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THE FUTURE OF AMERICAN PRIMARY CARE

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Abstract

Historically, primary care has been delivered by physicians in private practices. However, pre-medical and medical students considering primary care should consider that market trends and physician preferences are changing the delivery methods of primary care. This thesis aims to predict the future delivery methods of primary care in America. By analyzing current studies, articles, and physician polls, it asserts that private practices are not a financially viable practice model and that medical systems will dominate primary care. Firstly, it identifies low insurance reimbursement rates, increasing quality documentation requirements, and an unhealthy work-life balance as the primary obstacles to private practice sustainability. It predicts that private practices will shrink to service less than 20% of the primary care market. The practices that survive will be forced to form group associations or specialize in concierge practice to maintain financial viability. The thesis explores the financial effects of the future private practice transformation; however, it is unable to analyze the quality of care due to insufficient studies. Secondly, it argues that medical systems will dominate primary care because of high insurance reimbursement rates, physician retainment, and effective use of auxiliary staff. It predicts that health systems will reform primary care in three primary areas: Health systems will shift the burden of care from physicians to non-physician practitioners, physicians will become leaders of primary care teams and coordinators of care, and medical billing will adapt to prioritize value-based care. Although research is limited, it appears that future primary care delivery may value quantity over quality.

The Future of American Primary Care

The vision of the small-town doctor is rapidly disappearing. Primary care physicians provide for the common healthcare needs and preventative care of a community (Ellner, 2017). However, those considering primary care as a profession, particularly pre-medical and medical school students, should understand that primary care is a rapidly changing market and vastly different from the traditional practices of their mentors. Before the early 2000's, solo practitioners delivered most of the primary care in America (Derlet, 2021). Solo-practitioners or private practices are small business entities historically owned by physicians. These businesses are owned and managed by one or two physicians with a few employees (Nazarian, 1995). However, in the 1980's, medical systems began to acquire private practices, offering them significant benefits and a constant salary (Gassman, 2011). At the time, physicians and legislatures believed this would improve patient care and cut total healthcare costs (Derlet, 2021). A medical system is a company that specializes in providing medical care in hospitals, clinics, and nursing homes (Derlet, 2021). Unlike private practices, medical systems hire physicians as salaried employees. In 2017, health systems employed an average of 691 physicians per system (Agency for Healthcare Research, 2017). Since the 1980's, primary care physicians have increasingly shifted from private practices to medical systems (Bendix, 2015). Current research can predict how primary care delivery will change over the next few decades; however, there is inadequate research to conclude whether this is a net beneficial or harmful change. Primary care will continue its shift away from private practice delivery toward a medical system model. Some private practices will adapt by forming partnerships or becoming concierge practices. Meanwhile, medical systems will recognize the value of providing quality primary care and will reform the delivery of primary care to financially benefit medical systems.

Traditional private practices are no longer a viable business model because of low insurance reimbursement rates, increasing administrative burdens, and an unhealthy work-life balance.

Firstly, private practices are not reimbursed at the same rate by insurance companies as medical system-owned clinics, crippling their financial viability. In the modern market, 75% of healthcare spending travels through third-party insurance companies or public programs like Medicare and Medicaid (Manelin, 2020). This means that to receive reimbursement, physician practices must meet the requirements of these third-party insurance mechanisms. Private practices simply do not have the time or negotiating power to secure optimal payment. Dr. Derlet, the author of *Corporatizing American Healthcare*, notes that "health plans pay much more to hospital-based clinics [and] health plans reduce or deny payments to freestanding office practices" (Derlet, 2021, p. 54). This bias toward hospital systems is clear in the billing practices of government-run programs such as Medicare and Medicaid. Clinics that are owned by a medical system can charge Medicare and Medicaid additional facility fees that are not available to private practitioners: "A hospital-based clinic can charge the $100 professional fee plus a facility use fee upward of $300" (Derlet, 2021, p. 54). Additionally, insurance companies often refuse to reimburse private practitioners or reimburse them at lower rates (Gassman, 2011). The combination of government-funded programs underpaying and private companies refusing to pay is tragic and has rendered private practice a financially unstable investment.

