Report suggests compensation is key to fixing primary care shortage

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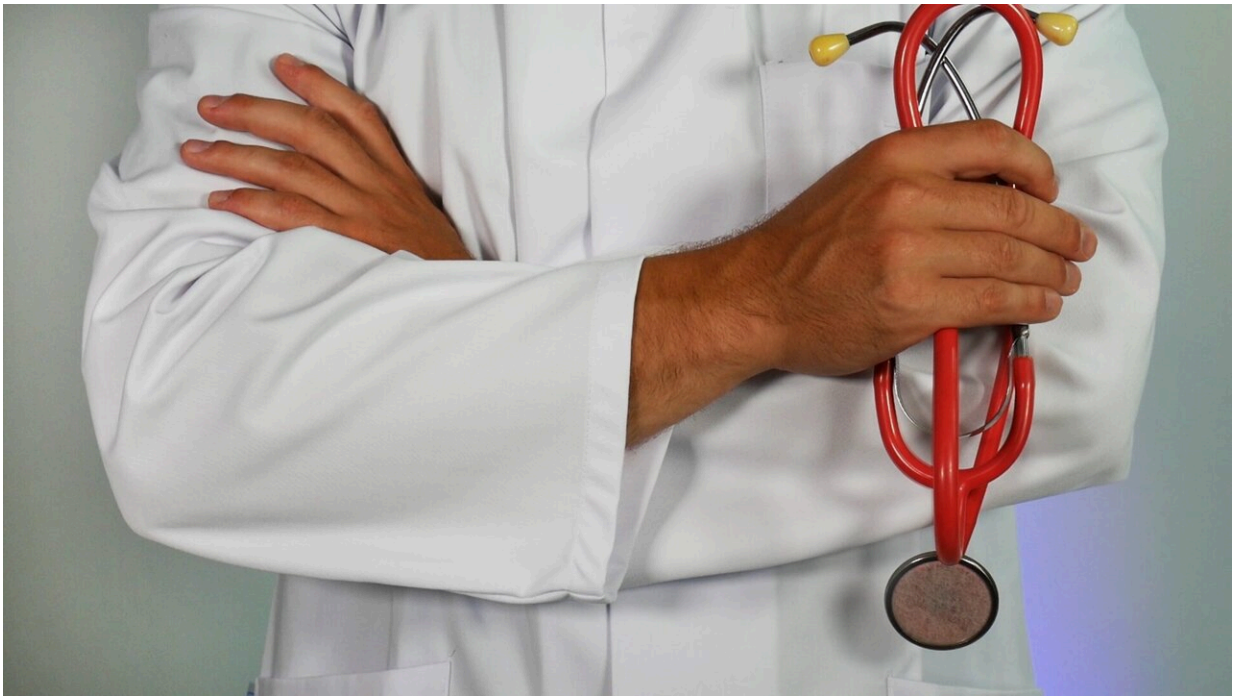

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Money talks.

The United States faces a serious shortage of primary care physicians for many reasons, but one, in particular, is inescapable: compensation.

Substantial disparities between what primary care physicians earn

relative to specialists like orthopedists and cardiologists can weigh into medical students' decisions about which field to choose. Plus, the system that Medicare and other health plans use to pay doctors generally places more value on doing procedures like replacing a knee or inserting a stent than on delivering the whole-person, long-term health care management that primary care physicians provide.

As a result of those pay disparities, and the punishing workload typically faced by primary care physicians, more new doctors are becoming specialists, often leaving patients with fewer choices for primary care.

"There is a public out there that is dissatisfied with the lack of access to a routine source of care," said Christopher Koller, president of the Milbank Memorial Fund, a foundation that focuses on improving population health and health equity. "That's not going to be addressed until we pay for it."

Primary care is the foundation of our health care system, the only area in which providing more services—such as childhood vaccines and regular blood pressure screenings—is linked to better population health and more equitable outcomes, according to the National Academies of Sciences, Engineering, and Medicine, in a recently published report on how to rebuild primary care. Without it, the national academies wrote, "minor health problems can spiral into chronic disease," with poor disease management, emergency room overuse, and unsustainable costs.

Yet for decades, the United States has under-invested in primary care. It accounted for less than 5% of health care spending in 2020—significantly less than the average spending by countries that are members of the Organization for Economic Cooperation and Development, according to the report.

A $26 billion piece of bipartisan legislation proposed last month by Sen.

Bernie Sanders, I-Vt., chair of the Senate Health, Education, Labor, and Pensions Committee, and Sen. Roger Marshall, R-Kan., would bolster primary care by increasing training opportunities for doctors and nurses and expanding access to community health centers. Policy experts say the bill would provide important support, but it's not enough. It doesn't touch compensation.

"We need primary care to be paid differently and to be paid more, and that starts with Medicare," Koller said.

How Medicare drives payment

Medicare, which covers 65 million people who are 65 and older or who have certain long-term disabilities, finances more than a fifth of all health care spending—giving it significant muscle in the health care market. Private health plans typically base their payment amounts on the Medicare system, so what Medicare pays is crucial.

Under the Medicare payment system, the amount the program pays for a medical service is determined by three geographically weighted components: a physician's work, including time and intensity; the practice's expense, such as overhead and equipment; and professional insurance. It tends to reward specialties that emphasize procedures, such as repairing a hernia or removing a tumor, more than primary care, where the focus is on talking with patients, answering questions, and educating them about managing their chronic conditions.

