that a strong primary care sector is associated with lower health care costs and improved quality. Peter Franks and Kevin Fiscella examined surveys from a nationally representative group of 13,270 adults who were asked if their personal physician was a PCP or a specialist. People with a PCP rather than a specialist as a personal physician had 33 percent lower annual health care spending and 19 percent lower mortality; cost and mortality data were adjusted for age, sex, ethnicity, health insurance status, reported diagnoses, and smoking status.[21] Other studies confirm that patients with a regular PCP have lower health care costs than those without.[22]

Michael Parchman and Steven Culler studied PCP-to-population ratios in twenty-six areas of Pennsylvania. Areas with more family physicians per capita

had lower hospitalization rates for several diagnoses than was the case in areas with fewer family physicians. For Medicare patients, hospitalization rates were 80 percent higher in areas with a shortage of PCPs than in other areas.[23] Countries with a greater proportion of their physicians practicing primary care medicine tend to have lower per capita health expenditures than those with a greater proportion of specialists.[24]

People with PCPs are more likely than those without PCPs to receive preventive services, to have better management of chronic illnesses, and to be satisfied with their care.[25] States with more PCPs per capita have lower total mortality rates, lower heart disease and cancer mortality rates, and higher life expectancy at birth compared with states that have fewer PCPs, adjusting for other factors such as age and per capita income.[26] In contrast, increases in specialist supply are associated with greater costs but not improved quality.[27]

In a remarkable study, Katherine Baicker and Amitabh Chandra examined Medicare data by state, using twenty-four quality indicators. States with more PCPs per capita had lower per capita Medicare costs and higher-quality care. States with more specialists per capita had lower-quality care and higher per capita Medicare expenditures.[28] All of these studies demonstrate that strong primary care is associated with reduced costs and better health outcomes.

Why Should Employers Care About Primary Care?

Employers can play an important role in building a strong primary care foundation for our health care system: Together with their employees, they pay for more than 40 percent of personal health care spending and face persistent premium escalations well in excess of wage increases.[29] Why should employers support a vibrant primary care sector? First, as the above evidence shows, primary care has the potential to contain health care costs, particularly by reducing ambulatory care–sensitive (ACS) hospital admissions, emergency department (ED) visits, and inappropriate specialty consultations. Second, prompt access to a well-functioning primary care "home" can improve employees' satisfaction with care, thereby reducing employers' need to handle employees' health care–related complaints. Finally, primary care is the site of most care for chronic conditions and has the potential to produce better patient outcomes and reduce the absenteeism and low productivity associated with chronic disease.[30]

Although their main concern is the cost of health care benefits, many employers, with their health plan vendors, have undertaken a range of quality initiatives that focus on care delivery: performance measurement; payment reform with "pay-for-performance"; and the initiatives of the Leapfrog Group, Bridges to Excellence, and other quality-focused organizations.[31] Employers should have an equally keen interest in undertaking initiatives to ensure that primary care is transformed into a sturdy foundation for the health care system. For primary care to realize its potential, however, it needs to return to its principles of continuous,

comprehensive, and integrated care and trusting relationships between caregivers and patients—elements that powerfully influence patients' behavior, decisions about how to use medical services, and clinical outcomes.[32] For primary care practices to accomplish these tasks, an adequate supply of clinicians and a quality-enhancing reimbursement structure are needed. Employers are becoming increasingly interested in addressing these practice-level issues.

What Can Employers Do To Address The Primary Care Crisis?

Rebuilding the primary care framework requires leadership with purchasing power.[33] Private-sector and government purchasers of health care—powerful forces for change—have this opportunity.

A few employers are applying reengineering methods to strengthen the availability of patient-centered primary care—for example, by supporting a patient-centered medical home model of care.[34] The Tax Relief and Health Care Act of 2006 authorizes primary care medical home demonstration projects, providing PCPs with care management fees and shared savings from positive health outcomes.[35] At the state level, the Community Care initiative of the North Carolina Department of Health and Human Services has sought to provide designated primary care medical homes to Medicaid recipients with chronic conditions.[36] On the private-sector side, early efforts in this arena include several initiatives.

