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Chapter

Primary Care in the USA: The Long Struggle to Build its Foundational Role

John Geyman

Abstract

Family practice was recognized as the 20th specialty in American medicine in 1969. With the hope that primary care would become the foundation of an improved health care system, vigorous efforts were launched in medical education, research and practice to achieve that goal. This chapter traces the history of that effort, together with negative system changes that have obstructed that goal. Although primary care physicians have been shown to improve access to care, contain costs, decrease inequities, and improve patient outcomes, they are still too few in number to meet national needs for primary care. The COVID-19 pandemic revealed the extent of inadequacy and vulnerability of the system. The U. S. still lacks a system of universal access as has been in place for many years in most other advanced countries around the world. Corporate stakeholders in a largely privatized financing and delivery system continue to challenge the future of primary care. Lessons from the failure of reform initiatives over the last 50 years are discussed, as are current reform alternatives, only one of which would at last bring universal access to health care in this country.

Keywords: primary care, family practice; access, costs, quality and outcomes of care; corporatization, medical-industrial complex, health care reform, Medicare for All

1. Introduction

The need for primary care to serve as the foundation of U. S. health care has been recognized for years. Many efforts have been taken to make that happen through medical education and practice. However, despite considerable progress toward that goal, the U. S. still lacks such a foundation, as international studies of 11 advanced countries clearly show.

This chapter has three goals: (1) to bring historical perspective to the evolution and progress of primary care in this country, despite system obstacles; (2) to describe current attempts to rebuild primary care; and (3) to briefly consider the road ahead.

2. Historical perspective

2.1 How primary care developed

Family practice, which became its own board-certified specialty in 1969, evolved from general practice, which just 20 years earlier represented 50 percent of all U. S.

physicians [1]. But specialization in the aftermath of World War II changed the ratio of generalist physicians to specialists from 80 percent of all physicians in 1930 to just 20 percent in 1969 when family practice was recognized as a specialty.

Medical care was fragmented by the 1960s among many non-generalist specialties to the point that three national groups issued three major reports—the Millis Report, the Willard Report and the Folsom Report. All strongly stated the urgent need for the primary or family physician as the backbone of personalized comprehensive medical care.

Those reports, together with a shift of federal and state funding priorities, led to new family medicine teaching programs in U. S. medical schools and hospitals. By 1990, impressive progress had been made, as shown by these markers:

- Clinical departments of family practice in more than one-half of departmentalized U. S. hospitals.
- Active clinical departments of family practice in most medical schools.
- 384 family practice residency programs with about 7,300 residents in training.
- More than 40,000 board-certified family physicians.
- Active research in many academic departments of family practice, together with some collaborative research networks involving community settings.
- Family practice in high demand, with leading role in managed care [2].

Fast forward, however, to 30 years later in 2020, and we still have an acute shortage of primary care physicians in an upside-down pyramid dominated by other specialties, with fragmented care the rule. A 2010 conference sponsored by the Josiah Macy, Jr. Foundation that brought together leading experts in health policy came to this conclusion:

> *The lack of a strong primary care infrastructure across the nation has had significant consequences for access, quality, continuity, and cost of care in this country. It also has had consequences for our health profession educational enterprise and the healthcare workforce, resulting in numbers and geographic distributions of primary care providers that are insufficient to meet current and projected needs ... We are facing an economic situation in which the current rate of rise of medical cost is unsustainable, and this situation is exacerbated by an aging population with higher care needs and expectations. These events have created a climate in which it is necessary and appropriate to question the models of care and health professions education on which we have relied [3].*

As the shortage of primary care persists with stagnation of the primary care physician workforce, part of this growing need has been filled by the rapid growth of nurse practitioners and physician assistants, typically working in teams with primary care physicians but sometimes more independently [4].

3. Negative system changes as obstacles to primary care

Other advanced countries around the world ensure universal access to health care with a stronger role of primary care. The U. S. has evolved a profit-driven medical-industrial complex with deregulated markets and little oversight and

accountability by government. Much of U. S. health care has been corporatized, with a shift to for-profit health care, increased privatization, and growth of investor-owned corporate health care. These changes have resulted in:

- prices to what the traffic will bear;
- uncontained costs;
- decreased choice and access to care;
- variable, often poor quality of care;
- erosion of a safety net; and
- rampant profiteering, even fraud.

