The most important primary care–related development of 2010 has to be the new healthcare reform law. While both welcome and overdue, the increase in real coverage options brought about by the law—and the requirement that people who can afford it take personal responsibility for purchasing health insurance, with subsidies for those who cannot—mean that demand for primary care will dramatically increase beginning in 2014, the year the health insurance exchanges begin operating and expanded eligibility for Medicaid goes into effect. We as a nation have at most a couple of years to figure out how to meet this coming need.

Drivers of Change

The law’s importance as a driver of change for primary care is not just because it represents the largest expansion of coverage since Medicare. The law also increases primary care payment under Medicare, and it provides more money for workforce development, federally qualified health centers (FQHCs), and other innovations, such as primary care extension agents, nurse-managed clinics, and co-location of mental health services in primary care settings. Also important is unprecedented funding for chronic disease prevention.

The recent recession and protracted recovery is another driver of change, but one with mixed effects for primary care. In the near term, high unemployment has increased the number of uninsured. A national survey of family physicians conducted during the recession found that financial obstacles were causing many patients to defer needed preventive care, resulting in more health problems (American Academy of Family Physicians 2009). But the economic downturn has also affected physicians and hospitals that are dependent on volume, particularly of more lucrative elective procedures, making strong ties to primary care even more essential to maintaining the specialty referral base.

A third development underscoring the rising prominence of primary care is the growing interest in the patient-centered medical home (PCMH), an approach to providing primary care that facilitates partnerships between patients and their personal physicians. Although the concept is still theoretical, in that no commercial payers actually pay more for PCMH care on a broad scale, a consensus is emerging on the key characteristics of the PCMH, and the National Committee for Quality Assurance (NCQA) has established voluntary standards for the recognition of physician practices as medical homes. Also related is the emergence of “accountable care” and the accountable care organization (ACO). Pilots for both the PCMH...
Trends

A continuing primary care supply gap. Even with the growth in midlevels, provider supply will continue to be a challenge. Medical student entry into primary care is at a nadir. A 2008 study of 1,177 fourth-year medical students found that 2 percent were planning to go into general internal medicine, 5 percent into family medicine, and 12 percent into pediatrics (fewer than half of whom go into primary care). Reasons include the salary gap vis-à-vis specialists, a low quality of work life, and a perceived lack of prestige (Hauer et al. 2008). The Macy Foundation’s recent conference report on the future of primary care concluded that low student interest in primary care is not just about money, but also reflects the fact that students and trainees do not like what they see in their clinical training (Cronenwett and Dzau 2010).

We cannot simply count on training more physicians to fill the primary care gap. Despite recent growth in the number of medical schools, most dedicated to producing primary care physicians, and expanded class sizes, the increase in the supply of new primary care physicians is likely to be incremental. Brook and Young (2010) have argued that over half of all medical students would have to enter primary care to begin to close the gap in provider supply. It will be interesting to see if the new healthcare law and the changes stemming from it increase interest in primary care careers, much as managed care did in the early 1990s.

The quality of their training experiences also affects the career choices of physician assistants (PAs) and nurse practitioners (NPs). Duke University started the first PA program in 1965. Today, the number of PAs and NPs is at an all-time high and rising. PAs in practice numbered 74,000 in 2008, and physician assistants are projected to be the second-fastest-growing health profession, after home health aides, in the coming decade. As of 2010, there were 135,000 practicing NPs, with 8,000 more being added each year (Rovner 2010).

However, even as the logic of using PAs and NPs for primary care becomes more self-evident, the same trend toward specialization is being seen. For example, over half of all new PAs are going into specialties. The proportion of PAs entering primary care declined from 54 percent in 1996 to 41 percent in 2005 and has declined still further since then; this is offset by a doubling in the absolute number of PAs over the same period (Morgan and Hooker 2010). Incongruously, part of this trend may be demand-related. Our experience has been that many patients and even physicians remain ambivalent about PAs and NPs—particularly in primary care—and thus they are not always used to the fullest extent of their abilities. PAs in the specialties are likely to be more valued.

The changing economics of primary care. The next few years will see hospitals and health systems investing in primary care to an extent not seen since the early 1990s. Unaffiliated primary care providers may find the going increasingly tough because of unfavorable contracts, but they may also find surprising new opportunities.

Another economic change taking place is the gradual carving out of primary care revenue streams at the upper-middle and top tiers, with 24/7 concierge service, same-day scheduling, and other “premium” conveniences. As demand for primary care grows, one might expect this trend to accelerate.

