

# The Continuing Need for Primary Healthcare as Our Systems of Care Evolve

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**A**FTER ALMOST 20 YEARS as a family physician in a small town and involvement in academic and organized medicine, I still believe that the primary care physician is as relevant and necessary today as ever. Many experts are again predicting the general demise of primary care and family medicine in particular, replaced by increasing technology, other healthcare workers, disease-specific clinics, and direct access to specialists. This prediction has been made at least two other times that I remember over the last two decades. Yet primary care remains the cornerstone of access to the healthcare system in North Carolina and an essential ingredient to any meaningful healthcare reform. This is played out all over the state where family physicians and other primary care providers continue to care for their patients in rural and underserved areas, make home visits, visit nursing homes, serve as team doctors, provide hospital care, volunteer, and are involved in their communities.

The doctor-patient relationship is alive and well, and it is evident daily at the local grocery, school function, and church as well as in the office. Yet primary care has failed to achieve the role in the larger healthcare system that was anticipated for it in the 1990s. A major reason for this failure has been the lack of investment in practice systems development to assure quality population management. Primary care practices have encountered increasing administrative burdens coupled with declining reimbursement and higher practice overhead. Despite these obstacles, our state is still blessed with an army of motivated and dedicated primary care physicians serving its citizens. The debate on the issues and difficulties facing the healthcare system should therefore focus not on the *relevance* of primary care but rather on how best to overcome the obstacles in achieving a system that delivers the key attributes of primary care as defined in the 1978 Institute of Medicine report.

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To achieve the ultimate goal of improving the health care for all our citizens, primary care is essential. Despite the major accomplishments of the early 1990s in increasing the supply of primary care physicians and midlevel providers in North Carolina through an emphasis in our residency programs and medical schools, this success has not universally translated into improved access to care for all North Carolina citizens.

Over the past decade, the number of NC citizens who are uninsured has gradually risen by more than 200,000 to well over a million.<sup>1</sup> This increase is more significant since it occurred during the same time period that NC provided increased coverage to the disadvantaged and to children through the Medicaid and S-CHIP (NC Health Choice) programs. The distribution of the uninsured, while a state-wide problem, is heavily concentrated in some of our most rural and “distressed” counties. The areas of most distress also correspond to some of the areas of most severe primary care shortage. In a study done by the Robert Graham Center for Health Policy in Washington, DC, the removal of family physicians alone from the NC healthcare workforce would result in 39 additional counties with critical shortages of healthcare, resulting in over 60% of the counties in NC being designated whole-county PCHPSAs (Primary Care Health Professional Shortage Areas). Primary care is critical to basic healthcare access in most of NC.

In general, NC’s rural population is older, and getting more so compared to metropolitan counties, and many of these people have complex medical problems requiring intense physician management and care coordination. It is estimated that, by 2020, the percentage of population in rural counties aged 55 years and older will exceed that in urban counties.<sup>2</sup> This advancing age, and the health care needs of this population, will place additional burdens on an already marginal delivery system in our rural communities and on the financially distressed primary care physician.

Despite a unique and widely distributed system of community and rural health centers and other safety net providers, including local public health departments, all but a few counties continue to have unmet health care needs.

**Table. Source of ambulatory medical care for selected common diseases in the US<sup>3</sup>**

Condition	Family physician	General internal medicine	Pediatrics	Other
Heart disease	27%	30%	0%	43%
Stroke	36%	22%	0%	42%
Hypertension	43%	38%	1%	18%
Diabetes	37%	31%	0.2%	32%
Cancer	7%	13%	1%	79%
COPD	41%	43%	1%	15%
Asthma	28%	28%	1%	44%
Depression	25%	13%	1.2%	60%

Problems of transportation, hours of operation, poverty, and limited community resources for nonmedical needs all contribute to the shortfall. The problem facing us may no longer be simply one of basic access for specific counties but rather access for specific subpopulations throughout the state. Clearly, the primary care system is very relevant to achieving healthcare access for all NC citizens.

Increasing healthcare costs and the most recent changes in managed care have now redirected our attention from *utilization control* to *disease management*. These initiatives in standardizing care promise to bring about quality improvement and long-term savings to the health system. The major question now is how best to motivate system change in a healthcare system so resistant to change. Many insurance companies have become more interested in prevention and providing direct “disease-management” programs. While often well intentioned, these programs have established relationships with the patient separate and distinct from the clinician. The information from these encounters often doesn’t get into the patient chart or physician-patient conversations during normal office visits; thus it contributes little to the primary care physician’s ability to provide continuity of care for the patient or to develop lasting system change. New disease-specific clinics have shown improved results with regard to the specific conditions they treat, but it is unclear whether they are actually more cost-effective when considered in the context of the patient’s overall healthcare costs, providing care to the entire population of NC, or serving patients with more than one chronic disease. Clearly there is not an adequate supply of specialists to serve NC citizens in the absence of primary care, and the supply is certainly not distributed in a way to provide access to all citizens. To exclude the primary care physician is to ignore a great resource in this quality movement. Looking at the most

frequent chronic diseases that affect the population nationwide, who is the patient’s major source of care for these conditions? It is still the primary care physician (See Table).<sup>3</sup>

Despite the often-fragmented delivery system of healthcare, family physicians and other primary care providers are present in the state’s neediest communities and are caring for their citizens. The opportunity exists to make a difference in the health status of North Carolinians by supporting and enhancing our fragile primary care system. Yet little has been invested in systems to assist the primary care physician in doing a better job. Future technology and information systems, such as affordable electronic medical records, hold the promise of improving the primary care of all populations.

The NC Medicaid program has successfully launched an aggressive pilot program (ACCESS II & III) designed to improve access and quality of healthcare to the poor and underserved by linking and supporting community-based systems of care. The key partners in this public/private partnership are primary care physicians (family practitioners, pediatricians, internists, obstetricians-gynecologists), health departments, hospitals, and local departments of social services. The development of supported case and care management initiatives utilizing the primary care system has shown impressive early results in improving quality while decreasing costs.

It is my hope that our healthcare system will succeed in overcoming the many obstacles facing primary care in North Carolina today. This must include payment equity, increased rural physician support, positive rewards for population-based outcomes, primary care information management system development, decreased administrative hassles, renewed emphasis on primary care provider production and distribution, and an increased spirit of collaboration among all NC healthcare providers to improve healthcare. If we are to provide quality healthcare to all North Carolinians and to deliver on the level of care defined in the 1978 IOM report, then we must make primary care very relevant.

#### REFERENCES

- 1 North Carolina Medical Society, Task Force on Health Care Access, 2001.
- 2 North Carolina State Data Center, 2002.
- 3 National Ambulatory Medical Care Survey, National Center for Health Statistics, 1996.