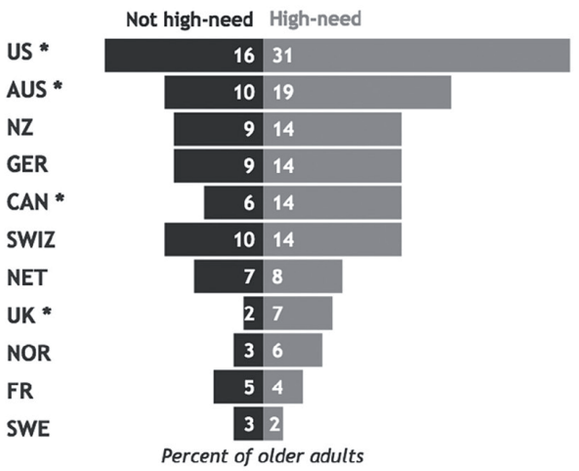
These changes have worked against the further development of family practice. Private equity firms have driven purchases of many physician-owned medical practices, driving many to become hospital-affiliated employees [5]. Almost two-thirds of U. S. physicians are now employed by others, especially by large hospital systems, where they are under pressure to maximize revenues for their employers. This is a far cry from a generation ago when family physicians ran their own practices, rounded in the hospital, and worked in the community [6]. Not surprisingly, small group practice has almost disappeared, while practice satisfaction has declined for many physicians together with increasing burnout rates [7].

Other generational changes have been taking place over the past 30 years which change the landscape for traditional primary care. One of these is the increasing numbers of millennials who do not want a family doctor, but instead value the convenience of dropping in to an urgent-care facility with an acute need without any continuity or comprehensiveness of ongoing care. National polls have found that up to one-third of millennials take this approach [8]. That change is further enabled by the increasing wait times for those who want to visit a family physician, which has gone up to almost a month because of their shortage [9].

Primary care physicians in practice are besieged by electronic health records, which have become billing instruments, and having to spend an average of $99,000 a year per physician for their billing activities that take away many hours from patient care [10]. They have to spend additional time in dealing with the different and changing policies of more than 1,000 private insurers over such everyday issues as restricted networks, drug formularies, pre-authorizations, and other requirements related to reimbursement.

The mantra of our unfettered marketplace holds that competition will bring efficiency and contain costs. That claim, however, has been proven false for years. As one example, the non-profit U. S. Center for Studying Health System Change conducted a nine-year study of 12 major health care markets in its Community Tracking Study involving 60 communities, 60,000 households and 12,000 physicians. It found four major barriers to efficiency: (1) providers' market power, (2) absence of potentially efficient provider systems, (3) employers' inability to push the system toward efficiency and quality; and (4) insufficient health plan competition [11].

The U. S. compares poorly among 11 countries periodically measured by the Commonwealth Fund, as illustrated by cost barriers for high-need older adults (**Figure 1**). Despite spending more for health care than any other country in the world (about $1.3 trillion a year), the U. S. lags behind other countries in terms of mortality amenable to health care [12].



Source: 2017 The Commonwealth Fund International Health Policy Survey of Older Adults

Figure 1.
High-need older adults experience greater cost barriers to receiving care.

3.1 Positive system impacts by primary care physicians despite obstacles

Despite their relatively small numbers system-wide, primary care has been found to be markedly beneficial by many studies around the country, as these illustrate.

- A study at Dartmouth Medical School in New Hampshire found that costs of care in regions with the most primary care physicians were 23 percent lower than in regions with the fewest number thereof. Medicare patients with most access to primary care patients also had fewer physician visits (including to other specialists), spent less time in the hospital, and were less likely to die in the hospital [13].

- A study conducted from 2005 to 2015 found that every increase of 10 primary care physicians per 100,000 population was associated with reductions of mortality of 0.9% to 1.4% from cardiovascular, cancer, and respiratory diseases [14].

- Another study found that the more primary care is used, the less use of emergency room visits and hospitalizations [15].

- Other studies have documented that increased density of primary care physicians is associated with reduced overall mortality [16–18].

- The business community, which pays the freight for our widespread system of private employer-sponsored health insurance (ESI), has found that it spends one-third less money for health care in places where primary care is available, with 19 percent lower mortality within its workforce [19].

3.2 Negative system impacts due to shortage of primary care physicians

The critical shortage of primary care physicians has led to these adverse system problems, which include increased costs and fragmentation of care of lower quality:

- Polypharmacy is a common problem among patients without primary care physicians who seek multiple physicians, who do not communicate with each other, for chronic health problems [20].

