

Primary Care Medicine in Crisis: Toward Reconstruction and Renewal

Gordon Moore, MD, MPH, and Jonathan Showstack, PhD, MPH

Primary care is in crisis. Despite its proud history and theoretical advantages, the field has failed to hold its own among medical specialties. While the rest of medicine promises technology and sophistication, the basic model of primary care has changed little over the past half-century. Why has the transition from general practice to today's primary care been so difficult? Many of the causes of this struggle may lie within primary care itself, ranging from failure to articulate to the public (and insurers and policy-makers) what value it, and it alone, can offer, to taking on an ever-broadening set of roles and responsibilities while all too often falling short of its promises. Perhaps most important, in the emerging health care system, the lack of a discrete definition of

primary care has allowed managed care organizations and payers, among others, to define the role of primary care to suit their own interests.

In response to a changing marketplace, political uncertainty, and shifting consumer expectations, primary care will need to reconstruct itself. The reconstruction will not be easy. Nevertheless, a process should begin that moves the field in the right direction. Building on its unique abilities, primary care can emerge as a redefined product that is attractive to patients, payers, and primary care practitioners alike.

Ann Intern Med. 2003;138:244-247.

www.annals.org

For author affiliations, see end of text.

Primary care is in crisis. The behavioral and economic evidence is ubiquitous (1). Patients are voting with their feet and pocketbooks by going directly to emergency departments and specialists (2, 3). After promoting primary care as the manager of access to specialty care, health maintenance organizations have backed off their gatekeeping strategy for such referrals. Alternative providers are an attractive and heavily used substitute for traditional providers (4, 5). Incomes of primary care physicians have decreased, and insurance companies are stripping payment for some types of primary care services out of benefit packages (6). Primary care residencies fail to attract enough applicants, while teaching hospitals continue to withdraw much-needed support for their primary care clinics. Despite primary care's proud history and theoretical advantages, the field has failed to hold its own among medical specialties.

Why has the transition from general practice to today's primary care been so difficult? Our thesis holds that many of the causes of this struggle lie within primary care itself, ranging from its failure to articulate to the public (and insurers and policymakers) what value it, and it alone, can offer, to taking on an ever-broadening set of roles and responsibilities while all too often falling short of its promises. Waiting times for primary care appointments are long, clinicians appear rushed and harried, and many patient problems are still referred to specialists. The lack of a discrete definition of primary care has allowed managed care organizations and payers, among others, to define primary care's role to suit their own interests (7). What started in the 1960s as an enlightened concept of a new type of generalist has, in many cases, deteriorated to filling in random gaps in an increasingly dysfunctional system. For primary care to gain control of its destiny, a newly reconstructed role must be developed that matches primary care's strengths with the needs of patients, the medical care system, and society.

THE EMERGENCE OF TODAY'S PRIMARY CARE

Until the middle of the 20th century, the general practitioner was the most common type of physician in the

United States. In cultural lore, the general practitioner was available 24 hours a day, healing the sick and aiding the needy. He was a scion of his community, avuncular, and friend of his patients in good and bad times. Over the past half-century, increased specialization in medicine and a greatly broadened role for the health care system produced changes in both the definition and the role of general practice (8). The romantic image has faded, largely displaced because of the stunning clinical successes of scientific medicine. The idealized doctor became the white-jacketed specialist, explaining the latest medical advance on the network news and performing medical miracles.

Partly in reaction to the trend toward specialization, by the late 1960s the term *primary care* began to be used to denote a new type of generalist, one who was better trained and would play important roles as the first contact for care, advocate for patients, and intermediary between patients and the increasingly complex and specialized health care system. This definition of primary care, however, was based on an idealistic conceptual framework that matches neither the realities of current U.S. medical care organization and finances nor the preferences of patients and physicians. From the early days of the transition from general practice, such definitions of primary care emphasized wide-ranging roles and responsibilities (often including such adjectives as "accessible," "comprehensive," "coordinated," "continuous," and "accountable" [9]), a set of characteristics that often proved to be burdensome and unrealistic.

