The Cycle of Interest in Primary Care

When Does a Recession Become a Depression?

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CONSIDER THIS QUESTION from a second-year family practice resident: *I grew up in Eastern North Carolina, and I have always wanted to go back to my community or one like it. They are very poor, and need help. But, with everything I'm hearing, I am wondering whether I will have a job in 5 or 10 years. Will I be able to go back to my community and be able to live there with my family?*

At first glance, the ebb and flow of primary care seems like the business cycle: boom in the '70s, bust in the '80s, boom in the early '90s, and now bust again. Despite a reaffirmation by the Institute of Medicine of the principles of primary care in 1996,[1] primary care seems no closer to the center of healthcare now than it did. Meanwhile, evidence accumulates that countries with organized primary care have better health outcomes, better patient satisfaction, and lower cost.[2] So…what is new now? When does a "recession" in primary care become a depression? I believe that the current crisis in primary care is much more significant than previous ones, because it involves not just cost but also access, outcomes, and the integrity of the profession as a whole.

Cost is certainly part of the problem. In the early '90s, managed care with an emphasis on primary care in a gatekeeping role succeeded in decreasing the rate of growth of expenditures, even as the growing economy reduced the apparent percentage of the GNP devoted to healthcare. In recent years, however, the cost of healthcare has reverted to its historical post-Medicare pattern, rising at double-digit rates. And, in the US, patients and employers bear the burden directly. Table 1 shows the recent increases in charges for the North Carolina State Employee Health Plan, one of the largest insurers in the state and representative of the trend. Family coverage is very expensive—and the figures in the Table do not include the deductibles and copays for physicians, hospital care and medications which are increasing sharply.

Table. Charges for health insurance/North Carolina State Employees Health Plan monthly premiums (total employee and employer contribution)

	Individual coverage	*Family coverage*
1991-1998	$ 144.60	$ 216.60
1999-2000	187.98	281.04
2001-2003	244.38	609.74

These price rises partially explain a second phenomenon of the nineties: an increase in the number of uninsured despite a record-breaking economic expansion. Nationally and in North Carolina, the number of the uninsured increased through almost the entire boom, and has spiked again with the recession and the effects of 9/11. Access to care remains a major problem. The issue is not access to specialty services such as PET scans and transplants but rather access to basic care for the diseases that cause the vast majority of suffering of the population of North Carolina: diabetes, heart disease, trauma, mental illness, cancer, and others. Access to care is particularly important in North Carolina, as this state's health status continues to be among the worst in the country. Our highly rural population and surging numbers of elderly and Hispanic residents will further hinder efforts to improve the health of the population.

Primary care provides an important safety net for these patients. Yet family physicians and their primary care colleagues are themselves facing a financial crisis. Reimbursement for primary care is dropping significantly, as Dr. Estes

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notes in his paper elsewhere in this issue, and government regulation has limited income from ancillary services like laboratory examinations. Often missing from the discussion is an understanding that primary care practices are small businesses that must make payroll in order to keep providing care. In recent years, the costs of care have increased dramatically—requiring additional staff to respond to insurance claims, computerize practices, and meet increased premiums for medical liability insurance and the costs of HIPAA. Most citizens understand what must inevitably happen to a business when revenue drops and costs rise. A first step is limiting care to patients who can pay. And then…loans, bankruptcy, and finally the closing of the practice, with all of its implications for the community. The safety net itself is at risk.[3]

Our coming crisis is about more than cost and access, however; it is also about the outcomes of care and the structure of our clinical research. We live in an age of press conferences about large randomized trials that promise to improve health outcomes dramatically. Unfortunately, the emperor has no—or, at best, few—clothes. The reach of modern medicine far exceeds its grasp, and, despite breathtaking increases in cost, improvements in health status for most of the population remain modest. Part of the explanation of this gap is the way we do research: since the Flexner report reforming medical schools early in the last century, our medical schools have been organized to do research around the basic mechanisms of disease. In recent years, we have begun to emphasize randomized clinical trials of specific therapies. While this approach to science has yielded important benefits, it is incomplete and does not directly serve the immediate interests of our patients. Clinical trials tend to focus on efficacy—the benefit of a therapy under ideal conditions—rather than effectiveness—the benefit of a therapy with actual patients in actual communities. To improve health outcomes for the latter, we have to focus on improving the care of all patients, not just those who are carefully selected, receive free medications and medical care, and get regular communications to remind them to come to the office and to take their medications. How care is organized, who gets it, and what actually happens to patients are the focus of the discipline of health services research. Our relative inattention to it sharply limits our ability to improve the outcomes of medical care to the population.