- A 2009 study found that about one-half of patient visits to specialists were already follow-up visits that could more appropriately have been handled by their primary care physicians [21].

- Although emergency physicians account for just 5 percent of the physician workforce, they handle one-quarter of all acute care encounters and more than one-half of those visits for the uninsured [22].

The COVID-19 pandemic has further exposed the fragility and inadequacy of primary care, as shown by these markers:

- With so many in-person physician visits being canceled across the country, the future financial viability of primary care practices was being called into question [23].

- Primary care physicians in smaller, independent practices faced such a large drop in patient volume that they thought that they may be forced to close their practices [24]; nine months into the pandemic, 16,000 had done so due to the stress of the pandemic [25].

- Only about 5 percent of all U. S. health care spending goes to primary care compared to an average of 14 percent in other wealthy nations [26].

- The lack of a national physician workforce plan by specialty was again made crystal clear, with serious shortages in primary care, psychiatry, and public health.

With our continued lack of a national physician workforce plan, despite all the warnings along the way, the U. S. still confronts a shortage of between 21,000 and 55,200 primary care physicians by 2032, according to the Association of American Medical Colleges [27]. Money has everything to do with that challenging prognosis as U. S. medical graduates continue to seek out more highly reimbursed specialties, such as orthopedic surgery, anesthesiology, radiology, and dermatology.

4. Current approaches to rebuild primary care

It has long been apparent that system reform will be required in the U. S. before primary care can grow and thrive at its foundation. Our non-system has been taken over by corporate stakeholders dancing to the tune of Wall Street investors, not the needs of patients, families and taxpayers. Before we can move back to a traditional service ethic in health care based on the public interest, major reforms will be needed. As the distinguished medical historian, Rosemary Stevens, observed 20 years ago:

> *The most important impediment to a clear-cut role for family practice has been the lack of a formal administrative structure for primary care practice on a nationwide basis in the United States [28].*

4.1 Lessons learned from past reform initiatives

Before having any success in bringing about change, we need to better understand the forces that blocked previous attempts. It has been more than a century since Teddy Roosevelt, running as a presidential candidate on the progressive ticket in 1912, proposed universal coverage through national health insurance. These are the major lessons that we can take from every attempt to reform health care since then, including passage of the Affordable Care Act (ACA) in 2010:

1. "Turning to the stakeholders, who themselves crafted the system's problems, for recommended solutions does not work.

2. The more complex a bill becomes, in an effort to respond to competing political interests, the more its legislative and public support erodes.

3. Strong presidential leadership from the start and throughout the legislative process is critical to enactment of health care reform.

4. Corporate power in our enormous medical-industrial complex, accounting for one-sixth of the nation's gross national product, trumps the democratic process.

5. The "mainstream" media are not mainstream at all, and have conflicts of interest based on their close ties to corporate stakeholders in the status quo.

6. We can count on opponents to use fear mongering to distort the health care debate.

7. Centrist middle of the road reform proposals for health care are bound to fail.

8. Framing the basic issues in the health care reform debate has been inadequate; the alternatives have been controlled by the special interests resisting reform so they will win.

9. History repeats itself, and we do not learn from our mistakes" [29].

A comprehensive report was published by the Institute of Medicine in 1996, *Primary Care: America's Health in a New Era*, calling for an urgent priority to prioritize primary care. But its recommendations were largely unheeded by legislators and policy makers as underinvestment in primary care continued. A recent 2021 report from the National Academies of Sciences, Engineering and Medicine again strengthened the case for primary care as the foundation of the U. S. health care system. Its 448-page report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care,* calls for policies that:

- "Pay for primary care teams to care for people, not doctors to deliver services;

- Ensure that high-quality primary care is available to every individual and family in every community;

- Train primary care teams where people live and work;

- Design information technology that serves the patient, the family and the interprofessional care team; and

- Ensure that high-quality primary care is implemented in the United States" [30].