Secondly, primary care physicians are expected to report and manage constantly increasing documentation requirements and quality control measures. Insurance companies and Medicare and Medicaid reimburse offices based on this quality measure documentation. When the Affordable Care Act was passed in 2010, it created entities called Accountable Care

Organizations (ACOs). These organizations unilaterally determine quality measures and fix reimbursement rates for participating hospital systems and physician practices (Fisher, 2010). Unfortunately, Accountable Care Organizations are difficult for private practices to join independently and require expensive electronic health records to maintain: "It is complex and expensive for small practices to participate in federal and commercial ACO programs" (Khullar, 2018, p. 2). This places private practices at another disadvantage compared to medical systems. The requirements of the 2010 Affordable Care Act are not only easier for medical systems to meet but also demonstrate the government's preference for medical systems (Gassman, 2011). Unfortunately, this preference is based on a 40-year-old, unproven presumption that medical systems are better at maintaining population health (Derlet, 2021). Consequently, physicians must spend significant portions of their workday documenting quality measures that add no value to the care they provide. Private practices spend an average of 785 hours per year on quality documentation for insurance companies and ACOs (Merritt Hawkins, 2017). This is time spent at a computer not seeing patients. While they complete this documentation to pay the bills, these requirements negatively affect physicians' work-life balance, prompting many to leave private practice.

Lastly, private practice physicians are faced with exceptionally demanding work hours. Primary care physicians serve a group of patients known as a patient panel. Panel size varies from practice to practice; however, the average panel size is 2000 to 3000 patients (Bauer, 2017). These panels are simply too large for practitioners to manage and maintain a healthy work-life balance: "Panel size for the typical primary care physician averaged over 2000 patients, creating an almost impossible task; for one practitioner to provide excellent preventative and chronic care would take 16 hours per day for a panel that size" (Bauer, 2017, p. 3). Additionally, private

practitioners see on average 19% more patients per day than employed physicians (Physicians Foundation, 2016, p. 8). This heavy workload has made it challenging for physicians to maintain their private practices:

> Marginal finances and other external constraints, as well as internal limitations of primary care practices, result in challenging work–life balance, high rates of physician and staff burnout, workforce shortages, poor quality of care, and lower salaries and prestige compared to other specialties … many primary care practices struggle to maintain financial sustainability. (Ellner, 2017, p. 2)

The exhaustive work hours demanded of a private practice physician make private practices an unappealing choice for both current and new physicians (Gassman 2011).

These pressures have caused a drastic transfer of physicians from private practice into corporate medicine. Current research demonstrates that physicians are leaving private practice for other employment opportunities: "17% of physicians are in solo practice, down from 25% in 2012." (Physicians Foundation, 2016, p. 5). Physicians are being forced out of private practice and into medical system employment. A preponderance of evidence demonstrates that unless action is taken, this shift away from private practice will continue until medical systems dominate almost all of primary care: "all sources indicate the number of independent physicians is declining and the number of employed physicians is increasing" (Physicians Foundation, 2016). Yet, some physicians believe private practices are worth preserving.

While private practices will not compose a significant portion of the market, they will not completely disappear. Instead, they will merge to form group associations or specialize in concierge practices.

Both concierge practices and Independent Practice Associations are future private practice models that will allow physicians to meet the challenges of billing and reporting requirements. Some private practices will form Independent Practice Associations primarily for "financial security, compliance and IT expertise, and the ability to compete for large population health management contracts" (Physicians Foundation, 2016, p. 22). These organizations will allow some future private practices to maintain their independence while meeting the documentation requirements for ACOs and gaining leverage over insurance companies (Pofeldt, 2014). Alternatively, other private practices may reject traditional insurance billing altogether and offer their services on a fee-for-service basis. Instead of joining an Independent Practice Association, these practices will function independently as concierge practices. Concierge practices charge a yearly fee for set services (Dalen, 2017). Most concierge practices manage a panel of 400 to 600 patients (Dalen, 2017) which allows physicians to spend adequate time with each patient. Unfortunately, this model disproportionately favors high-income clients which makes it both inaccessible to lower-income households and limits its market potential: "this model may be expected to exacerbate disparities in care, as the most vulnerable will be most likely to face access issues. The result could be a tiered system of primary care" (Shrank, 2017, p. 3). The emergence of these models testifies to the patient's and physician's determination to keep private practice alive. Both models will attract private practice physicians in the coming years but will not significantly impact the primary care market.