CHALLENGES TO PRIMARY CARE

Perhaps not surprisingly, many of the hoped-for benefits and rewards from development of the new field of primary care have not materialized. Ironically, in the current health care quagmire, patients' desires for a physician who is accessible and an advocate and coordinator of their care highlight the potential importance of primary care while at the same time making primary care's "failure" all the more disappointing and apparent to patients. Primary

care now faces additional challenges, some of which may threaten its very existence. These threats include increasing fragmentation, growing competition, changing consumer preferences, the advent of “population” models of care, adverse changes in payment systems, the emergence of new primary care subspecialties such as hospitalists, and new paradigms for health care delivery.

FRAGMENTATION

The redefinition of general practice resulted in the establishment of the specialty of family medicine in 1969, soon followed by primary care internal medicine and general pediatrics. We now have a variety of different “primary care” clinicians, including family physicians, general internists, general pediatricians, and nurse practitioners. The definition of primary care has also been broadened at times to include such specialties as obstetrics and gynecology, whose principal role is related to a particular patient characteristic but that are defined as “primary care” because they are often a patient’s first or usual contact with the medical care system.

Many primary care clinicians have sought even further subspecialized niches. As described by Stevens, “Playing the game of specialization . . . led family practice into competitive subspecialization” (10) (for example, the subspecialty of geriatric medicine was established in 1985, sports medicine in 1989, and adolescent medicine in 2000). This subspecialization may, at times, be motivated by sound logic and need, but it has also confused patients, clinicians, and policymakers about the appropriate role of primary care and has diffused primary care’s political power.

SUPPLY, COMPETITION, AND SUBSTITUTION

The appeal of primary care as a career has waxed and waned among medical students, but current downward trends are worrisome. Although interest in primary care residencies increased in the early 1990s, primary care today is not competing well against other specialties. For example, in 2002, only 79.1% of available residency spaces in family medicine were filled, and the number of seniors in U.S. medical schools who matched to generalist specialties decreased 5.6% between 2001 and 2002 (11). In contrast, in 2002, 98% of spaces in emergency medicine residency programs and 94.4% in categorical surgery residency programs were filled.

Is a shortage of primary care clinicians looming, or are medical students accurately reading a diminishing future need for primary care physicians? Forecasts of the health workforce are notoriously difficult to develop and are often inaccurate (12). Because of the number and fluidity of the roles and responsibilities of these clinicians, it is particularly difficult to estimate how many primary care clinicians will be needed in the future and, therefore, whether we have “enough” physicians, nurses, and others to meet the

needs of patients and the general population. The need for primary care clinicians depends largely on the definition of the scope of primary care practice and how clinicians with various types and degrees of skills are assigned to particular roles and responsibilities (13).

The more that other providers are able to assume the functions of primary care, the greater the likelihood that the need for primary care physicians will decrease. Nurse practitioners and physicians assistants are contending for many of the roles and niches that have, in the past, usually been limited to physicians (14). Alternative medicine is growing rapidly, and pharmacists and drug stores are increasingly providing consultative services.

As competition increases for primary care and specialty niches, today’s primary care clinicians are at a distinct disadvantage compared with specialists. Primary care may stake a claim to caring for patients with chronic illness (15, 16), but evidence suggests that outcomes may be better if specialists provide principal care for patients with certain types of chronic illness, such as diabetes and rheumatoid arthritis (17, 18). It is even more difficult to make the case that a primary care provider could provide principal care for the types of patients seen by most subspecialists.

CHANGING CONSUMER PREFERENCES

The primary care “product” seems to be losing appeal among consumers. Patients today are better educated about health, have greater access to health information, and are more determined to take control of their health care than ever before. Consumers are increasingly sophisticated, informed, and assertive. In an accompanying article in this supplement, Safran (19) describes patients’ deteriorating perceptions about primary care and its clinicians. Suffice it to say that patients view their relationships with primary care clinicians with some concern and have indicated a decline in this relationship in recent years.