■ **Patient-centered collaborative.** The Patient-Centered Primary Care Collaborative, a coalition of major employer and physician groups, represents more than 300,000 PCPs.[37] Its goals are to help transform how primary care is organized and financed to provide better patient outcomes; more appropriate payment to physicians; and better value, accountability, and transparency to purchasers and consumers. The collaborative has been active in integrating the primary care association models for medical homes to facilitate employer engagement; advocating in Congress for a central role for patient-centered primary care in all health care reform legislation; calling for governmental leadership through demonstration project funding of patient-centered primary care projects in Medicare; and creating a forum for diverse parties including employers, organizations such as AARP, providers, health plans, and others to collaborate in patient-centered primary care initiatives.

■ **National Business Group on Health.** The National Business Group on Health's workgroup on primary care was formed to develop strategies for employers to increase support for primary care. Its priorities for action are patient-centered medical homes, health information technology (IT) for practice transformation, payment policies that recognize the value of primary care services, and educational and loan programs that encourage physicians and other health professionals to work in primary care.[38]

■ **Individual employers.** Individual employers are mounting demonstration projects such as the IBM Corporation's patient-centered primary care initiative, which has engaged primary care providers such as the Austin Regional Clinic in

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Texas and Geisinger Health System in Pennsylvania. These are efforts to undertake primary care practice transformation and payment reform to deliver improved patient access, counseling/coaching, preventive care, care coordination, and chronic disease management within primary care medical homes. The American Academy of Family Physicians' TransforMED initiative and the American College of Physicians' Center for Practice Improvement are leading the practice transformation, change management, and evaluation components of the initiative.

Such approaches challenge the accepted wisdom that employers cannot directly engage caregivers in a buyer-producer dialogue. By structuring demonstration projects around medical-home models, willing primary care practices and employers can experiment with new modes of reimbursement that support prompt access, population management of chronic conditions, patient self-management support, electronic medical records (including personal health records), and care coordination between primary care practices and other sites of care.

Some employers are examining PCP reimbursement embedded in private health plans' contracting arrangements to understand how they have, perhaps inadvertently, reduced income for primary care doctors. The failure of PCPs' income to keep pace with that of specialists—aggravated by diminished influence in contracting negotiations compared to their specialist colleagues—contributes to driving down the supply of PCPs.[39] Employers can help stem the tide by building a more balanced allocation of spending between primary and specialty care into their health plan partner network and contracting strategies.

Employers are also key stakeholders in containing Medicare costs. For Medicare Part B, the galloping volumes of procedures and imaging services and the large discrepancy in Medicare costs among different regions of the country are driven to a large extent by high Medicare fees for certain medical specialties. As noted above, Medicare costs are lower when primary care, rather than specialty, resources are greater.[40] Employers have the opportunity to advocate for fixes to the Medicare cost problem that also remedy the disparity in payment for cognitive versus procedural services.

Placing Primary Care On Employers' Health Care Agenda

The primary care initiatives described here cannot by themselves solve employers' health care challenges. However, the crisis of primary care is conspicuously absent from the list of national priorities and scarcely visible on the private-sector agenda for health care reform. It has been easier for employers to support familiar, business-friendly processes, such as motivating healthier lifestyles or driving disclosure of prices and performance. In part, lack of interest in primary care is a

holdover from the early managed care years, with "primary care" eliciting—for employers and employees—negative visions of gatekeepers with financial incentives to restrict care. A primary care resurgence backed by employers would not return to those managed care failures.

Health care crises resulting from shortages of personnel—in this case, PCPs—take years or decades to resolve. The leadership of private-sector employers, understanding that they will benefit from an investment in primary care, is a key element in preventing primary care's demise.

