Will The Real Primary Care Provider Please Stand Up?

The supply of primary care providers becomes ever more important with a marketplace that emphasizes the delivery of cost-effective care by primary care physicians. The promise of federal reforms combined with marketplace forces suggests that incentives for primary care physicians will increase while opportunities for subspecialist physicians will diminish. The widespread perception[1,2] that there are insufficient numbers of primary care providers to meet this nation's health care needs and that an adequate supply cannot be restored for a very long time has prompted policy makers to think that the training of non–primary-care providers to deliver primary care services might be a critical short-term solution in the United States.[3]

In this environment the issue of who delivers primary care and who properly can be called a primary care provider has become especially contentious. An increasing number of specialty medical organizations and nonphysician health care providers now assert that they provide important amounts of primary care. Indeed, there is some support for their contention that some of the clinical activities which occur in the offices of limited specialists are appropriate primary care activities.[4-6]

The current debate appears to center on the competencies of different provider groups to deliver primary care services[7] and the degree to which primary care services are provided by existing health care providers. Primary care has been characterized in many ways. Its attributes include the following: first-contact care that is neither organ-specific nor disease-specific; illness-based care and care for undifferentiated health concerns; comprehensive, person-centered care; continuous or longitudinal care; coordinated care or responsibility for orchestrating a range of other health services that relate to the patient's care; accessible care; community-oriented care; and care that offers both preventive and curative services.[8,9] Few of these attributes have been operationalized in such a way as to make possible an evaluation of the degree to which primary care services are delivered.

Central to any discussion of who provides primary care is the definition one uses. Rosenblatt, et al.[10] define a primary care episode as "a nonreferred ambulatory visit to a physician for a common medical disorder" and consider a primary care specialty as one having "a broad diagnostic repertoire capable of addressing the full spectrum of diagnostic presentations for a large, defined segment of the population." They used a well-established method, diagnostic clusters, to examine National Ambulatory Medical Care Survey (NAMCS) data from 1980 and 1989. They first apply their method to all nonreferred visits to the entire physician sample and select the top 20 clusters as primary care encounters because they are the most common. They then compare these top 20 primary care clusters with those of selected provider specialty types.

Weiner and Starfield[6] described primary care in terms of its dimensions: principal care, nonreferred care, first-contact care, accessibility, comprehensiveness, and continuity. This definition is far richer than that employed by Rosenblatt, et al.[10] but is frankly difficult to apply in a secondary analysis of a large, yet limited, data set. Family-centeredness, a critical component of their definition, is impossible to operationalize in such an analysis yet is perhaps the only patient-defined measure of primary care.

While reporting the percentage of all visits made to each provider specialty, Rosenblatt, et al. do not specify the relative number of physicians sampled in each specialty group. Representativeness and generalizability of NAMCS data for certain specialties must be questioned when the number of those sampled is quite low. In fact, the number surveyed is far too small to make statistically valid conclusions represented in the NAMCS data for most specialties except for family practice, internal medicine, pediatrics, general surgery, and obstetrics-gynecology.

According to the analysis by Rosenblatt, et al., the diagnostic profiles of family physicians and general internists appear to be quite similar, representing a broad range of conditions. General surgeons encounter an even greater spectrum of

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common conditions than family physicians and general practitioners, which raises the interesting question of whether general surgeons should be considered primary care physicians. In many rural areas of the United States, one suspects that the activities of general surgeons closely resemble those of family physicians.

Rosenblatt, et al. conclude that family practice, general internal medicine, and general pediatrics qualify as primary care specialities. Few would find this conclusion very controversial. Family physicians are clearly the most versatile of the three primary care specialties and provide more ambulatory care to more persons of all ages and both sexes. The recent inclusion of obstetrics-gynecology as a primary care discipline by the Clinton administration, however, has particularly inflamed the family practice community. Weiner and Starfield suggest that obstetrician-gynecologists provide a considerable amount of primary care to women of childbearing age just as general pediatricians provide primary care to a patient population limited by age. We suggest, however, that the types of care provided by obstetrician-gynecologists appear to be specialty-specific, that is, their care is confined to pregnancy, breast disease, gynecologic conditions, and limited preventive care activities. Although Rosenblatt, et al. concluded that women use family physicians, internists, and other physicians for many of their primary care needs, this conclusion cannot be substantiated directly through an analysis of NAMCS data.

To those on the front lines, this argument might seem like idle academic banter. The political ramifications of this seemingly "hair-splitting" exercise, however, should not be understated or underestimated. The reasons behind analyses to determine which provider specialty(ies) delivers important amounts of primary care are motivated less by science than by anticipated flow of financial support for clinical training, for reimbursement of care, and for future employment. Perhaps in response to this, the American Academy of Family Physicians at its 1994 Congress of Delegates meeting went so far as to define "limited primary care providers" as those not trained in the traditional primary care disciplines but who "sometimes provide limited patient care services within the domain of primary care."[11] This category includes physicians from nonprimary care specialties, as well as nurse practitioners, physician assistants, and others who at times provide specific primary care services (e.g., prevention, chronic care) but who should work "in close consultation with fully trained primary care physicians."

Though rhetoric supporting primary care and family practice sometimes appears to be both deafening and disingenuous, it does indeed appear that many are going to great lengths to define themselves as primary care providers (e.g., of neurology, cardiology, dermatology). It clearly does not take a genius to reveal the underlying reasons for this new-found conversion to primary care. Until recently, executives of managed care plans and HMOs have been unconvinced that limited specialists can provide cost-effective primary care. Recent "point of service" packaging by integrated service networks might attempt to circumvent primary care case management to attract additional subscribers. How these plans manage the increased costs attributed to these additional non–primary-care providers will ultimately determine their long-term financial success in the health care marketplace.

The next debate we will surely witness will be over the quality and cost-effectiveness of primary care provided by different specialties. We contend that this debate, fueled by a conspicuous absence of data but an ample supply of opinion, is already underway in the highest circles of medical politics. One can already make the case that in spite of the data presented above, consumers and managed care planners know what kind of providers they want and seek them out in the marketplace according to their skills and demonstrable performance. Those who have less faith in the marketplace, particularly health care payers, will demand evidence of who provides high-quality primary care at an acceptable price. This debate about outcomes and quality of care cannot be addressed adequately using large survey data, and existing administrative data bases might not be able to focus beyond more general aspects of care. The frontier of primary care research awaits innovative approaches to the analysis of computerized clinical records and the routine assessment of health outcomes to answer these critical questions.

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