That report went further to recommend, with a sense of urgency, that major government programs such as Medicare and Medicaid shift money to primary care and away from the non-primary care specialties, which are so highly reimbursed in our present system. The report concluded that:

> *High-quality primary care is the foundation of a robust health care system, and perhaps more importantly, it is the essential element for improving the health of the U. S. population. Yet, in large part because of chronic underinvestment, primary care in the United States is slowly dying [31].*

4.2 Coalition of primary care organizations

A coalition of 7 primary care organizations, representing 400,000 members and diplomates, has come together to emphasize the urgent need for primary care to serve as the foundation of the U. S. health care system. These include the national organizations in family practice, general internal medicine, and general pediatrics. Together, they call for a new paradigm for primary care to be established based on coordination and continuity of comprehensive person-based care for the majority of health care conditions, with the capacity to decrease disparities and inequities. They also bring a unified voice calling for payment and regulatory reform to stabilize and strengthen practice [32].

4.3 Current approaches to health care reform

Three major reform alternatives will be considered in a deeply polarized Congress with corporate lobbyists descending on Washington D. C. to try to ward off reform one more time. Here are briefly encapsuled summaries of the alternatives.

4.3.1 Building on the ACA

The ACA has been helpful as an incremental step to needed reform by bringing health insurance to some 20 million people since its passage in 2010, mostly through expansion of Medicaid in 31 states. It has also provided coverage to 8 million Americans who lost coverage during the pandemic [33].

On the other hand, these points show how far short from needed reform that this alternative is:

"It will still be just another Band-Aid on a broken system without universal coverage.

- It has failed to contain costs, and will continue to do so since a profiteering, inefficient private insurance industry is left in place.

- Insurance and health care will remain unaffordable and inaccessible for a large part of our population.

- Continuing inequities, with many Americans still delaying or foregoing essential care.

- Health insurance still pricey and volatile as employer-based coverage is further stressed.

- Regulation of network size has been inadequate as has been gaming by insurers.

- Many insurers abandon markets that are not sufficiently profitable, often with little advance notice.

- A continued Medicaid coverage gap exists in the 12 states that refused to expand Medicaid" [34].

4.3.2 A public option

This was included in the ACA in 2010 whereby private non-profit CO-OPs were established to sell insurance in an effort to compete with private insurers under the same rules and on a level playing field. The hope was that they could compete, reduce costs, and increase the value of health insurance. They failed to do so, however, and only 5 of the initial 23 CO-OPs survive to this day, serving just 1 percent of the 11 million people who initially obtained this coverage through the ACA's exchanges [35].

Unfortunately, the public option of one kind or another is still being talked about in some circles, despite this lesson that we should have learned—incremental steps leaving the private health insurance industry in place, which has been subsidized by government funds for many years, will never achieve universal coverage.

4.3.3 Single-payer Medicare for all

This is the only way forward that can get bring system reform to our present non-system, with its inadequate access, unaffordable prices and costs, unacceptable quality, and widespread disparities. A fix can be on the way if we can muster the political will to enact an updated Medicare for All bill now in the House of Representatives in Congress, H. R. 1976. As stated by Rep. Pramila Jayapal (D-WA), one of its two lead sponsors, when the bill was introduced:

> *While this devastating pandemic is shining a bright light on our broken, for profit health care system, we were already leaving nearly half of adults under the age of 65 uninsured or underinsured before COVID-19 hit. And we were cruelly doing so while paying more per capita for health care than any other country in the world [36].*

Among its many benefits, H. R. 1976, when enacted, will bring:

- A new system of national health insurance with comprehensive benefits based on medical need, not ability to pay, and with full choice of hospitals,

- physicians, and other health professionals anywhere in the country.

- Coverage for all medically necessary care, including outpatient and inpatient services; laboratory and diagnostic services; dental, hearing and vision care; prescription drugs; reproductive health, including abortion; maternity and newborn care; mental health services; and long-term care and supports.

- Administrative simplification with efficiencies and large-scale cost controls, including negotiated fee schedules for physicians and other health professionals, global annual budgeting of hospitals and other facilities, and bulk purchasing of drugs and medical devices.

- Cost savings that will enable universal coverage through a single-payer, not-for-profit public financing system.

- Elimination of cost-sharing at the point of care, such as co-pays and deductibles, as well as the current need for pre-authorization through private insurers.

- Establishes an Office of Health Equity to monitor and eliminate health disparities and promote primary care.

- Sharing of risk for the costs of illness and accidents across our entire population of 330 million Americans [37].

