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FEATURES:

Primary Care's Dim Prognosis

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The hard choices that health-care reform overlooks

Given the chorus of approval for primary care emanating from every party to the health reform debate, one might suppose that the future for primary physicians is bright. Yet this is far from certain. And when one looks to history and recognizes that primary care medicine has failed virtually every conceivable market test in recent years, its prognosis is — to use doctor jargon — "guarded" at best.

Start by asking: Do primary care careers appeal to today's American medical students? Not so much. Barely 2 percent of them opt for careers in internal medicine and a mere 7 percent go into family practice. These numbers are down by 80 percent over just the past few years, and the trend will lead to shortages and the importation of foreign-trained physicians to cover the deficit. The problems of low pay and long hours that are blamed for the present predicament are likely to be exacerbated by new arrivals who typically are willing to work harder for less pay. A patient may find his new primary physicians difficult to understand, but he will nevertheless be grateful for their availability.

The generation of internal medicine specialists that was trained after World War II fundamentally reshaped American medicine. Three additional years of residency training beyond internship made them diagnosticians and consultants to both patients and other physicians. As they spread across the land, they brought modern medicine, once the province of large metropolitan areas, to small towns. This created the fertile soil in which a host of specialists and subspecialists would eventually thrive.

But general practitioners, sensing both a loss of status and not wanting to be left behind professionally, began renaming themselves family practitioners and extending their own residency training after medical school to equal that of the internists. Naturally, this blurred the difference between the two groups of doctors and added to the difficulty of defining what is meant by "primary care." The entry of nurse practitioners only added to the confusion. Could they really replace physicians? And could they do so at lower cost?

This, then, is the dilemma. Nobody has difficulty imagining what an obstetrician or an orthopedic surgeon does. But what does "primary care practitioner" really mean? The truth is that defining primary care and its scope has proved vexingly difficult. Does it include delivering babies or setting simple fractures? What about emergency room and in-hospital care? And is primary care really as easy as many specialists — and patients — believe it to be?

These uncertainties contribute to the sinking status of primary care medicine. In truth, much of primary care is indeed simple and straightforward. The initial care of a routine flu or backache isn't complicated and most of the time it doesn't matter who provides the care. The tricky part comes in identifying which factors make a certain case different from the last one. Because the outcome will, most of the time, be predictable, it can be difficult for an individual primary physician to prove his worth. There is nothing in primary care as clear as, say, mortality rates after coronary bypass surgery, which is the quality standard by which cardiac surgeons are measured.

Hospitals have resolved this quandary in how much training is needed for each individual task by deconstructing the job of nurses. So-called technical partners, after as little as one week's training, now may take patients' vital signs — blood pressure, pulse, temperature, and respiratory rate — that were once taken by registered nurses. This is usually harmless. But former janitors, tray carriers, and aides aren't the equivalent of rns when it comes to identifying the tell-tale signs of a turn for the worse. Nor can they always resist the temptation to answer patients' medical questions that are instigated by the white coats that the technical partners wear. Using these partners saves money — something that is easy to measure — but at a cost that is hard to measure.

So it is with primary physicians. Should those of us with good training and extensive clinical experience be ensconced above the fireplace like heirloom rifles, to be taken down and fired at confusing or difficult medical problems only when lesser-trained medical providers are baffled? It may be an appealing concept in efficiency terms, with only one troublesome proviso: It won't work. More than four decades in the practice of internal medicine and endocrinology have taught me that primary care is inherently inefficient. It is necessary to see many patients — young and old, rich and poor, sick and well — in order to maintain a solid perspective on the normal versus the abnormal. If I were to be an heirloom rifle, I would quickly lose my clinical skills.

To be frank, many of my patients over the years have probably overpaid me for allowing me to maintain those skills. I hoped that, in the course of time, they would eventually benefit from that training and be happy that I was there for them when a more difficult, less regular problem occurred with their health. This, however, is a tough argument to make now that patients are in constant motion based on insurance coverage that may arbitrarily exclude any given physician no matter how long and what the relationship is with the patient. Besides, insurance carriers and government, seeking to pay bottom-dollar for every single medical service, no longer leave any flexibility to generate funds that might be used to enhance skills and services elsewhere in the practice.

