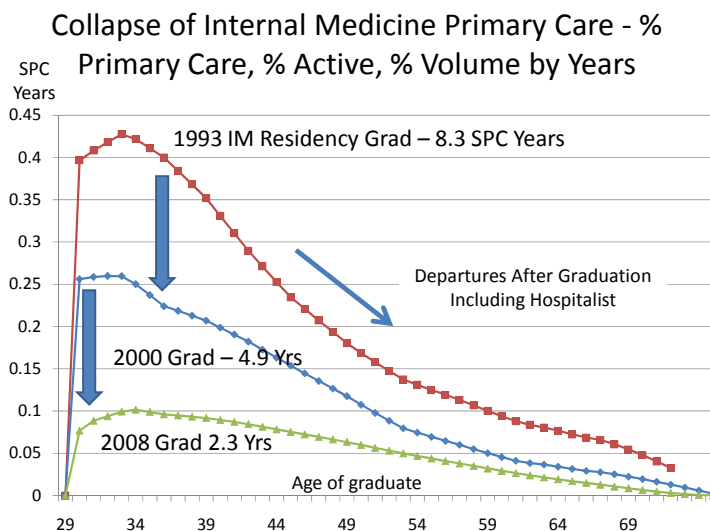


Ten Biggest Myths Regarding Primary Care in the Future

Introduction: This article is by Robert Bowman, MD, of the AT Still College of Osteopathic Medicine in Mesa, AZ. Dr. Bowman is a long time scholar of primary care and rural health workforce issues. He identifies and comments upon 2 important workforce concepts. The first is "primary care forms" of training, which include 3 physician forms (family medicine, general internal medicine, and general pediatrics), and primary care nurse practitioners and physician's assistants. The second is the Standard Primary Care (SPC) year, which allows us to look at the success of the different "forms" in terms of how many SPC years they provide per graduate. This takes into account the percentage of graduates who enter primary care, the portion of their practice that is primary care, at what rate they leave primary care for another area, the number of years they practice, and the percent time (part time/full time) they practice. Thus if a form of training has 100% of graduates entering primary care who practice full-time for an average of 35 years with 100% primary care practice, that form would produce 35 SPC years per graduate. If another form had only 50% of its graduates entering primary care, who averaged 50% primary care practice, practiced for an average of 20 years with an average of 75% FTE, that form would produce an average of only 3.75 SPC years per graduate (do the arithmetic: 20 years x 75% FTE x 50% of grads in primary care x 50% of practice is primary care). This is important in comparing projections - one can't just say, for example "nurse practitioners will take care of our primary care needs" without doing such a calculation.

- **Myth Number 1: Primary Care has collapsed.** Primary care internal medicine has collapsed with lowest production and lowest primary care retention levels. Those associated with internal medicine primary care perceive collapse.

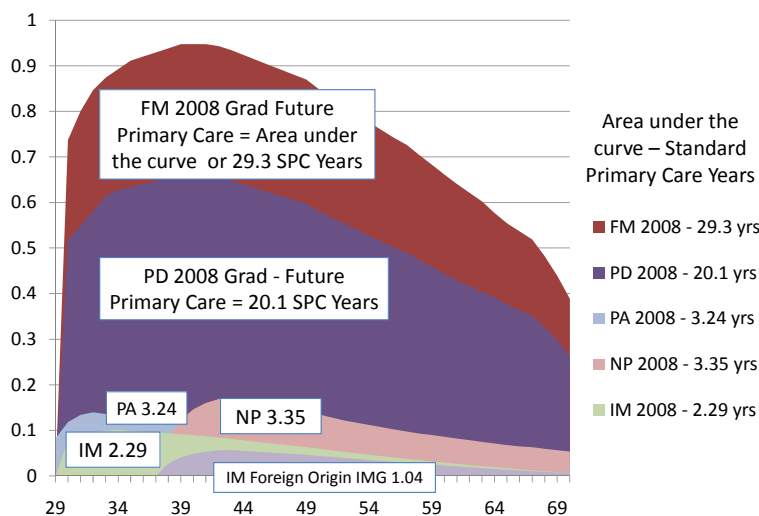


Standard primary care (SPC) years are career length x % remaining in primary care times volume of primary care (100% for family physicians, 86% for IM) times % remaining active (not part time or inactive). The foreign born international medical graduate in IM (45% of IM residency graduates) has half of the above level of SPC years because of an average of 8 years delayed entry and the fact that 30% deliver no healthcare in the US after graduation.

