Scalpel, Please

Start cutting away at the salaries and the numbers of specialists out there, or whatever health care system we have will cost too much

by Christopher Georges

"Everyone told me it was the wrong thing to do," recalls Dr. Jennifer Weyler, explaining her decision two years ago as a medical student to become a family doctor. "My teachers discouraged me; administrators discouraged me. They told me I was too smart to go into primary care or that the job wouldn't be enough of a challenge." And sure enough, Weyler, now a resident in family medicine at the University of Massachusetts School of Medicine, is frustrated—but not by her job, which she loves. "It frustrates me," she explains, "to have to continually explain to people what a primary care practitioner is."

It was only 50 years ago, after all, that no one had to be told what a family doctor was, mainly because that's about all there was. Eighty-seven percent of all doctors in the thirties were general practitioners—namely internists, pediatricians, and family doctors. Today that figure has dropped to 30 percent.

That might appear, at first glance, like good news: As researchers become more sophisticated about what causes diseases and how to treat them, we need physicians who can focus on complex subfields of medicine. As medical technology evolves from stethoscopes to x-rays to CAT scans, we need doctors who can make the most of high-tech advances.

But it's also true that, despite the media's obsession with heart-warming stories about ice-packed kidneys air-lifted across America, the vast majority of medical treatments require little more than a visit to a generalist, where a check up, a prescription, or some simple medical advice will do the trick. More than three-fourths of all symptoms for which people seek treatment, studies show, can be fully treated by primary care doctors.

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Problem is, the vast majority of doctors, namely specialists, aren't trained—or willing—to provide this kind of all-important treatment. All of which means that as Americans line up outside the neurologist's or radiologist's office to get their specialized care, we are wasting, according to one recent study, hundreds of millions of dollars annually on unnecessary procedures and other services prescribed by test-happy specialists. At the same time, the quality of care is dropping as preventive care—which is underprescribed by many specialists—takes a back seat.

Specialized tastes

While these problems have dogged our medical system for years, the real trauma of the primary care shortage is yet to come. Unless we act immediately to double the percentage of family doctors in America, any of the vaunted attempts to repair our system is doomed to fail. That's because—as everyone from Hillary to the AARP has agreed—the keys to repairing health care are eliminating waste, creating better "management" of health care resources, and beefing up emphasis on preventive care through HMOs and cooperative systems. To do this, they say, the point people must be generalists who would handle most cases on their own and curb expensive treatments.

But as things now stand, we haven't nearly enough generalists to make such a system work. One recent study showed that universal coverage would increase primary care office visits by 64 million a year—requiring 9,000 additional primary care doctors. And if the current rate of decline in medical school students interested in becoming primary care doctors continues, the percentage of generalists will drop from its current 30 percent to under 28 percent by 2010. Instead of a more efficient system, we'll end up with longer lines at emergency rooms, clinics, HMOs, and doctors' offices. This is sure to undermine not only our health, but our faith in the system (not to mention the Clinton administration). Regardless of which kind of health care system we end up with, failing to remedy the shortage of primary care doctors, *and fast*, will cost us enormous sums and may even serve to *lower* the quality of care Americans receive. The government, medical schools, and the entire medical community must act swiftly to undo the present morass.

How thick is that morass? Consider, for example, that the number of gastroenterologists grew by more than 1,000 percent from 1965 to 1990; cardiologists by 900 percent; neurologists by 325 percent; and plastic surgeons by 300 percent. In the same period, the number of primary care physicians grew by just 66 percent.

Specialists, unlike primary care doctors, are prone to order costly, unneeded tests: A New England Medical Center's Health Institute study in 1992 found that specialists order more tests, perform more procedures, and hospitalize patients more often than primary care doctors treating similar symptoms. Family practitioners are less likely to hospitalize patients than specialists treating patients who had similar levels of illness, according to a recent *Journal of the American Medical Association* report. A 1990 study estimated that a 50-50 mix of primary care doctors to specialists would produce a 39 percent reduction in total expenditures for physician services. "Primary care protects people from unwanted procedures," explains Fitzhugh Mullan, an assistant U.S. surgeon general. "General practitioners look at risks and benefits, both in terms of care and costs."