NOTES

1. R.S. Galvin and S. Delbanco, "Between a Rock and a Hard Place: Understanding the Employer Mind-Set," *Health Affairs* 25, no. 6 (2006): 1548–1555.
2. P. Drucker, "They Are Not Employees, They're People," *Harvard Business Review* 80, no. 2 (2002): 70–77.
3. Galvin and Delbanco, "Between a Rock and a Hard Place."
4. K. Grumbach and T. Bodenheimer, "A Primary Care Home for Americans: Putting the House in Order," *Journal of the American Medical Association* 288, no. 7 (2002): 889–893.
5. A. Catlin et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs* 26, no. 1 (2007): 142–153.
6. J.C. Martin et al., "The Future of Family Medicine: A Collaborative Project of the Family Medicine Community," *Annals of Family Medicine* 2, no. 1 Supp. (2004): S3–S32; Grumbach and Bodenheimer, "A Primary Care Home for Americans"; and American College of Physicians, "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care," 2006, http://www.acponline.org/hpp/adv_med.pdf (accessed 3 October 2007).
7. K. Grumbach et al., "Resolving the Gatekeeper Conundrum: What Patients Value in Primary Care and Referrals to Specialists," *Journal of the American Medical Association* 282, no. 3 (1999): 261–266.
8. R. Graham et al., "Family Practice in the United States: A Status Report," *Journal of the American Medical Association* 288, no. 9 (2002): 1097–1101.
9. ACP, "The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health" (Philadelphia: ACP, 30 January 2006).
10. P.A. Pugno et al., "Results of the 2005 National Resident Matching Program: Family Medicine," *Family Medicine* 37, no. 8 (2005): 555–564.
11. C.P. West et al., "Changes in Career Decisions of Internal Medicine Residents during Training," *Annals of Internal Medicine* 145, no. 10 (2006): 774–779.
12. H.T. Tu and A.S. O'Malley, "Exodus of Male Physicians from Primary Care Drives Shift to Specialty Practice," Tracking Report no. 17, June 2007, http://www.hschange.org/CONTENT/934 (accessed 10 October 2007).
13. H.C. Sox, " Leaving (Internal) Medicine," *Annals of Internal Medicine* 144, no. 1 (2006): 57–58.
14. T. Bodenheimer, "Primary Care—Will It Survive?" *New England Journal of Medicine* 355, no. 9 (2006): 861–864.
15. Tu and O'Malley, "Exodus of Male Physicians."
16. R.A. Rosenblatt et al., "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," *Journal of the American Medical Association* 295, no. 9 (2006): 1042–1049.
17. B.C. Strunk and P.J. Cunningham, "Treading Water: Americans' Access to Needed Medical Care, 1997–2001," Tracking Report no. 1, March 2002, http://www.hschange.org/CONTENT/421 (accessed 10 October 2007).
18. H.T. Tu and P.B. Ginsburg, "Losing Ground: Physician Income, 1995–2003," Tracking Report no. 15, June 2006, http://www.hschange.org/CONTENT/851 (accessed 10 October 2007).
19. T. Bodenheimer et al., "The Primary Care–Specialty Income Gap: Why It Matters," *Annals of Internal Medicine* 146, no. 4 (2007): 301–306.
20. Ibid.
21. P. Franks and K. Fiscella, "Primary Care Physicians and Specialists as Personal Physicians: Health Care Ex-

penditures and Mortality Experience," *Journal of Family Practice* 47, no. 2 (1998): 105–109.