This intellectual crisis of our profession is parallelled by a moral and spiritual crisis. About a year ago, JAMA published a trial comparing celecoxib with other NSAIDS and concluding that, over a six-month time frame,[4] the new agent caused fewer ulcers. It subsequently emerged, however, that the company filed information with the FDA on the same set of subjects indicating no advantages with the new agent when the analysis was extended to 12 months. The editors of JAMA responded firmly, but the incident remains a dramatic example of the rising tension between commercial interests and the scientific integrity of our academic medical centers.

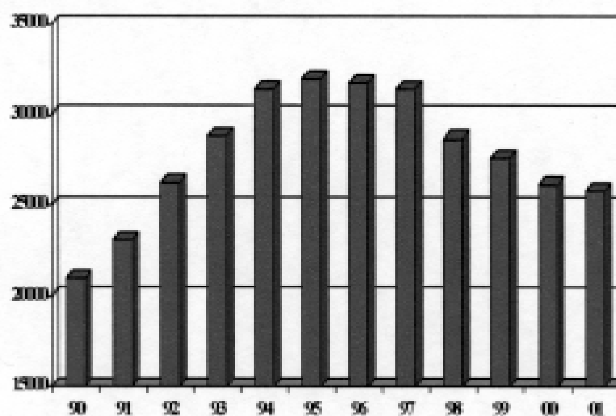

Figure 1. Applicants to medical school 1990-2001

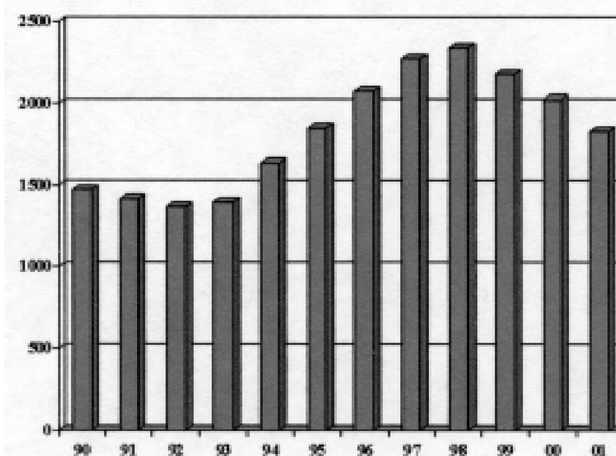

Figure 2. American medical students who matched in family practice, 1990-2001

A broader issue is our profession's commitment to service. As Figures 1 and 2 depict, the number of students applying to medical school has dropped rapidly in recent years, paralleling the drop in fourth-year US medical students who choose Family Medicine. While many factors have contributed to this trend—including the hassles of managed care and the liability crisis—I believe that one important factor is the perception that our commitment as a profession to serving our patients and communities is waning. If potential applicants with a commitment to service see a profession unmoored from its patients and guided by commercial interests, why should they join?

An Answer to the Resident: *I believe very strongly that you will indeed have a job in 10 years. Barring fundamental changes in the organization and culture of health care, it will be very difficult to practice primary care in the way that will best benefit your patients and your community. But the need will*

remain for the key attributes of primary care: access, comprehensiveness, effectiveness, continuity and coordination. In the end, the people will demand these functions and will want clinicians who can provide them close to home and at a reasonable cost. And we physicians have a responsibility to organize ourselves on behalf of our patients to make these happen, using all of the tools we have developed since the first report of the Institute of Medicine.

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