This medical mess has been a long time in the making. In the decades following World War II, the federal government—in an effort to apply the same crush-the-enemy spirit it adopted in defeating the Axis—began funnelling huge sums of money into basic medical research, increasing federal spending on research from about $45 million in 1940 to more than $16 billion in 1987. This reflected the attitude that if we threw enough money at any *specific* problem (as opposed to focussing on preventive or general medicine), such as heart disease or kidney failure, we'd cure it. More specialized researchers, suddenly well funded, came through with more and more specialized procedures and equipment, which in turn fueled the need for specialized physicians. As a result, great gains have been made, but it's also true that as medicine became Balkanized, primary care became health care's unwanted sibling.

These days, while the federal government pours about $10 billion annually into biomedical

research, primary care research receives a paltry $100 million. And while Medicare—the federal government's largest research funding program—doles out $5.5 billion to residency programs in hospitals and medical schools, virtually all of it goes toward training and support of specialists.

This bias has, predictably, snowballed at many medical schools. Administrators soon realized that the more specialized programs they developed, and the more students and faculty concentrating in sub-areas, the more federal dollars they could pull in. Because medical schools rely on federal grants for more than 20 percent of their revenues, going after such funding has become a top priority. As the money has come in, bigger, more expensive buildings have been built, and more departments have been created, each with their own faculties, staffs, and bureaucracies. The name of the game has become not just medicine, but survival and prestige. As in any large bureaucracy, competition has grown fierce among each of the sub-specialities to recruit more students and faculty.

While medical students have been pawns in this game, it's also true that just about every incentive pushes them towards careers as specialists. You have to have your head buried deep in *Gray's Anatomy* not to notice that the superstar faculty—those earning the largest salaries, running the biggest labs, giving the big-shot lectures—are specialists. Add to that the pressure placed on students by specialist faculty who no doubt want to perpetuate their own fields, and so push their brightest students to follow in their footsteps. For those students who do want to pursue family medicine, programs with big money and large commitments are rare.

All of which help explain why more than 30 percent of students entering medical school indicate a preference for primary care, but only about half of these end up choosing it. At Boston University's medical school, for example, the number of medical graduates entering residencies in internal medicine or family practice fell by 20 percent from 1986 to 1992. At Yale, which once had one of the larger contingents going for primary care medicine, just 31 percent of the grads went for residency in primary care last year. Nationwide, that figure was 15 percent.

For those 15 percent who do stick with it, there is—once they graduate—a relative lack of money and prestige. Primary care physicians earn, on average, 50 to 60 percent less than specialists. The median for, say, an anesthesiologist or surgeon is $200,000. (Family doctors aren't exactly in the poorhouse. Median income is $93,000.) Considering that most med school students find themselves $50,000 in the hole the day they graduate, it's no wonder they feel they have little choice but to move into a high-paying sub-field.

While generalists' salaries are at the low end of the medical scale, the jobs are, in many ways, the most challenging. The amount of material primary care students must master is 20 times greater than it was 50 years ago, and they are expected to know about more areas than specialists. Their patients are generally the most difficult to deal with, such as those with chronic or degenerative disorders. Moreover, Medicare provides no reimbursement for check ups, and in 22 states, Medicaid also refuses to pay. And primary physicians have to deal with all of the insurance paperwork hassles for less money.

Internal debt

For all the negatives, many primary care physicians say that the substance of the field is quite satisfying. That should come as no surprise considering the rewards it brings: developing long-term relationships with patients, the challenge of solving a range of problems, etc. Sculpting noses is also important, but it is not hard to understand why many specialists—despite the fact that they're hauling in the big bucks—can lose interest in their jobs.

But the way the system now works, non-medical issues loom so large that they cannot simply be put aside. "I entered internal medicine because I found it diverse, dynamic, a real challenge," explained one young El Paso doctor who recently quit serving as an internist to specialize in nuclear medicine. "But it was costly, especially having four children. My [loan] repayment comes to a total of $144,000. Plain and simple, I couldn't afford to stay in. Nuclear medicine isn't exactly what I wanted, but since it offered a lucrative pathway, I took it."