Medical students may not be familiar with the particulars of how the payment system works, but their clinical training exposes them to a punishing workload and burnout that is contributing to the shortage of primary care physicians, projected to reach up to 48,000 by 2034, according to estimates from the Association of American Medical Colleges.

The earnings differential between primary care and other specialists is also not lost on them. Average annual compensation for doctors who focus on primary care—family medicine, internists, and pediatricians—ranges from an average of about $250,000 to $275,000, according to Medscape's annual physician compensation report. Many specialists make more than twice as much: Plastic surgeons top the compensation list at $619,000 annually, followed by orthopedists ($573,000) and cardiologists ($507,000).

"I think the major issues in terms of the primary care physician pipeline are the compensation and the work of primary care," said Russ Phillips, an internist and the director of the Harvard Medical School Center for Primary Care. "You have to really want to be a primary care physician when that student will make one-third of what students going into dermatology will make," he said.

According to statistics from the National Resident Matching Program, which tracks the number of residency slots available for graduating medical students and the number of slots filled, 89% of 5,088 family medicine residency slots were filled in 2023, compared with a 93% residency fill rate overall. Internists had a higher fill rate, 96%, but a significant proportion of internal medicine residents eventually practice in a specialty area rather than in primary care.

No one would claim that doctors are poorly paid, but with the average medical student graduating with just over $200,000 in medical school debt, making a good salary matters.

Not in it for the money

Still, it's a misconception that student debt always drives the decision whether to go into primary care, said Len Marquez, senior director of government relations and legislative advocacy at the Association of

American Medical Colleges.

For Anitza Quintero, 24, a second-year medical student at the Geisinger Commonwealth School of Medicine in rural Pennsylvania, primary care is a logical extension of her interest in helping children and immigrants. Quintero's family came to the United States on a raft from Cuba before she was born. She plans to focus on internal medicine and pediatrics.

"I want to keep going to help my family and other families," she said. "There's obviously something attractive about having a specialty and a high pay grade," Quintero said. Still, she wants to work "where the whole body is involved," she said, adding that long-term doctor-patient relationships are "also attractive."

Quintero is part of the Abigail Geisinger Scholars Program, which aims to recruit primary care physicians and psychiatrists to the rural health system in part with a promise of medical school loan forgiveness. Health care shortages tend to be more acute in rural areas.

These students' education costs are covered, and they receive a $2,000 monthly stipend. They can do their residency elsewhere, but upon completing it they return to Geisinger for a primary care job with the health care system. Every year of work there erases one year of the debt covered by their award. If they don't take a job with the health care system, they must repay the amount they received.

Payment imbalances a source of tension

In recent years, the Centers for Medicare & Medicaid Services, which administers the Medicare program, has made changes to address some of the payment imbalances between primary care and specialist services. The agency has expanded the office visit services for which providers can bill to manage their patients, including adding non-procedural billing

codes for providing transitional care, chronic care management, and advance care planning.

In next year's final physician fee schedule, the agency plans to allow another new code to take effect, G2211. It would let physicians bill for complex patient evaluation and management services. Any physician could use the code, but it is expected that primary care physicians would use it more frequently than specialists. Congress has delayed implementation of the code since 2021.

The new code is a tiny piece of overall payment reform, "but it is critically important, and it is our top priority on the Hill right now," said Shari Erickson, chief advocacy officer for the American College of Physicians.

It also triggered a tussle that highlights ongoing tension in Medicare physician payment rules.

The American College of Surgeons and 18 other specialty groups published a statement describing the new code as "unnecessary." They oppose its implementation because it would primarily benefit primary care providers who, they say, already have the flexibility to bill more for more complex visits.

But the real issue is that, under federal law, changes to Medicare physician payments must preserve budget neutrality, a zero-sum arrangement in which payment increases for primary care providers mean payment decreases elsewhere.

"If they want to keep it, they need to pay for it," said Christian Shalgian, director of the division of advocacy and health policy for the American College of Surgeons, noting that his organization will continue to oppose implementation otherwise.

Still, there's general agreement that strengthening the primary care system through payment reform won't be accomplished by tinkering with billing codes.

The current fee-for-service system doesn't fully accommodate the time and effort primary care physicians put into "small-ticket" activities like emails and phone calls, reviews of lab results, and consultation reports. A better arrangement, they say, would be to pay primary care physicians a set monthly amount per patient to provide all their care, a system called capitation.

"We're much better off paying on a per capita basis, get that monthly payment paid in advance plus some extra amount for other things," said Paul Ginsburg, a senior fellow at the University of Southern California Schaeffer Center for Health Policy and Economics and former commissioner of the Medicare Payment Advisory Commission.

But if adding a single five-character code to Medicare's payment rules has proved challenging, imagine the heavy lift involved in overhauling the program's entire physician payment system.

MedPAC and the national academies, both of which provide advice to Congress, have weighed in on the broad outlines of what such a transformation might look like. And there are targeted efforts in Congress: for instance, a bill that would add an annual inflation update to Medicare physician payments and a proposal to address budget neutrality. But it's unclear whether lawmakers have strong interest in taking action.

"The fact that Medicare has been squeezing physician payment rates for two decades is making reforming their structure more difficult," said Ginsburg. "The losers are more sensitive to reductions in the rates for the procedures they do."