It is little known that our multi-payer private health insurance industry has been propped up by various subsidies from the federal government for many years,

	ACA	**Public option**	**Medicare for all**
Access	Restricted	Restricted	Unrestricted
Choice	Restricted	Restricted	Unrestricted
Cost containment	Never	Never	Yes
Quality of care	Unacceptable	Unacceptable	Improved
Bureaucracy	Large, wasteful	Large, wasteful	Much reduced
Universal coverage	Never	Never	Yes
Accountability	No	No	Yes
Sustainability	No	No	Yes

Table 1.
Comparison of three reform alternatives based on evidence.

	ACA	**Public option**	**Medicare for all**
Health care a human right?	No	No	Yes
Commodity for sale?	Yes	Yes	No
Profits to service ethic?	No	No	Yes
Medical need vs. ability to pay?	No	No	Yes
Full choice of physician & hospital?	No	No	Yes
Accessible, reliable, efficient?	No	No	Yes
Not for profit, reduced waste?	No	No	Yes
Population-based shared risk?	No	No	Yes
Science-based?	No	No	Yes
Common good, public interest?	No	No	Yes

Table 2.
Comparison of three reform alternatives based on values.

averaging about $685 billion a year today [38]. Well known economist Gerald Friedman, who has studied the costs of Medicare for All for more than ten years, estimates that we would have saved more than $1 trillion in 2019 had it been in place at that time [39].

The U. S. has tried market-based alternatives for many years, and they have all failed the public interest. Privatization and commodification of health care leads to higher prices and costs, decreased access and worse outcomes of care, as well as more bureaucracy and waste. **Table 1** compares our three reform alternatives in terms of experience and evidence, and **Table 2** compares them in terms of values [40].

5. Whither the future of primary Care in the U. S.?

5.1 Corporate alliances against reform

The COVID-19 pandemic exposed the inadequacy of our system to deal with its disastrous consequences. As the urgency for health care reform has grown in its aftermath, including support for universal coverage through a public financing system under Medicare for All, reactionary opposition from corporate stakeholders and their allies has increased apace, as these examples illustrate:

- Major insurers, hospitals, and some unions joined together under the banner of the Alliance to Fight for Health Care [41].

- The private health insurance industry has spread propaganda and disinformation about how unaffordable, disruptive, and unwanted such a government-based program would be [42].

5.2 Some continuing threats to primary care

5.2.1 Telehealth and corporatization

The growth of telehealth during the COVID-19 pandemic filled a pressing need for safe virtual medical visits. Because of its prevalence, it soon became reimbursed by insurers, typically at the same price as in-person consultations. Despite its utility in some circumstances, as we move beyond the pandemic, it poses a risk of worse care, price gouging, and more inequities since many patients in need may not have access to high-speed internet [43, 44]. Some employers and insurers, such as Amazon and United Healthcare, are promoting virtual first care plans as if they are as effective as in-person physician visits, despite the accumulating evidence that major conditions can be missed. Wall Street and venture capital have also discovered the profit potential of expanded telehealth [45]. with one recent example being the acquisition by Walmart of MeMD, a big telehealth provider [46].

5.2.2 Continued underinvestment in primary care

Primary care visits in the U. S. account for 35 percent of health care visits but make up about 5 percent of health care expenditures, compared to an average of 14 percent of all health care spending in OECD countries [47]. A promising development now is the expected introduction of legislation by Senator Bernie Sanders

authorizing 14,000 new Medicare-supported residency programs over seven years. That bill, if enacted, would also importantly establish new criteria for the distribution of residency slots, with one half allocated for primary care [48].

Another way that the government could, and should address the shortage of primary care physicians is to establish ways that can cover their debt, now averaging $200,000 for medical school graduates, if they enter primary care. Reimbursement policies should also be changed to more highly value time-intensive care involved in primary care with fewer currently overly reimbursed procedures driving high costs of care by other more procedurally oriented specialties [49].

6. Conclusion

As is obvious from the foregoing, the U. S. still lacks a primary care base for its health care system, despite a long struggle over many decades. Health care services are still treated as a commodity for sale on in a largely unfettered marketplace. Although the ideologic claim that the competitive free market will contain costs has been proven conclusively false, the political battle continues over the role of government vs. an open market. It has become obvious to much of the public and many health policy experts that the time has come to put in place a system of universal coverage based on a service ethic for the common good. As Winston Churchill observed many years ago:

> *You can always count on Americans to do the right thing— after they've tried everything else.*

That time has finally come, so let us hope for the future!

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