Thus, the key to ending the shortage is to eliminate many of the negatives that weigh

down primary care. Reform could bring the ratio of generalists to specialists to 50-50 by focusing on change in two key areas:

➤***Eliminate medical school bias against primary care.***

If this means using the heavy hand of government regulation, so be it. Since most medical schools, long aware of the primary care shortage, have done little to alter their curriculum to encourage students to move into primary care (and instead have continued to lobby fiercely for federal specialization research funds), it's time the federal government mandates that schools provide students with experiences in primary care, such as required clerkships in either family medicine or primary care in the third year.

Med schools will, no doubt, battle to retain control over their curriculums, but there is little question that exposing students to primary care medicine early on works. Fewer than half of the nation's medical schools offer family medicine as a mandatory part of the curriculum, but those that do send more than twice the number of graduates into general practice than schools that don't.

Just to make sure medical schools get the message loud and clear, the federal government can ensure this requirement sticks by using the leverage provided by the $5.5 billion Medicare doles out each year in medical training and research grants. Senator Jay Rockefeller, who has led the drive in Congress to increase the number of primary care doctors, recently unveiled a plan that would cut off government money from any medical teaching facility that does not train an equal number of primary care doctors and specialists.

➤***Increase compensation for primary care doctors and offer more loan forgiveness for those who agree to serve as generalists.***

Both Rockefeller and the Clinton administration have been pushing to beef up funding for the National Health Service Corps, a program that offers scholarships to medical school students, physicians, assistants, and nurse practitioners who agree to practice in medically-underserved (mostly rural and inner city) areas. (There are now only about 1,500 physicians in the program, down from more than 8,000 before it was cut back by Reagan and Bush.)

But solving the crisis now will require even bolder steps. Here's one immediately workable measure that would give young or even middle-aged doctors the incentive to transfer to general practice: forgive a portion of medical school debt for each year a physician remains in primary care practice. If a doctor at some point leaves primary care, the remaining debt would not be forgiven. For example, if a doctor had a debt of $75,000, and $5,000 was forgiven for each year he practiced primary care, the entire loan would be forgiven after 15 years. If the physician decided to leave primary care after 10 years, he would owe the lender $25,000. This of course would mean spending tens of millions of federal dollars, but it's also true that this investment would, in a very short time, be repaid through savings in timely preventive care. More importantly, loan forgiveness works: According to one recent study, 41 percent of internal medicine residents said that debt had influenced their training or career decisions. And the money that we'd save from having fewer specialists could immediately help pay for universal coverage.

Solving the other half of the money problem—making primary care practice lucrative enough to allow it to compete with high-paying fields like surgery—will require both government and private sector action. The most obvious route is aggressively equalizing primary care salaries—it won't be enough to raise generalists' salaries; the specialists' must come down. Some HMOs have taken tentative steps in that direction. In desperate need of family care doctors, they are now offering generalists bonuses and salaries double those of five years ago. (One southwest HMO pays its GPs $100,000 more than it pays some of its specialists.)

Medicare should follow this lead. Reimbursement rates for generalists are still relatively much lower than those for specialists. The government should not only raise reimbursement rates for check-ups and other primary care services, but offer payments for more preventive services, such as cancer screening and smoking cessation programs (which, remarkably, aren't covered now). Because private insurers often follow Medicare in setting their payment rates, the ripple effect will spill over into the private sector.

Most important, however, is that whatever change does occur comes quickly, since the administration is closing in on health care reform. If we have any hope of reversing this trend within the next five years, steps should be on the agenda now. □

MEMO OF THE MONTH

The Under Secretary of Energy
Washington, DC 20585

December 3, 1992

MEMORANDUM FOR SECRETARIAL OFFICERS

SUBJECT: NE/NE-60 Concurrence

Recently, memoranda have been prepared for my signature or directed to departmental offices from other departmental offices which contain statements regarding whether the direction contained in the memorandum is applicable to Naval Reactors (NE-60). Several memoranda have been incorrect in their assumption regarding the effects on NE-60, resulting in unnecessary further correspondence to correct the misunderstanding.

Applicability to NE-60 of a contemplated action is not always obvious. In many cases, the impact is either indirect or the direct impact is not appreciated due to lack of understanding of the scope of NE-60 responsibility. To avoid misunderstandings in the future, you are requested to consult NE regarding applicability statements before they are made and before memoranda are presented to me, the Secretary, or Deputy Secretary for signature.

I appreciate your attention to this matter.

Hugo Romrehn