

Reinventing the Wheel, Yet Again!

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In 1966, I became the chair of a new department at Duke University created to address the growing shortage of primary care physicians in North Carolina and the nation. Computers, physician assistants, and new models of care were among the “solutions” that emerged from this effort. In 1978, I chaired a major task force of the Institute of Medicine of the National Academies to “formulate a cohesive health manpower policy for assuring the accessibility and appropriateness of primary health delivery.” Reduction in payment disparities between primary care physicians and other physicians and payment to physicians for health education and preventive services were among the recommendations. Preferential selection of medical students likely to go into primary care, clinical experience in primary care settings, and training of all medical students in a team approach were some of the other recommendations.

Forty years later, we are facing the same problems of insufficient numbers of primary care physicians and maldistribution of practitioners, plus an added shortage of other essential medical specialists and a projected shortage of all medical practitioners. As can be seen in the North Carolina Institute of Medicine Primary Care and Specialty Supply Task Force report, we are proposing many of the same solutions. Why have we not solved these problems? Why were many of these recommendations not implemented?

The health care system is a ponderous, complex, and expensive system with many parts and no single controlling authority. Each of the component parts has decades of experience and investment in the *status quo* and resists change. The system clearly responds to new infusions of money, but there has been little investment in ordinary medical care and the infrastructure for its delivery. At the same time, there has been a huge investment in science and technology. Each advance brings forth a call for even more investment and

the promise of even more spectacular new advances, but at an ever increasing cost. New specialized treatment centers and new “dreaded disease” research centers have more appeal to citizens at large and to legislatures than new investments in primary care or other shortage specialties.

The disparity in available health care between larger cities and small communities and rural areas seems greater now than 40 years ago, in spite of a modest increase in per capita supply of physicians. At that time, generalist physicians and doctors delivering babies were available in most small communities, and small hospitals were still viable. In the interval, general internists and pediatricians have joined general practitioners and family doctors on the endangered list, and small hospitals are disappearing at an increasing rate. Large hospitals and technical specialties appear to thrive, but the expense of possessing and maintaining the latest technology and keeping up with similar

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enterprises is taxing their financial capacity.

No logical person would argue that every North Carolina town should have the same medical facilities and personnel as the major medical centers. But the fact is that even in our most privileged communities, well-insured citizens now have difficulty obtaining the personal medical advice and care that was generally available 40 years ago. This disparity is compounded when the community is hours away from a medical center, is economically

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distressed as a result of recent plant closings, and has no major shopping centers or desirable social amenities.

The recommendations in the NC IOM report are aimed at increasing the overall number of medical practitioners, but they are principally directed at those areas and communities that are at the bottom of the pile in practitioner supply. They call for both increased production and measures to move practitioners into shortage areas and to increase the number of minority practitioners. Many of the recommendations are remarkably similar to those made decades ago. Why should we think that these recommendations will work now, when they have not solved the problem in the past?

Perhaps the fact that the problems are worse will convince decision makers in the health care system to work harder at solutions and to make the needed changes. More and more ordinary citizens and recipients of health care are unhappy with our system. Business and industry leaders are increasingly alarmed with the cost of health care and the fact that we are not achieving the level of benefit seen in other countries with less expensive systems. The lack of care available in some areas of our state, combined with the financial distress of poor counties that must pay their share of Medicaid costs, leads to calls for adjustments in the distribution of state tax dollars.

The unpleasant predictions of this new task force may not seem very alarming to most people or to most health professionals. A shortage of medical practitioners in 2030 may seem to be a distant and even unlikely possibility, in spite of the sound analyses upon which this prediction is based. To some, asking the legislature, philanthropic organizations, and the public to support this set of recommendations will seem foolish, especially to those who fear bigger government roles, higher taxes, and intrusions into personal and professional lives. Why should legislators risk their political future by directing new money to increase the supply of medical practitioners several decades in the future? Why should leaders of academic medical centers retool to recruit a new type of student, change curricula, increase enrollment, and take other measures when this course can be predicted to divert resources and attention from the current highly rewarding path of research and the development of technical superiority in highly specific diagnostic and treatment methods?