In the future, private practice primary care will have limited market influence, will be more expensive than medical system care, and requires quality of care research to vindicate. Firstly, the number of private practitioners is decreasing and will continue to decrease unless the market changes. As of 2014, only 18% of physicians were independent practitioners, down from

41% in 1983 (Bauer, 2017). Due to student debt levels and the financial and lifestyle strain of private practices, a 2017 survey of graduating residents reveals that only 1% of graduating residents would consider entering private practice (Merritt Hawkins, 2017). The pressures that are currently forcing physicians out of private practice are also keeping new physicians from entering the field. As current private practitioners retire, new physicians are not replacing them in equal numbers.

The greatest disadvantage of future private practices is that they will be expensive for either the patient or the physician owner. Since group associations form specifically to gain leverage over insurance companies and meet ACO's requirements (Gassman, 2011), group associations should not charge the patient extra for their services. However, joining an independent practice association may increase the practice's overhead costs: "There will, however, be expensive and time-consuming changes to computerization, common protocols, and electronic health record coordination that practices will need to undertake to participate in these [independent practice associations]" (Gassman, 2011, p. 4). To manage these additional costs, physicians may need to either see more patients or accept an income cut. Conversely, concierge practices form to specifically service clients who are willing to pay extra for care. While some of these practices do accept standard insurance (Lemma, 2019), their primary characteristic is a yearly service fee. This retainer fee averages "$1500 per year to $1700 per year, approximately $135 per month" (Dalen, 2017, p. 1) with some charging as high as $13,000 per person per year (Nemzer, 2020). Since these retainer fees are not covered by insurance companies, concierge medicine is unaffordable for most lower income households (Shrank, 2017). Additionally, because concierge practices do not rely on insurance for their income and charge retainer fees, concierge practices spend less time on documentation and tend to be more lucrative than group

associations: “The models tend to be highly lucrative, with a more manageable work schedule, less paperwork, and greater flexibility and time to care for their patient panels” (Shrank, 2017, p. 3). In summary, in concierge models, the patient pays the extra cost. Both group associations and concierge practices will continue to exist for primary care; however, group associations will cost the physician, and concierge will cost the patient.

Nonetheless, future private practices will be beneficial because they will maintain physician independence, allow patient choice, and uphold quality values. Private practice owners believe independence is worth the difficulties (Bendix, 2015). In private practices, physician owners make all staffing, billing, and policy decisions (Derlet, 2021). Secondly, private practice allows patients to choose their provider through market competition. This contributes to a common perception that private practices provide a higher quality of care. It seems logical that future private practices, especially concierge practice, would provide quality care since these providers personally see the patient, will develop models to allow appropriate time for each appointment, and have the benefit of a medical school education. However, there are currently no peer-reviewed studies that contrast the quality of care delivered by group associations or concierge practices with medical systems (Khullar, 2018). Nonetheless, there are several clear differences between the care provided by these modified private practice models and health systems. Significantly, private practices have been the standard for primary care for the last 60 years (Derlet, 2021). These standards include examination by and time with a physician (Nemzer, 2020). Both concierge and group associations emphasize these standards. Particularly, concierge physicians spend quality time with patients during visits: “smaller panel size allows the concierge physician to spend 30 minutes or more for each visit … the extra time allows the concierge physician to offer a comprehensive assessment and customize treatment plan,

including lifestyle and preventative services for optimum health" (Dalen, 2017, p. 1). Nonetheless, with the lack of peer-reviewed evidence, it is impossible to judge whether these practices guarantee a higher quality of care or assess what is lost and gained from a quality standpoint (Dalen, 2017). In conclusion, the number of traditional private practices will decline and either evolve into group associations and concierge practices or be absorbed by a medical system.