Primary care has failed its market test. This is most conspicuously seen in the public's response to "concierge medicine." A small number of doctors, fed up with complying with the ever-increasing and byzantine rules and regulations of insurance carriers and government, have offered to provide unlimited appointments and availability plus other amenities in exchange for a monthly fee. The condemnation this evoked has been inordinate. Most often, the concierge doctor is accused of aiming only to get rich at the expense of patients. This may have some validity when monthly retainers of up to $1000 are requested. But it is unlikely to be true when prices are much lower, such as $500 for a full year. Nevertheless, pickings for these doctors are slim no matter what the fee. Many patients just don't think it's a good value. As one very wealthy patient remarked, "Why should I pay for what I can get for free with my insurance?"

Nor has primary care done well with payers. Fees for nonoperative services, which constitute the bulk of primary care, have languished far behind what medical and surgical specialists and hospitals have been able to win for themselves with their ever-enlarging array of technological services. General medicine has always been the lowest-paid specialty. But whereas the distinction between primary physician earnings and those of narrowly defined specialists differed by only 30 percent in 1980, the differential has risen recently to 300 percent or more.

This is because specialists have more new services that are highly technical and therefore aren't limited by old fee schedules. But politics also plays a large part. There are more specialists than generalists (and many more specialty than generalist organizations) and they exert pressure on Medicare and private insurers to protect their own turf when it comes to setting fees. Even the American College of Physicians, which has the promotion of primary care internal medicine as a core value, has found it necessary to pledge to its specialist members that any effort to redress the income disparity between specialists and generalists will not be sought at their expense. The praise for primary care that emanates from physician specialty organizations is rhetorically effusive, but stingy in practice.

Only the tacit approval of the public has permitted this situation to occur. As long as essential services are still available, the incomes of doctors aren't the public's chief concern. Nor has the world caved in when millions of patients were weaned from the care of their longstanding physicians and conditioned to live with replacements from "provider lists" offered by their newly chosen (often by their employer alone) health maintenance or preferred provider organizations. These signal progeny of managed care have had another effect: the introduction of the concept of responsibility for the health of populations of patients as well as individual patients — sometimes even before the physician has ever seen them. Heretofore, doctors were responsible for patients only after they had personally established a doctor-patient relationship. Now, the assignment of a primary physician to a patient, even by the insurer, creates new responsibilities, especially for health screening for early signs of disease.

This is as it should be, according to physician and medical ethicist Ezekiel Emanuel, the brother of Rahm Emanuel who was recently appointed as White House health policy advisor. In fact, Dr. Emanuel goes further: He believes that physicians are too narrowly focused on their individual patients, as prescribed by the Hippocratic Oath, and instead should be obligated to society at large as well. This idea, of extended physician responsibility, has proven highly popular to government, private health insurers, employers, and patients themselves. Indeed to everyone except primary physicians, who discovered themselves holding the short end of the stick. There was no funding for outreach to patients. Soaring expectations confronted the shrinking length of office visits. Now, primary physicians are subject to data collection on their clinical performance, prescribing patterns, and the compliance of "their" patients with preset norms for Pap smears, mammograms, cholesterol levels, etc. Collecting data is a fine idea, but in the absence of sufficient time or money it becomes a burden not lost on the next generation of physicians who choose to be "special" and not "general."

So why is so much lip-service being paid to primary care? Initially, it came from the observation that in Europe, where 60 percent of the doctors are generalists, health care costs are much lower than in the U.S. Though our ratio of specialists to generalists is the exact opposite of Europe's, some measures of U.S. health care outcomes are worse or similar at best. Recent studies of Medicare patients also show that in localities with a higher percentage of specialists, costs are higher but outcomes may be not only no better, but sometimes poorer. But the current fascination with primary care as a means of lowering health costs is, actually, just a rerun of the events of the 1980s. Government support for primary care training and an enormous amount of propaganda about the central role of the primary physician in coordinating and managing patient care then led to some of the brightest medical students choosing primary care careers. They were deceived. It is one thing to have your physician help you make health care choices, but quite another to discover your doctor has been transformed into a gatekeeper whose permission is needed for tests and consultations. This became as difficult for primary doctors as for patients. For one thing, it proved impossible to know enough about every specialty in addition to one's own to properly "manage" care. Specialists fought back, and like patients, began to see primary physicians as adversaries. The consequence has been a shift away from more highly controlled hmos to ppos, where patients have more freedom (albeit for a higher price).