- But primary care remains. Existing dedicated primary care practitioners continue to deliver primary care despite insufficient support. There are 5 training sources of primary care. Some are remaining steady and some are dropping. The ideal primary care provider would contribute 35 Standard Primary Care (SPC) years: a 35 years career, actively in practice 100% of those years, and 100% remaining in primary care and 100% or top volume of primary care. Among the 5 forms of primary care training, family medicine remains steady in primary care with over 25 Standard Primary Care (SPC) years per graduate. Pediatrics is also steady, but with only 16 SPC years per graduate. The other 3 forms have more graduates who are inactive or part-time, have fewer years in a career, retain a lower percent of graduates in primary care (retention), and have a lower volume of primary care. They thus make limited contributions with fewer SPC years per graduate. Internal medicine, nurse practitioner, and physician assistant forms have declined to less than 4 SPC years per program graduate. Collapse of primary care is found for forms that depart primary care during training, at graduation, and each year after graduation under the assault of poor primary care support.¹*

2008 Changes in Primary Care Contributions Age 29 – 69

Calculations include % Primary Care, % Active, % Volume



- Myth Number 2: Nurse practitioners will take over more primary care duties.** Nurse practitioners will continue to supply less than 12% of the primary care supplied by the five primary care training forms using past measures as well as future estimates.^{1, 2} Increasing departures to hospital and specialty careers, lowest activity (inactive, part time), lowest volume of primary care, and greatest delays in entering primary care limit nurse practitioner primary care contributions.
- Myth Number 3: Physician assistants will take over more primary care duties.** Less than 30% of new physician assistants enter primary care and active physician assistants will dip below this level in the next 3 years.³ Physician assistants will continue to supply less than 12% of the primary care supplied by the five training forms. Increasing departures to emergency medicine and subspecialty careers, lower activity (inactive, part time), and lower volume of primary care limit physician assistant primary care contributions.

Only if physician assistants or nurse practitioners were required to stay in the family practice mode of care would they be able to increase share of primary care, rural primary care, and underserved primary care duties.

- **Myth Number 4: Internal medicine graduates from international medical schools will make significant primary care contributions.** *Internal medicine residency program graduates from foreign origins and international medical schools will contribute the fewest years of primary care averaging 1.3 SPC years per graduate. The limitations are substantial with lowest primary care retention after graduation, loss of 8 years due to delayed entry into the United States workforce, and losses after graduation including 20% departing the United States for home nations, 8% chronic unemployment, and increasing fractions departing for other nations.^{4,5} Lowest primary care also means lowest rural primary care and underserved primary care. A family practice residency graduate contributes greater than 30 times the rural or underserved primary care per graduate. Changes in the J-1 Visa waiver program and increasing uses of international graduates by the military and teaching hospitals will further limit primary care, rural, and underserved contributions.*
- **Myth Number 5: The United States is unable to produce enough primary care.** *Through policy, medical education efforts, and statewide efforts, the US has been consistently successful. The US was able to quadruple primary care graduates in the 1970s. The US increased primary care production 50% during the span of a few years in the 1990s. Historically Black, osteopathic, and many allopathic public schools have been successful for over 100 years. Primary care contributions are maximized when schools and states focus together on health access in birth to admission preparation, admission preferences, training curricula/faculty/locations, and health policy.⁶*

To sum up: the only way that the United States can fail to produce primary care is to admit the most exclusive students (lowest probability primary care), train in locations with the least health access emphasis (lowest influence), fail to graduate enough family physicians (permanent form), and create a health policy that rewards the most exclusive careers and locations. This, of course, is exactly how US health care is structured.

- **Myth Number 6: Generic expansions of medical school, nurse practitioner, or physician assistant graduates can increase primary care.** *During the current time period with the worst health access policy in decades, fewer students are choosing primary care and those that can move away from primary care are leaving. Osteopathic (DO) graduates will more than double from 2004 to 2017 but, with the current steady declines in family practice percentages, the end result will be only a gain of 100 more family physicians or a 20% increase despite a 100% increase in graduates. With primary care retention rates dropping steadily at 1 or 2 percentage points each year in the large and growing nurse practitioner and physician assistant pools (over*

230,000 combined), new graduates entering the workforce in primary care are not able to keep up with losses of active primary care plus departures from active practice. Only specific expansions of family practitioners that remain in the family practice mode (physicians, nurse practitioners, and physician assistants) can address primary care and health access needs. Retention in the family practice mode is much less likely for NPs and PAs since they can and do depart the family practice mode at any time.

- **Myth Number 7: Nurse practitioners make substantial rural primary care contributions.** *Rural primary care requires both rural location and primary care contributions. While 20-25% of nurse practitioners are rural, they do not have the primary care component. Nurse practitioners contribute 1 rural Standard Primary Care year per graduate (4 SPC years times 25% rural) in rural workforce whereas family physicians contribute 5 Standard Primary Care years per graduate (25 SPC years x 20%) in rural locations.*
- **Myth Number 8: Primary care is not marketable to the American consumer.**^{2,7,8} *It is very hard to understand how respected authorities in leadership positions could make such statements. Only a severe lack of awareness explains their comments. Workforce experts, trainers and educators in major medical centers and medical schools, leaders in the Council of Graduate Medical Education and the Association of American Medical Colleges all live in areas with the highest concentrations of people, physicians, and medical schools. These experts have spent their entire lives in locations that employ the fewest primary care physicians and support primary care at the lowest levels. They have tolerated the training of medical students and residents in dysfunctional primary care settings.⁹ It is not surprising that primary care does not appear marketable to those clustered in the 3,300 US zip codes which make up 4% of the land area with 75% of physicians and 95% of medical schools. This limited perspective ignores the 38,000 zip codes in which 65% of the American population and 70% of the elderly are cared for by the remaining 23% of total physicians. In these locations, 30 – 100% of the total physicians are primary care physicians.*

