

## PRESIDENT'S COLUMN

## Policy That Would Help Make Primary Care Primary

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A few days ago, I heard a story that reminded me again how far we are from having primary care that works. Jane (not her real name), a very fit woman in her 40s, volunteered for a clinical research study, and a protocol-based colonoscopy detected an adenomatous polyp. She was referred to a series of specialists, leading to 55 medical visits over the ensuing one-year period. She underwent many high-tech imaging studies, tests, procedures, and several operations, only one of which was clearly indicated. (Although it was, in retrospect, unnecessary, the colectomy showed that the polyp already had been successfully removed by colonoscopy.) Her life was completely disrupted, huge amounts of money were spent by her and her insurers, and yet arguably nothing ultimately helpful was done.

This was bad for Jane and bad for society, but it was a natural consequence of our current medical care system. There are many reasons for such cascades of evaluations, tests, and procedures leading to waste and often net harm. However, key among the causes for Jane was the lack of a primary care physician to act as her advisor and advocate as she tumbled down the medical cascade. Indeed, in the past, Jane had primary care physicians, but when she moved years before she never got another one—feeling that even if well-meaning, they often were not available for her when she wanted access and that the visits were too short to illustrate to her the value of primary care. So in the middle of this cascade, this very bright woman didn't even think about having a primary care physician who might have advocated for a less

specialty-driven path of evaluations and interventions.

In our daily practice, we all know that our ability to provide personalized primary care of this sort is severely compromised by many circumstances, and while we are disappointed, we are not surprised by what happened to Jane. Why is this the case? It's not the intent of general internists, or other primary care clinicians, to shortchange patients in terms of time, attention, or access—but that is the case. In fact, this is the direct result of policy decisions made by the government, payers, and our profession. What is SGIM doing to address this?

Certainly part of the situation is due to inadequate support for training of primary care physicians. SGIM has been a strong supporter of Title VII HRSA funding for primary care training, advocating on our own and as part of coalitions to protect and grow the crucial funding for these programs. We were delighted to see these programs reauthorized at higher levels by the Affordable Care Act (ACA) and the Training in Primary Care Medicine portion increased from \$39 million in FY11 to the President's recommendation of \$52 million for FY12—plus \$86 million from the prevention and public health fund. However, what will come out of the Congressional appropriations process now is uncertain and worrisome. Unfortunately, this will be driven by overall budgetary goals and a balance between the Senate's understanding of the importance of primary care and the House's aversion to funding anything related to the ACA. At this point, the Senate Appropriations Committee recommenda-

tion for FY12 is the same as this year's \$39 million; a bill introduced in the House, which was never considered by the committee, would eliminate the primary care training program. This is not the picture of a coherent march toward training more primary care physicians, so SGIM continues to advocate for needed stable increases in this program.

Even as some House Republicans try to disassemble provisions and funding of the ACA, we should acknowledge the great improvements to address the primary care physician shortage that are embedded in this historic legislation. The inclusion in the ACA of the 10% Medicare bonus payment for primary care services and upward adjustments in Medicaid reimbursement, although not on a scale to be a sea change and not permanent, could start correcting the currently insufficient financial compensation and security that deters medical students from undertaking careers in primary care. Also, various new organizational approaches to health care hold some hope of re-balancing payment for primary care relative to other care, which also may mitigate the disincentives for entering primary care. SGIM and its membership, outside and inside the government, were deeply involved in including these favorable provisions in the ACA, and we will do whatever we can to help preserve and implement this important legislation.

Another way SGIM is trying to address the poor circumstances for primary care is by the creation of the National Commission on Physician Payment Reform. The Commission will address the central role that pri-

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mary care should have in situations like Jane's—physicians' dual responsibilities to their patients, who deserve the best care possible, and to society, which deserves careful stewardship of its resources. The Commission will start very soon and is to be led by two very prominent physician leaders in American health care, with members representing primary care, subspecialties, and other societal stakeholders. The Commission will develop recommendations that align these dual responsibilities and help eliminate the contributions due to payments to unnecessary and uncoordinated care. We hope to have these recommendations out in about a year, and we hope they will engender wide comment and support.

In the meantime, SGIM strongly supports efforts such as those by the American Academy of Family Physicians to correct the longstanding imbalances created by the AMA

Relative Value Update Committee (RUC) in the payments for subspecialty care, procedures, and diagnostic tests relative to primary care. (SGIM has no seat on the RUC, but family medicine does, and thus we support their protest from that seat.) We could have predicted the impact on health care of the incentives built into the payments suggested by the RUC and embedded in the Medicare payment system. Now that we have the clear result, the experiment continues to run anyway. It's time to respond to the results. We must do whatever we can to address this problem.

Unfortunately, just as our nation has started to address the factors that contribute to the current situation in primary care, there is intent to snatch defeat from the jaws of the ACA victory. We, and Jane, know that this is bad for our patients and for our nation. We need to redouble

our efforts to communicate about and advocate for reform of the payment system to mitigate its perverse incentives and to be sure all Americans have access to primary (and other) care. SGIM is completely committed to this, and our members must be, too. We must constantly remind our elected officials of the need to improve the situation for primary care. (Background information can be obtained from the health policy tab on our website <http://www.sgim.org>.) Our best care of our own patients is important, but without a change in policy, Jane and many other citizens will continue to get way more care than they need because they received too little primary care. It is our responsibility in the care of patients generally to work to improve this situation. I look forward to hearing from SGIM members' experiences in addressing this issue.

*SGIM*