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Many of that generation of primary care physicians continue to feel used and deceived. In retrospect, they were promoted as a means to save money for others, principally the insurance industry and government. The logic of trained physicians rather than patients managing their own care made sense on paper only. Patient rebellion was predictable — and rational — considering that doctors were doubly conflicted by their dual role, which included saving money for the health plans and government. Perhaps the biggest misfortune in this redefinition of primary care, many features of which persist to the present day, is the failure to offer something new and real to motivate an increased closeness with patients and continuity of care, which for primary physicians has always served as a substitute for more money.

This is no accident. Payers, starting with Medicare, have believed that when patients, doctors, and hospitals become too chummy, they will bilk the third-party payer. The result is a host of rules and regulations to prevent any such ganging up. So now we have an adversarial climate that has each party keeping an eye on the other. This distrust falls heavily on primary physicians because they are the entry-point into the health system. Ironically, it is their prescriptions that lead to large expenditures for drugs and diagnostic testing, but there is no profit to the primary physician in writing them. In order to contain costs, guidelines are used by both government and private insurers to see that tests and prescriptions conform to the latest evidence of effectiveness. Of course, better care at lower cost is desirable. But for the primary physician, the resulting bean counting has been demoralizing and threatens to get only worse since an entire industry has arisen to watch and judge physicians. Once again, primary care is subject to pummeling from all directions. And because these doctors are not leading-edge specialists in any particular field, it is hard to argue with authority. The easiest solution is to simply follow the rules.

Managed care has begun making attempts to compensate primary physicians when their patients are seen to comply with recommendations on both prevention and treatment in the care of common diseases like diabetes, hypertension, and asthma. This is called “pay for performance,” and it has yet to show real-world benefits. Most primary physicians probably resent the implication that they have to be bribed in order to provide high-quality care. This isn’t surprising because an extensive literature in industrial psychology shows that paying for performance, far from increasing worker satisfaction, usually undermines morale and eventual productivity. (Nobody likes to feel manipulated.) Yet this particular bandwagon rolls on unimpeded as a vast experiment that targets primary physicians almost exclusively.

I have not painted a picture of a job that many people would want. I have focused only on the negative aspects because they help explain the difficult predicament for primary physicians and for those thinking of a career in primary care. If these doctors were ordinary businesspeople, it is likely that most of them would have moved on by now. But there are saving graces. Contact with patients is appealing. Medicine is intellectually challenging. And while earnings are low in comparison to physicians in other specialties, primary care physicians are paid better than most Americans. Yet, according to one study, they fail to earn back the opportunity cost of their dozen years of pre-med, medical school, and graduate medical education. Specialists, by contrast, do earn it back. And so do architects and lawyers. In addition, when based on hours worked, specialist nurses can currently out-earn primary physicians.

Everything I have said so far applies to the vast majority of American physicians who practice either solo or in small groups of under ten, usually in the same specialty. It is a little different for the large multispecialty clinics like the Palo Alto, Cleveland, or Mayo Clinics and for Kaiser Permanente, which is a unique comprehensive care system. As integrated groups, they can use a portion of the profits from ancillary services like x-ray, laboratory, pharmacy, and everything else, from nutritional

counseling to physical therapy, to support primary care. And if this isn't enough, they can also shave a bit off the salaries of specialists and redirect the money to pay higher salaries to primary physicians.

Nothing similar exists to beef up primary care outside the nation's few large multispecialty clinics. Sharing income from other physicians or medical services is called fee-splitting and is illegal. And since there just isn't enough income from independent primary care itself to update computer systems and apply the latest technology, most American primary physicians are unable to practice at the level they would prefer. With costs rising relentlessly and fees largely fixed, they are trapped. Their principal value seems to lie more in their referrals for expensive hospital and specialist care than in anything they themselves provide in the way of medical care.

So why aren't there more multispecialty clinics that utilize primary physicians more rationally than seems possible in community practice? Kaiser Permanente has been in business for 75 years but in all that time, no rivals have appeared. Other large multispecialty practices usually date back many years as well. The lack of more than a handful of new entrants is not for want of trying. As far back as the Kennedy years, large group practice was heavily promoted in the medical literature and through government policy. But little has come of it. Very likely this is because capitalizing large practices in the private sector is very costly, with an uncertain return on investment. Even Kaiser Permanente, while successful in expanding into several states from its California base, has had to close pilot programs in Texas, North Carolina, and three Northeastern states.