The first task is to convince citizens of the state that the predictions contained in the report are valid and that change is needed. Most will turn to physicians, other health care leaders, and government experts for confirmation. This report is the first step in this process. It must receive wide attention, and the serious consequences of inaction must be recognized. Community leaders must have access to the details and understand that our state must compete with our neighbor states and other parts of the country, which face the same problems and have not previously worked as hard as North Carolina to recruit new practitioners. We must accept that change is necessary and be willing to work unselfishly to achieve it.

Even with widespread acceptance of the impending shortage of practitioners, can we be assured that the needed changes will occur? The leaders of our current academic health centers must play a huge role in achieving the objectives outlined in the report.

They face a daunting task. How can they recruit more students from minorities and from small North Carolina communities (those most likely to settle in small towns) without curtailing those activities in their current mix that produce a large part of the financial rewards supporting their work? How can they convince their current faculty, largely engaged in research and cutting edge practice, that these new students have equally important life goals which must be nurtured and respected? How can they be convinced that training family doctors for rural towns is equal in importance to training potential Nobel prize winners and achieving a higher score in the *US News and World Report* annual ranking? Financial incentives and added attention to their role in achieving these new goals must be among their rewards.

One of the most important ways to improve the supply of needed specialists is to reduce the current payment disparities between specialties. It is no coincidence that the specialty groups in short supply are those in the bottom tier of professional incomes. An anesthesiologist earns 2 or 3 times as much as a family physician, yet has a more predictable schedule and personal life. It is not hard to see why career choices are made as they are today. This could be corrected by increasing reimbursement for low paying specialties, by reducing the pay of higher paying specialties, or by a mixture of both. Payment of physician services is largely determined at a federal level through the Medicare payment scale but North Carolina legislators and administrators have an important role through their influence in the NC Medicaid Program and the State Employees Health Plan.

These and other key objectives can only be achieved with the approval and support of the North Carolina General Assembly. It has an absolutely critical role in assuring that we have the practitioners we need in 2020 and 2030. This group must work in a bipartisan fashion and show great political courage because adopting these recommendations will face opposition from powerful groups including some that will receive less as a result of reallocations of funds. The NC General Assembly must recognize that good medical care is a necessary component in the restoration of prosperity in areas of the state that have been hardest hit by the decline of tobacco as a crop and the relocation of manufacturing to other countries. Legislators must see that the greatest potential for economic recovery lies in achieving productive employment for the young people in these communities. They must see that there is no better solution to this problem than the creation of higher level health careers and investing these careers in health care in their own home towns.

Other groups critical to implementing the recommendations of the current report are the professional groups representing health care providers such as physicians, nurses, and hospitals. They too must recognize that investments to enhance the prosperity of low-wealth counties eventually enhance the prosperity of the state as a whole. Some who have prospered from previous investments may see this as a setback for their own prosperity, but, in the longer time frame, these groups will also benefit from the more equitable distribution of both health and prosperity in the entire state.

It is also important to recognize that the recommendations in the NC IOM report involve more than the health care sector. Our educators and educational institutions are heavily involved. Identification of young people who have the intellectual and personal skills to become caregivers, guiding them into careers without limitations as to level, and equipping them to assume professional roles in needed areas of our state, is a major objective of this report. This investment has profound implications for our state which state leaders must recognize and support.

It is my sincere hope that the North Carolina Institute of Medicine Primary Care and Specialty Supply Task Force report will produce a more profound and long-lasting effect than those activities cited at the beginning of this article. I see it as blazing a trail for a more prosperous and optimistic North Carolina, with more equitable opportunities for young people, with more equitable health care, and an even better state in which to live. I also hope that those who must clear the trail and make it a well established roadway to progress will share this vision. **NCMJ**



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