“Lean” primary care—a bare-bones mix of urgent care and low-overhead primary care business, sometimes with ancillaries (X-ray, lab) that keep additional revenue coming into the practice—is yet another change, one that has the potential to deliver primary care at a price point even cash-paying, uninsured patients can afford. This is the direction in which retail-store-based franchise operations like MinuteClinic appear to be moving.

A move to greater accountability and with it greater clinical and financial integration. The chief medical officer of our primary care network has asked, Is the rush to “accountable care” simply new wine in old bottles? That is, are we seeing the second coming of capitation and managed care for providers not touched by it now? To some extent, probably yes.

But there are at least three major differences between the early 1990s and now. In these new ACO-type arrangements, any “shared savings” risk sharing is spread across an entity that spans the entire healthcare spectrum. Thus, by design, primary care providers would not solely bear the risk for utilization they have no reasonable way of controlling.

The second major difference, where it exists, is collaboration. ACOs will require participation by primary care, both legislatively and functionally. Tighter clinical integration—between primary care and specialists, between physicians and hospitals—is likely to be needed to overcome legal and antitrust concerns. This means primary care providers could receive financial support from other actors in the healthcare delivery chain for essential but unreimbursed activities such as care coordination, and would no longer be solely dependent on payers. Even outside a formal ACO context, rationales for such integration exist, including the penalties on hospitals for...
# FUTURESCAN SURVEY RESULTS: Primary Care Physicians and Nonphysician Clinicians

## Questions and Surveys Results (2016)

1. A survey of hospital CEOs released in November 2009 by the national Council on Physician and Nurse Supply reported an 11 percent vacancy rate for physician jobs, a 6 percent rate for nursing jobs, and a 5 percent rate for allied health professionals. By 2016, these vacancy rates will have doubled.

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2. Interest in family medicine has been declining recently. For example, 75 fewer positions in family medicine residency programs were filled in 2009 than 2008 through the National Resident Matching Program. Hospitals will help to foster interest in this specialty by offering more family medicine clinical clerkships to medical students.

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3. An unintended consequence of clinical guidelines is that the art of doctoring is diminished in favor of formulaic tasks that are easily codified and performed by nonphysician clinicians (e.g., advanced practice nurses, physician assistants, pharmacists; also called clinical extenders). In 2016, most primary care will be provided by nonphysician clinicians.

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4. In response to crushing patient demands for service, physicians who have opposed enlarging clinical extenders’ roles will reverse their stand.

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5. Nonphysician clinicians without prescribing rights currently must have their prescriptions signed by a physician—a practice that interrupts service delivery, irritates patients, and reduces healthcare efficiency. By 2016, these rules will be revised in your state.

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6. Nonphysician clinicians cost less to employ than physicians, but their lower productivity and less efficient use of resources will result in no cost savings.

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7. One constraint to nonphysician clinicians’ role enlargement has been insurers’ prohibiting charges for services provided by them. In response to pressing patient care demands, health insurers will alter their stand.

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<td>35</td>
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8. General surgeons are increasingly subspecializing in bariatric, breast, and colorectal surgery and other surgical areas. By 2016, there will be no such thing as a “general” general surgeon.

**Note:** Percentages in each row may not sum to 100% due to rounding.
What Practitioners Predict

Hospitals expect more clinical vacancies and will offer family practice clerkships. Nearly three-quarters of respondents agreed that current vacancy rates for physician, nursing, and allied health professional jobs will double by 2016. Moreover, in response to declining interest in family medicine residencies, 82 percent of practitioners predict that hospitals will help to foster interest in the specialty by offering more family medicine clinical clerkships to medical students.

Clinical extenders will provide the bulk of primary care. Two factors will expand the clinical extender role: (1) the development of clinical guidelines and (2) pressing patient care demands. According to two-thirds of practitioner respondents, it is likely clinical extenders—advanced practice nurses, physician assistants, and pharmacists—will provide most primary care in 2016. In response to pressing patient care demands, 82 percent think physicians who have opposed enlarging clinical extenders’ roles will reverse their stand. Two-thirds agreed that regulations in their states will be revised to allow nonphysician clinicians to prescribe without a physician’s countersignature. A third factor driving expansion of the clinical extender role may be the potential for cost savings. Seventy-one percent of respondents rejected the premise that nonphysician clinicians’ lower productivity and less efficient use of resources will balance out the cost savings of employing these physician extenders.