The total elimination of health care for millions is unconscionable and this is what is suggested by the statement that primary care is not marketable. The locations that depend upon primary care are also locations that offer better primary care salaries, better primary care support, better practice options to generate more revenue, lower costs of delivering health care, and lower costs of living. Those designing health care for an entire nation must place much more emphasis on care for the 65% of the population left out of the current health care design. All of medicine and medical education will pay dearly for the choices of a few leaders. Current leaders appear to have abandoned Butler's call to a season of accountability and social responsibility for medical education.¹⁰

- **Myth Number 9: The nation needs more pediatric graduates to meet primary care needs.** *More pediatric graduates will not meet primary care needs. According to pediatric leadership,*

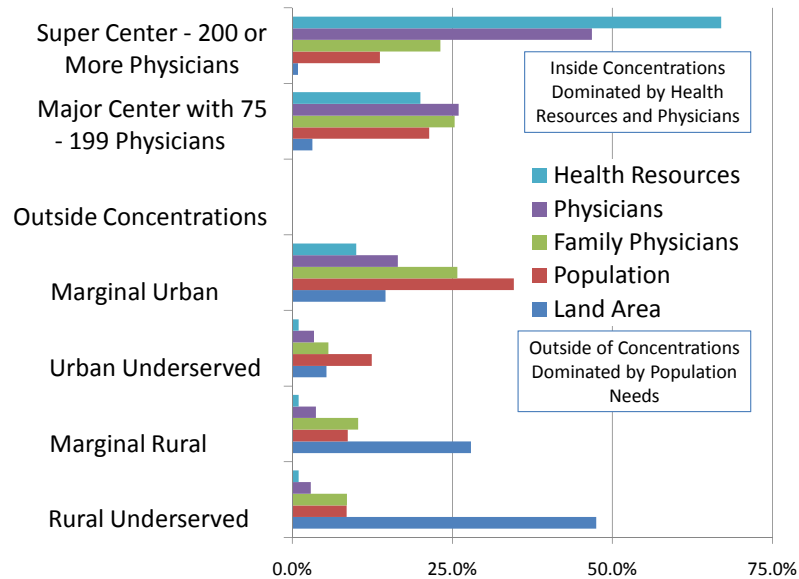
pediatric primary care is saturated in the locations where pediatricians choose to locate, at the same time that the United States has fewer children. Even though 15% of white female medical students remain committed to pediatric residency choices, they and other pediatric graduates will compete with all other primary care graduates already delivering pediatric primary care. This is likely to result in more practicing in part time, specialty, hospital, urgent, and emergent pediatric care settings.¹¹

- **Myth Number 10: Care for Age 65 and Up Will Be Provided By Geriatric Specialists.**

Geriatricians are a small fraction of new physicians, they are less likely to be found in locations with concentrations of older Americans, they have limited support, they have lower volume of patients, and they have some of the most complex patients. Older patients move toward locations with lower costs of living and health care and they move away from concentrations of internal medicine physicians, geriatricians, geriatric training programs, stroke centers, and heart attack centers.¹² They move steadily toward locations served predominantly by family physicians.

National studies confirm patterns of care for the elderly and for all seeking ambulatory care in the United States in 2004. About 62.5% of age 65 and older patients saw a family physician compared to internists for 29%, and somewhat less than 19% seeing a nurse practitioner.² This is not what numbers of graduates predict since both internal medicine graduates and nurse practitioner graduates are about twice the number of family practice graduates. In 2004 family physicians led in all but one ambulatory category. In addition to seniors, family physicians were seen by 43.4% of adults seeking care, and 39% seeking women's health care. The family physician share of 20% was second to pediatricians although family physician percentages increased for children over age 4 and for the 65% of the population beyond concentrations of pediatricians.² This is why increased family physicians can address pediatric care needs while more pediatricians cannot.

Myths persist unless they are compared to reality. Primary care must be measured according to a standard and the standard is set by forms of primary care training that produce providers who remain for 35 years of a career, who continue to provide primary care, who remain in the wide range of most needed locations, who continue to serve the populations most in need of care, and who continue to do so whether the current "policy era" is supportive or unsupportive of primary care. For physicians, nurse practitioners, and physician assistants, the standard is set by those that remain in the mode of care known as family practice.



Inside of concentrations in Super Centers and Major Centers in 3386 zip codes with 75 or more physicians - 90% of health resources, 75% of physicians, 47% of family physicians, 35% of the population, 4% of the land area

Outside of concentrations – the rest of the US, 96% of the land area, 70% of the elderly, 65% of the population, 40 – 60% of family practice forms of physicians, nurse practitioners, and physician assistants (greater for osteopathic and health access focused or decentralized or FP focused programs), 23% of total physicians and small fractions of health resources.

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