“POPULATION” MODELS OF CARE

The often poor performance of traditional medical care for chronic conditions, such as diabetes or asthma, has led to the growth of population approaches that often remove the patient from the care of an individual primary care clinician. Examples of these approaches, such as “chronic illness management” (15), include systematic programs to manage diabetes, asthma, congestive heart failure, and depression. In another article in this supplement, Anderson Rothman and Wagner describe and analyze these models of care (20), in which patients with specific chronic conditions are enrolled in systems developed to improve care. Although this model may be successful for patients with a specific chronic illness, such models are, in essence, another type of specialization, and their effect could easily complicate, undermine, or even remove the role of the primary care provider.

ADVERSE CHANGES IN PAYMENT SYSTEMS

The reimbursement system has never been particularly advantageous to primary care, and recent trends in health care payment suggest that the funding available for primary care services will decrease further in the future (6, 21). These trends result from the adaptation of purchasers and insurers to the rapid escalation in the costs of medical care, with employers and governments capping their payments to insurers and passing premium increases on to the insured (22). To increase the proportion of low-risk patients in the insured pool, insurers have increased deductibles and co-payments and limited benefits. As this model becomes more prevalent, patients will pay more, perhaps much more, of the costs of most primary care services, with the likely effect of reduced reliance on, and visits to, “first-contact” clinicians.

In this supplement, Sandy and Schroeder (23) describe one possible result of the changing economics of care: a “tiering” of patients and clinicians into socioeconomic levels, which they suggest might create “the dissolution of primary care as a single concept, replaced by alignment of clinicians by economic niche.” Whether Sandy and Schroeder are correct in their prediction of these relatively drastic changes in primary care, current trends in payment systems seem likely to continue to disadvantage primary care clinicians.

THE HOSPITALIST AS A SPECIAL NICHE

Of all the trends in health care over the past several decades, the creation of the “hospitalist” may be the most sobering, and perhaps threatening, to some basic tenets of primary care (24). In most incarnations of this concept, an outpatient primary care physician “hands off” to the hospitalist care of and responsibility for patients when they are hospitalized. Evidence suggests that in some situations outcomes are better if inpatients are cared for by a hospitalist rather than by their primary care provider (24), and some primary care clinicians may be happy to be relieved of inpatient duties.

The hospitalist model, however, breaks the continuity of care, and many patients may be disturbed by the transfer of care to someone who is relatively unknown to them. It could be an ominous sign for the future of primary care that many graduates of primary care residencies are choosing to become hospitalists rather than office-based primary care clinicians, perhaps because hospitalists are perceived to be more specialized and have more attractive working conditions than office-based clinicians. At the very least, the hospitalist model presents one more fragmentation of the ideal of comprehensive, continuous care.

NEW PARADIGMS FOR HEALTH CARE DELIVERY

Possibly the most important challenge to primary care will be its ability to respond to demands for a new para-

digm of care. The “vision of the future,” as presented in the Institute of Medicine’s *Crossing the Quality Chasm* report (25), is “a scenario depicting care as it could be if the six aims [of quality care] were realized.” The scenario includes several factors that are central to most definitions of primary care, such as the primary care clinician as a trusted advisor. Most striking about this vision are the centrality of the patients’ role in actions and decisions about their care and the relatively reactive role of both primary care and specialty clinicians. Most of the initiative in the scenario rests with patients, with advanced information systems allowing them to readily obtain information and interact with the health care system. The primary care clinician in this scenario could just as easily be a nurse practitioner, for example, as a physician trained in primary care (14). How will primary care define and market itself when many traditional roles, such as providing education and information, are no longer the sole province of the physician or even of other health care professionals?