This is important because large academic centers and very large group practices view themselves as models of how medicine should be practiced. (And President Obama concurs in the case of the Mayo and Cleveland Clinics.) There is much to be said for the financial strength, immunity from antitrust law, and personnel depth that permits the acquisition and maintenance of large computer systems and the ability to build teams of nurse practitioners, physician assistants, and other support personnel that can expand the effectiveness of primary physicians — as, for example, in the care of chronic diseases like asthma, diabetes, and hypertension. The ability to collect and analyze data makes it possible to do studies and publish. Grant funds support this research and professionals who feel like pioneers in recasting the future of medicine work with gusto and create templates for others to follow. Physicians who are involved have an exciting life. And nonprofit status allows access to capital and tax-advantages that furthers their efforts.

But there are also problems in exporting ideas that work in one environment to another. For one thing, promising research ideas normally do not fare nearly as well once they become part of everyday, humdrum practice. Nor is there a shred of evidence to suggest that physicians will be able to — or willing to — borrow the massive amounts of capital needed to create new large multispecialty practices themselves. Nor does big business (for that is what it would have to be) or government seem interested in buying land and building and staffing clinics, let alone then running them as medical businesses. There is also the all-important matter of patient preference. Some people are very happy with large institutional practices. Others prefer smaller, more intimate settings.

So it is likely that American medicine will continue to provide a tapestry of small, medium, and large medical practices. And that most primary care physicians will remain frustrated and have to cope with the pressure of escalating demands that they cannot afford. The idea of saving money for the entire health system may be a worthy goal, but it will not inspire passion and dedication in many pressured medical students or practitioners. Furthermore, this is an age of specialization, and attempts to recreate the family doctor of old, shorn of authority and burdened with seemingly endless obligations, including responsibilities to unseen patients, are absurd. One would think that medical schools would be alarmed by the drastic fall of primary care from favor. But they are ambivalent. Working at the cutting edge of medical research, faculties are dominated by specialists and seem paralyzed in their response to their failure to make primary care a more appealing prospect for their students.

Insurance carriers and government, both concerned with cost controls, fraud prevention, and accountability are preoccupied with devising new schemes to seek better value. For the primary physician, they offer little hope for improvement in working conditions, let alone reimbursement.

There is no easy fix to this situation. It is because, as presently constituted, primary care must compete for funding with all the far costlier services offered by specialists and hospitals. New high-tech drugs, equipment, and procedures, which are big revenue generators, are heavily promoted. This drains away resources and leaves primary care with nothing new, special, or dramatic to offer — a perpetual loser in the competition for funding. This is an untenable state of affairs that serves only to add to health care inflation. But in the climate described, many proposals to bolster primary care constitute little more than wishful thinking. Often, the deal would have primary physicians supply their time, skill and money to upgrade care and afterwards be paid back out of eventual “savings” to the system — with insurers and government both doing the calculations and sharing in the benefits. This is a recipe for corruption and cynicism.

A far more straightforward way to restore balance would be to allocate a percentage of the budgets of health insurers and government health programs to outpatient primary care. The percentage would reflect expected value to overall patient care, including a reduction in unnecessary services. A segregated and protected budget would restore a sense of worth to primary care and inspire optimism and creativity among its physicians. Large, multispecialty practices are already doing this informally because they are aware that a solid primary care base improves care and is highly cost-effective. Elsewhere, adoption will be difficult. For segregated budgeting to be effective, it must enhance support for primary care without waiting for “proof” of savings. This inevitably will cut into existing budgets for other services. Powerful opposition will result.

The American Medical Association can be expected to be a major opponent. The ama has a monopoly in controlling the coding manual for physician services that is supposed to equate the value of similar services across primary care and specialty lines. The ama has long held that similar services should command similar fees no matter what type of physician performs them. The premises sound democratic, but when put into practice they have done a lot to weaken primary care and raise pay-rates for specialists. It is axiomatic that primary care must be able to stand on its own if it is to have long-term viability. Yet it is spoken of as if it was something akin to an immobilized whale, needing rescue to survive. In characteristic language, Thomas Bodenheimer, Kevin Grumbach, and Robert Berenson, three experts on primary care, write in the New England Journal of Medicine of “A Lifeline for Primary Care.” Apart from tinkering with Medicare payment rates, a perennial topic for discussion, their lifeline offers complicated and iffy support measures for primary care that include strengthening infrastructure and organization and attracting more U.S. medical students into the field.