In contrast, health systems will continue to dominate the primary care market until they become local healthcare monopolies. They will continue to experience significant financial success because of reimbursement from insurance companies, physician retainment, and effective care management. Firstly, health systems exert significant leverage over insurance companies (Ellner, 2017). As was mentioned earlier, medical systems can charge Medicare and Medicaid patients additional facility fees simply because the clinic is part of a medical system (Derlet, 2021). Concurrently, medical systems can purchase expensive electronic health records and medical reporting and note-taking programs that enable them to easily meet ACO and insurance quality measure requirements (Gassman, 2011). These billing practices have allowed medical systems to bill to the highest capacity and receive full reimbursement (Derlet, 2021).

Secondly, health systems are retaining physicians at higher rates. While private practices are losing physicians in increasing numbers, medical systems are actively seeking out primary care physicians to manage care "due to their role as leaders of interdisciplinary clinical teams and because they are the indispensable managers of care and resources in emerging quality driven delivery models such as ACOs" (Merritt Hawkins, 2017, p. 17). Furthermore, 94% of residency graduates would prefer to be employed by a medical system and receive a salary than enter private practice (Merritt Hawkins, 2017). Dr. Derlet highlights this shift toward medical

system employment when he states, “would a newly minted physician with $300,000 in educational debt take a job for $75,000 as a solo practitioner or a corporate job that offers $200,000?” (Derlet, 2021, p. 52). Physician residency graduates listed higher salaries and a superior work-life balance as the primary reasons they prefer employment to private practices. (Merritt Hawkins, 2017). Yet in return, physicians lose their freedom to independently practice medicine.

Finally, health systems utilize auxiliary staff to maximize physician efficiency. This staff includes nurse practitioners, physician assistants, scribes, dietitians, nurse managers, and social workers (Sawin, 2019). Consequently, medical systems can delegate certain aspects of primary care and lower the system’s overhead costs:

> [Medical systems] are forging teams that share the care, reserving the time of [primary care physicians] to provide diagnosis and treatment while utilizing non-practitioner clinicians for chronic disease management, health coaching, care coordination with the medical neighborhood, [electronic medical record] documentation (scribing), and panel management to ensure patients are offered all recommended routine preventative and chronic care services. (Bauer, 2017, p. 3)

This means that patients in these systems will not be primarily seen by physicians. Clearly, this saves the system money. A study of primary care reform methods concludes that health systems can save financially by investing in primary care and efficiency measures (Harvey, 2020). Health systems maximize physician efficiency by coordinating care between team members and ultimately saving on overhead costs. Together, these factors allow medical systems to succeed financially without proving they provide a superior product, quality medical care.

As health systems continue to become the dominant primary care providers, they will reform primary care delivery to financially benefit health systems.

Firstly, health systems will shift the delivery of primary care from physicians to nurse practitioners and physician assistants. Health systems will adopt this model for several reasons. Firstly, nurse practitioners are cheaper for health systems to employ than physicians (Derlet, 2021). Secondly, there is a growing shortage of primary care physicians in America. Current research predicts that America will face a shortage of 23,600 primary care physicians by 2025 (Bauer, 2017). Nurse practitioners and physician assistants will fill this physician deficit. Finally, health systems contend nurse practitioners and physician assistants can provide adequate primary care for the majority of patients. Nursing Journals assert that "nurse practitioners and physician assistants are capable of providing 70% or more of the care required for adults and 90% in pediatrics" (McCleery, 2014, para. 1). However, there are limited studies concerning the quality of care nurse practitioners and physician assistants provide as primary care providers. The few studies that are available only assess the success of nurse practitioner's quality of care from patient satisfaction ratings (Swan, 2015). This is not equivalent to true standard of care measures and should not be accepted as evidence. Nonetheless, health systems are already using nurse practitioners and physician assistants as primary care providers because they are cheaper and easier to employ (McCleery, 2014). The number of offices that employed a nurse practitioner or physician assistant increased from 20% in 1990 to over 50% in 2009 and is continuing to increase (Bauer, 2017). As medical systems reform primary care delivery, nurse practitioners and physician assistants will become the primary providers of primary care.