22. L.J. Weiss and J. Blustein, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans," *American Journal of Public Health* 86, no. 12 (1996): 1742–1747; J.M. De Maeseneer et al., "Provider Continuity in Family Medicine: Does It Make a Difference for Total Health Care Costs?" *Annals of Family Medicine* 1, no. 3 (2003): 144–148; and S. Greenfield et al., "Variations in Resource Utilization among Medical Specialties and Systems of Care: Results from the Medical Outcomes Study," *Journal of the American Medical Association* 267, no. 12 (1992): 1624–1630.
23. M.L. Parchman and S. Culler, "Primary Care Physicians and Avoidable Hospitalizations," *Journal of Family Practice* 39, no. 2 (1994): 123–128; and M.L. Parchman and S.D. Culler, "Preventable Hospitalizations in Primary Care Shortage Areas: An Analysis of Vulnerable Medicare Beneficiaries," *Archives of Family Medicine* 8, no. 6 (1999): 487–491.
24. B. Starfield, *Primary Care: Balancing Health Needs, Services, and Technology* (New York: Oxford University Press, 1998).
25. A.B. Bindman et al., "Primary Care and Receipt of Preventive Services," *Journal of General Internal Medicine* 11, no. 5 (1996): 269–276; D.G. Safran et al., "Linking Primary Care Performance to Outcomes of Care," *Journal of Family Practice* 47, no. 3 (1998): 213–220; and A.L. Stewart et al., "Primary Care and Patient Perceptions of Access to Care," *Journal of Family Practice* 44, no. 2 (1997): 177–185.
26. Starfield, *Primary Care.*
27. B. Starfield et al., "The Effects of Specialist Supply on Populations' Health: Assessing the Evidence," *Health Affairs* 24 (2005): w97–w107 (published online 15 March 2005; 10.1377/hlthaff.w5.97).
28. K. Baicker and A. Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* 23 (2004): w184–w197 (published online 7 April 2004; 10.1377/hlthaff.w4.184).
29. Catlin et al., "National Health Spending in 2005"; and G. Claxton et al., "Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest," *Health Affairs* 25 (2006): w476–w485 (published online 26 September 2006; 10.1377/hlthaff.25.w476).
30. R.Z. Goetzel et al., "Health and Productivity Management: Establishing Key Performance Measures, Benchmarks, and Best Practices," *Journal of Occupational and Environmental Medicine* 43, no. 1 (2001): 10–17.
31. R.S. Galvin et al., "Has the Leapfrog Group Had an Impact on the Health Care Market? *Health Affairs* 24, no. 1 (2005): 228–233; J. Hahn, "Pay-for-Performance in Health Care" (Washington: Congressional Research Service, 12 December 2006); Bridges to Excellence home page, http://www.bridgestoexcellence.org; and Integrated Healthcare Association, "Top Performing Physician Groups," Press Release, 5 October 2006, http://www.iha.org/p4ptoprf.htm (accessed 4 October 2007).
32. K. Davis, S.C. Schoenbaum, and A.M. Audet, "A 2020 Vision of Patient-Centered Primary Care," *Journal of General Internal Medicine* 20, no. 10 (2005): 953–957.
33. Pacific Business Group on Health, "Value-Based Purchasing," http://www.pbgh.org/programs/value_based_purchasing.asp (accessed 18 September 2007).
34. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, "Joint Principles of the Patient-Centered Medical Home," March 2007, http://www.medicalhomeinfo.org/Joint%20Statement.pdf (accessed 4 October 2007).
35. *Tax Relief and Health Care Act of 2006,* H.R. 6111, Division B, Title II—Energy Tax Provisions, Section 204, http://www.rules.house.gov/109_2nd/text/hr6111/1092nd_hr6111.pdf (accessed 4 October 2007).
36. L.A. Dobson, "Community Care of North Carolina: Improving Medicaid Quality and Controlling Costs by Building Community Systems of Care" (Presentation of the ERISA Industry Committee at the Patient-Centered Primary Care Roundtable, Washington, D.C., 12 March 2007).
37. ERISA Industry Committee, "ERIC Announces Release of Patient-Centered Primary Care Collaborative Principles," Press Release, 10 May 2007, http://www.eric.org/forms/documents/DocumentFormPublic/viewDoc?id=B3470000000F (accessed 4 October 2007).
38. National Business Group on Health, "National Health Care Reform: The Position of the National Business Group on Health," July 2006, http://www.businessgrouphealth.org/pdfs/nationalhealthcarereformpositionstatement.pdf (accessed 18 September 2007).
39. Bodenheimer et al., "The Primary Care–Specialty Income Gap."
40. Baicker and Chandra, "Medicare Spending."