THE NEED FOR RECONSTRUCTION AND RENEWAL

Do the threats to primary care matter? Would it make a difference if the field were to fail? Of course, no one knows whether these challenges will mortally wound primary care. If primary care were to fail, some would argue that it was the market’s way of benefiting consumers by replacing outdated approaches with those of competitors who responded better to changing consumer needs. History shows, however, that many excellent, even superior, products are lost through accidents of timing and the crude and often distorting forces of the market (26). We believe that primary care may well be in the latter category, and we therefore challenge primary care medicine to reconstruct itself during this complicated and unsettling, and yet exciting, time of transition in U.S. medical care.

Primary care has important core abilities that are vital to patients and are not found among specialty physicians. Many experts point out that primary care is an essential, common feature of the most successful health care systems (27). Primary care’s most important strengths derive from placement close to the patient, broad perspective, the disciplinary strengths of constituent specialties, and flexibility and adaptability. In addition, of all the attributes of primary care valued by patients, continuity ranks among the highest (19, 28). To address the challenges described here, primary care must focus on these core strengths and abilities.

In the future, the public will need an efficient, cost-effective system that can deliver the highest-quality health care within available resources and do so in a way that serves patients attentively and respectfully, supports their participation, and gains their trust. Primary care physicians can and should play an important and central role in that system by providing immediate and convenient access to care, sorting out the problems, delivering much of the care,

referring accurately, and coordinating and integrating subspecialty care. Primary care could provide trust-enhancing continuity, be an advocate for and coach of patients, and partner with patients in shared decision making. Primary care could also expand beyond its more restricted role as a provider of medical care and become engaged in analysis of population needs and provision of preventive interventions for risk groups, communities, and other specific populations. The danger, of course, is that primary care's new role will be even more expansive and varied than today's already diverse activities. A redefinition of primary care must be cognizant of this risk, focus on optimizing primary care's core strengths, and avoid assuming too many peripheral responsibilities in its reformulation.

In response to a changing marketplace, political uncertainty, and shifting consumer expectations, primary care in general, and primary care medicine in particular, needs to reconstruct itself. There is no easy prescription for what primary care should become. The reconstruction process will not be easy. Old enmities must be set aside and hidden assumptions revealed. Hard-nosed realism must replace romantic idealism while we seek to hold on to the core elements of primary care. Nevertheless, a process should begin that moves the field in the right direction. Building on its unique abilities, primary care can emerge as a redefined, more focused product that is attractive to patients, payers, and primary care practitioners alike.

From Harvard Medical School/Harvard Pilgrim Health Care, Boston, Massachusetts; and University of California, San Francisco, San Francisco, California.

Acknowledgment: The authors thank Ellen Weber, MD, for her advice and suggestions.

Grant Support: By grant 039940 from the Robert Wood Johnson Foundation.

Corresponding Author: Jonathan A. Showstack, PhD, MPH, University of California, 3333 California Street, Suite 265, San Francisco, San Francisco, CA 94118-1944.

Current author addresses are available at www.annals.org.