Insurers will pay for services of nonphysician clinicians. In response to pressing patient care demands, health insurers will begin reimbursing for nonphysician clinicians’ services, according to 82 percent of respondents.

Views are mixed on the outlook for general surgery. Although general surgeons are increasingly subspecializing in bariatric, breast, colorectal, and other surgical areas, a majority (56 percent) of respondents thought it unlikely the “general” general surgeon will disappear by 2016.

Implications for Hospital Leaders

Hospital and health system leaders should proactively grow new models of primary care. Conversely, unaffiliated primary care providers should look for novel opportunities to craft new relationships with hospitals and health systems. Not enough primary care physicians can be trained to meet the demand 30 million new insured patients will generate, certainly not in the next two years. New models will have to be embraced to avoid long wait times for primary care. As noted above, new relationships between hospitals and primary care providers are likely to emerge.

What could these new models look like? Picture physician-to-extender ratios in the 1:3–4 range, borrowing a page from the anesthesiology playbook. Certified registered nurse anesthetists (CRNAs) have transformed anesthesia care and the specialty of anesthesiology, elevating the latter into a mixed supervisory and direct care role. Primary care could use a similar transformation.

Differentiation in primary care will result from superior service in three areas: convenience, care management, and cost-consciousness (on behalf of patients trying to control out-of-pocket costs). As demand for primary care grows, making a quantum leap in 2014, providers will find it difficult to maintain even their current level of service. Care coordination in the near term is likely to be more fractured, not less, at least until there is ongoing financial support for needed personnel, which will take time. Primary care providers and networks that are able to elevate customer service and manage care through the use of multiple channels (in addition to face-to-face visits) to maintain efficient, continuous healing relationships with patients will stand above the rest. Such networks will be a source of real competitive advantage to hospitals and health systems that have them as part of their referral base.

Related to improving service, the focus of health IT investments needs to move from the capture and presentation of static data toward dynamic, back-and-forth electronic communication among members of a care team, between primary care and specialists,
between hospital and clinic, and between providers and patients. Decision support technology should expand beyond the physician to support the work of other members of the care team—in real time—and even to automate patient-direct reminders (e.g., for preventive services). Finally, a much greater investment is needed in the analytics that will help us all make sense of our data—that is, business intelligence tied to outcomes, not just volumes and throughputs. Current patient safety and quality measurements are definitely a start but by no means represent all we could be doing to understand which services improve the health of patients in a cost-effective manner.

Helping patients navigate care-related financial issues will become a third source of competitive advantage for providers. High-deductible plans figure to be the cheapest in the health insurance exchanges. But unlike the car owner with cheap auto insurance, who may find that nobody will repair his damaged car, a patient with a high-deductible plan who has a costly but preventable hospitalization (or ER visit) or a costlier-than-necessary elective procedure becomes a potential source of “preventable” bad debt for the hospital.

**Rural and underserved areas will continue to struggle, but opportunities exist there, too.** Rural hospitals and primary care providers should continue to develop training relationships with medical schools, residencies, and NP and PA programs to help draw learners into their communities, and they should work hard to create superior training experiences. FQHCs can be a focus for efforts to recruit and retain talent as well as a source of funding for new construction. Billions of dollars will be available to establish new FQHCs, and the various pilots authorized by the new healthcare law are potential sources of revenue.

**Conclusions**

Leaders of hospitals and other healthcare institutions should not only consider creative partnerships with primary care providers in care delivery, but also should engage medical and other health professional schools in education, training, and leadership development. Look at building primary care–like capabilities in new areas, such as the prehospital and posthospital stages of care. Invest in health IT not just for data exchange but to improve communication, particularly with patients, and provide decision support for the entire care team, not exclusively for already stretched physicians. Embrace new supervisory arrangements that increase the ratio of PAs and NPs to physicians. Finally, a number of provisions in the new healthcare law seek to increase primary care capacity through both established and novel approaches. These should not go unnoticed, particularly by providers in underserved areas.

If things do not change, the primary care experience risks continuing to deteriorate as demand increases. As substitutes such as DIY (do-it-yourself) care and direct-to-specialist self-referrals become more prevalent, hospitals could see their referral bases erode further. By 2020 today’s hospitals could resemble legacy airlines, as Southwest Airlines–type entrants (e.g., a reinvented MinuteClinic) poach younger, healthier, and ultimately more profitable patients.

The good news? There is no shortage of opportunities to avoid such a fate—for the prepared.

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**References**


