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OPINION

Real 'change' is necessary in primary care

For real "change" to be more than a political sound bite, the new administration will need vision and courage to provide a better health care system. Part of that vision will need to be a strong and vibrant primary care work force.



GUEST COLUMN Dr. N.S. Damle

The U.S. ranks among the lowest for developed countries in primary-care functions (prevention of infant mortality, obesity, vaccination rates, chronic disease management), lowest in health care outcomes and highest in cost.

Paradoxically, our medical educational system attracts some of the best and brightest; it trains them well in its medical schools and provides unparalleled training in its postgraduate programs in a variety of specialties. Our research institutions, private industry and universities have given us new therapies and technologies that are among the finest in the world.

Despite these advances, we have 45 million people without health insurance, a crumbling access and supply of primary care and a system we cannot afford. Health insurance premiums increased 114 percent between 1999 and 2007, while worker's earnings increased by 27 percent. Health care spending in the United States is 16 percent of the gross domestic product and increasing yearly.

The path to high quality and affordable health care can only be forged with a vibrant primary care work force. National studies demonstrate better health outcomes (decreased death from cancer, heart disease and stroke) in states with higher ratios of primary-care physicians to population.

Compounding the above problems is the crisis in providing primary care in Rhode Island and the United States. The following are important factors that have contributed to this problem and potential solutions:

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- A widening gap between supply and demand for primary care;
- A decline in interest in primary care;
- The culture of physician training and preferences is tilted toward subspecialty care.
- Numerous studies demonstrate a twofold to threefold difference in compensation with a widening gap between primary care and any procedural medical subspecialty or noninternal medicine–based specialty.

The Solution

Recognition by the general public, legislators and policymakers of the value of a strong primary care work force. Primary care can be a powerful driver for controlling costs and maintaining a high quality health care system through the following measures:

- Provide health–prevention strategies, combat obesity, manage diabetes and heart disease and other chronic illnesses that account for 75 percent of health care costs.
- Provide care coordination utilizing a team approach (Patient Centered Medical Home, PCMH) and health–information technology in the form of the electronic medical record, electronic prescribing and a health information exchange.
- A change in the reimbursement model which brings primary care income in parity with procedural subspecialists in internal medicine, as well as some other specialties in medicine.

The source of funding for these changes is the big question. The answer has several elements:

- Studies reveal there is already enough money in the health care system to fund these changes, but is not being spent wisely and is offering poor quality at high costs.
- Technology costs will have to be substantially decreased through judicious use and proven benefits.
- Savings from decreased rates of hospitalization, health prevention, promoting healthy lifestyles and management of chronic illnesses.
- Studying the comparative effectiveness of therapies (procedural, medical and surgical) and costs and safety concerns. •

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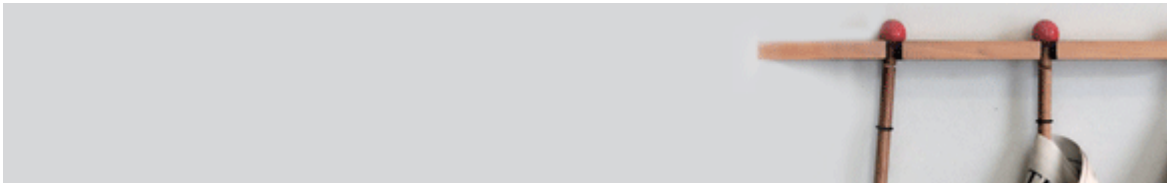
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