References

1. Grumbach K. Primary care in the United States—the best of times, the worst of times [Editorial]. *N Engl J Med*. 1999;341:2008-10. [PMID: 10607821]
2. Billings J, Parikh N, Mihanovich T. Emergency Department Use in New York City: A Substitute for Primary Care? New York: The Commonwealth Fund; 2000.
3. Young GP, Wagner MB, Kellermann AL, Ellis J, Bouley D. Ambulatory visits to hospital emergency departments. Patterns and reasons for use. 24 Hours in the ED Study Group. *JAMA*. 1996;276:460-5. [PMID: 8691553]
4. Eisenberg DM, Davis RB, Ettner SL, Appel S, Wilkey S, Van Rompay M, et al. Trends in alternative medicine use in the United States, 1990-1997: results of a follow-up national survey. *JAMA*. 1998;280:1569-75. [PMID: 9820257]
5. Astin JA. Why patients use alternative medicine: results of a national study. *JAMA*. 1998;279:1548-53. [PMID: 9605899]
6. Merlis M, for the Task Force on the Future of Health Insurance. Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity. New York: The Commonwealth Fund; 2002
7. Bodenheimer T, Lo B, Casalino L. Primary care physicians should be coordinators, not gatekeepers. *JAMA*. 1999;281:2045-9. [PMID: 10359396]
8. Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. Primary Care: American's Health in a New Era. Washington, DC: National Academy Pr; 1996.
9. Institute of Medicine. A Manpower Policy for Primary Care. Washington, DC: National Academy of Sciences; 1978.
10. Stevens RA. The Americanization of family medicine: contradictions, challenges, and change, 1969-2000. *Fam Med*. 2001;33:232-43. [PMID: 11322514]
11. Lostumbo EM, Beran RL. Results of the National Resident Matching Program for 2002. *Acad Med*. 2002;77:587-9. [PMID: 12063210]
12. Weiner JP. A shortage of physicians or a surplus of assumptions? *Health Aff (Millwood)*. 2002;21:160-2. [PMID: 11900069]
13. Rosenblatt RA, Hart LG, Baldwin LM, Chan L, Schneeweiss R. The generalist role of specialty physicians: is there a hidden system of care? *JAMA*. 1998; 279:1364-70. [PMID: 9582044]
14. Munding MO, Kane RL. Health outcomes among patients treated by nurse practitioners or physicians. *JAMA*. 2000;283:2521-4. [PMID: 10815182]
15. Wagner EH, Austin BT, Davis CL, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence to action. *Health Aff (Millwood)*. 2001;20:64-78. [PMID: 11816692]
16. Larson EB. General internal medicine at the crossroads of prosperity and despair: caring for patients with chronic diseases in an aging society. *Ann Intern Med*. 2001;134:997-1000. [PMID: 11352700]
17. Greenfield S, Rogers W, Mangotich M, Carney MF, Tarlov AR. Outcomes of patients with hypertension and non-insulin dependent diabetes mellitus treated by different systems and specialties. Results from the medical outcomes study. *JAMA*. 1995;274:1436-44. [PMID: 7474189]
18. Hiss RG. Barriers to care in non-insulin-dependent diabetes mellitus. The Michigan experience. *Arch Intern Med*. 1996;124:146-8. [PMID: 8554207]
19. Safran DG. Defining the future of primary care: what can we learn from patients? *Ann Intern Med*. 2003;138:248-55.
20. Anderson Rothman A, Wagner EH. Chronic illness management: what is the role of primary care? *Ann Intern Med*. 2003;138:256-61.
21. Pear R. Many doctors say they are refusing Medicare patients. *New York Times*. 17 March 2002;A1.
22. Robinson JC. Renewed emphasis on consumer cost sharing in health insurance benefit design. Accessed at www.healthaffairs.org/WebExclusives/Robinson_Web_Excl_032002.htm on 26 August 2002.
23. Sandy LG, Schroeder SA. Primary care in a new era: disillusion and dissolution? *Ann Intern Med*. 2003;138:262-7.
24. Wachter RM, Goldman L. The hospitalist movement 5 years later. *JAMA*. 2002;287:487-94. [PMID: 11798371]
25. Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Pr; 2001:56-8.
26. Rogers EM. Diffusion of Innovations. 4th ed. New York: Free Pr; 1995.
27. Starfield B. Primary Care: Balancing Health Needs, Services, and Technology. New York: Oxford Univ Pr; 1998.
28. Mainous AG 3rd, Baker R, Love MM, Gray DP, Gill JM. Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom. *Fam Med* 2001;33:22-7. [PMID: 11199905]

Current Author Addresses: Dr. Moore: Harvard Medical School/Harvard Pilgrim Health Care, 133 Brookline Avenue, 6th floor, Boston, MA 02215.

Dr. Showstack: University of California, 3333 California Street, Suite 265, San Francisco, CA 94118-1944.