Secondly, physicians will cease to be the primary providers and will become managers of primary care teams. Teams of nurse practitioners and physician assistants will be the primary

care providers for individual patients and a single physician will oversee a team: “the healthcare system is evolving toward management of care by primary-care led clinical teams” (Physicians Foundation, 2016, p. 20). Effectively, this means future primary care physicians will not see patients. Within a medical system, primary care physicians can either become administrators or specialist coordinators. As patients become increasingly complex, primary care teams will act as a bridge between various specialists to coordinate a single patient’s care (Ellner, 2017). While some physicians will continue to manage unusually complex patients (Ellner, 2017), most primary care physicians will become team managers, and nurse practitioners and physician assistants will directly manage primary care patients. This is an immense loss to both the patient and the physician.

Finally, health systems will begin to reform medical billing to prioritize value-based and preventative care instead of fee-for-service. As health systems begin to manage larger populations, they are beginning to recognize that investment in primary care improves overall population health and cuts system costs:

> Most of the high functioning models of primary care in the U.S. that we are aware of, however—including established healthcare systems, such as Kaiser Permanente (KP) and the Southcentral Foundation (SCF) of Alaska, and newer, for-profit, direct primary care companies—are in some way paid on a capitated basis … Primary care investment in these systems generally amounts to about 10% of the total costs of healthcare (roughly twice the national average) and is more than offset by reductions in total medical expenditure. (Ellner, 2017, p. 3)

Consequently, health systems will begin to value quality primary care, including preventative care (Shrank, 2017). As health systems begin to prioritize value-based care, payment models

must reform concurrently to allow this transition: “Payment must support the primary care functions and reward value, facilitating a paradigm shift away from visit-based healthcare” (Ellner, 2017, p. 3). Evidence suggests that both insurance companies and Medicare and Medicaid are shifting their payment models to accommodate value-based primary care payments (Manelin, 2020). Together, health systems and insurance companies will reform primary care to financially benefit the health system model. Of the coming reforms, this promises the most positive outcomes. Investment in primary care should improve overall population health and lower medical costs although the specific savings are unknown (Ellner, 2017). Nonetheless, it may be naïve to completely trust the future quality of care of a business with no value-based incentive and a total geographic monopoly.

At this time, it is impossible to objectively judge what is gained and lost in the shift to health system managed primary care because of a profound lack of research. The primary care physician loses independence and the opportunity to practice medicine while gaining financial security and an administrative role. The patient loses physician choice, market competition, and the relationship with his or her physician while gaining the resources of the health system. On the surface, the current future of primary care appears to value quantity over quality. Yet, to truly judge, the academic community must recognize, acknowledge, and study this shift. They must organize and publish studies concerning the quality of care provided by nurse practitioners and physician assistants in medical systems. Researchers must contrast the long-term health outcomes of populations managed by medical systems to those traditionally managed by private practices. Economists should begin nationwide analyses of health system costs. Legislatures should recognize that health systems are becoming local monopolies of primary care and should consider the consequences of additional legislation like the 2010 Affordable Care Act that favors

medical systems. Finally, both patients and physicians must publicly share their experiences under both systems, especially physician employees considering the recent Covid-19 pandemic. Without these developments, the true nature of this shift will remain pure speculation.

In conclusion, primary care delivery will experience significant changes in the coming decades. Private practices will be forced out of the market by economic pressures and physician preferences. Those that remain will condense into independent practice associations or specialize in concierge care. Meanwhile, health systems will become the dominant primary care providers in America. As their influence grows, health systems will recognize that investment in primary care results in lower overhead costs. Together, health systems and insurance companies will reform primary care billing to promote value-based and preventative care. Since health systems will predominate primary care, research teams should analyze the consequences of the shift to medical system delivered primary care. Once the consequences are known, either physician preference for independence or patient preference for private practices could reverse current trends. Alternatively, legislation such as the implementation of a single-payer health system could invalidate current predictions. Ultimately, current market trends raise three essential questions that both the medical society and country must answer: To what extent are physicians needed, who is responsible for medical care, and what should healthcare value? Pre-medical and medical students should consider the future of the field before choosing this specialty.

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