Other medical and surgical specialties seem able to negotiate more effectively, for two very good reasons. First, again, it is easy to grasp what a specialist does. A neurosurgeon operates on the brain and other parts of the nervous system. An orthopedist fixes bones and joints. A cardiologist diagnoses and treats the heart and blood vessels, most often without doing any cutting. And so forth. But it takes a lengthy essay to describe primary care. Secondly, nobody but another specialist can replace a specialist. The public would balk at the idea of trying to hire lesser-trained professionals to do specialists’ jobs. But the list of applicants to substitute for primary care physicians is long and already operational in many settings. Nurse practitioners aim to foster independent primary care practice, a far cry from their original role as assistants to overloaded primary care physicians. Chiropractors aspire to be recognized as primary care experts, lack of training notwithstanding. Doctors of nursing practice seek to position themselves as equal or superior to physicians in delivering primary care. Nurse practitioners have met with generally good acceptance by patients. So that even in health care “teams,” primary physicians are not simply assisted by these other professionals, but also find them to be competitors who have less training and are often willing to

work for less, especially when they do not have the responsibility of running a medical practice. Their presence, however, undermines the status of primary physicians and makes it unclear whether physicians are even needed to do much that is encompassed by primary care.

With competition both from above and below, primary care practice may be doomed in its present form no matter how many lifelines are thrown to it. The loss of professional identity and sense of self amidst the host of measurers and naggers bent on redefining what the primary physician is and does has very likely gone too far to turn the clock back. It is not edifying to be tied down like a Gulliver and to have put so much into an education without earning a sense of professional dignity and autonomy such as any accountant, lawyer, and architect or, for that matter, medical or surgical specialist expects as a matter of course.

For now, I would suggest that, if government and insurance carriers believe that patients need reminders to have evidence-based health screening, they should send them out directly. Patients can interact with payers directly, without making the physician an intermediary except when professional judgment is needed. Why? Because the mailing and data-storage capabilities of large organizations far exceed the capacities of physicians in small practices, who are also busy treating emergencies and chronic diseases. Besides, payers are convinced that preventive medicine will save money in the long run and they will be the beneficiaries — even though the medical literature offers scant support for this proposition and few practicing doctors believe it. This does not mean that physicians doubt the personal value of preventive medicine to patients, but only the consequent economic benefits to the overall health system.

In the longer run, the public health role of primary physicians must be reexamined. It was never realistic to graft it onto the duties of existing medical practitioners in the first place. A study of the recommendations of the authoritative U.S. Preventive Services Task Force (self-described as “an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services”) showed that if a doctor with a practice of 2,000 patients complied with all its recommendations, there would be only 30 minutes per day left to care for the sick and injured. Somehow, the inherent foolishness of such an arrangement has been ignored. Physicians — and especially primary physicians — have not been subjected to the time-motion productivity studies that have been commonplace in industry for many years. Apparently, critics who used to complain that physicians were trying to play God now expect physicians to be superhuman. Tasks keep getting added with little apparent thought to their impact.

In addition to a segregated budget, mentioned above, another initial counter to overload and burnout might be to make medical education and its debt-load (amounting to between $100,000 and $150,000 for most medical students, and often much more) less burdensome. Debt-relief for physicians going into primary care might help redirect the majority of medical students who say the need to earn more money to pay back their educational debts automatically points them toward the higher-paying specialties. Another possibility is the restoration of the “rotating internship,” a year in which new medical graduates rotate through medicine, surgery, pediatrics, and other services, after which they are eligible to go directly into practice. That’s the kind of internship I had, and it has stood me in good stead throughout my professional career, even though I chose to take additional training in internal medicine and endocrinology. The rotating internship is good way to gain an overview of clinical medicine, but it is inconvenient for academic medical centers because of the more frequent personnel turnover. Incentives and support may be needed to promote the rotations that would be ideal for office-based primary physicians.

Many states now require a two-year minimum of postgraduate training for U.S. medical graduates and three years for international medical graduates. But these extra years are largely spent in the hospital assisting in caring for complex cases that will not be relevant unless the physician plans to

continue treating very sick patients in the hospital once training has ended. The trend has been away from that in primary care. Internists and family practitioners frequently have come to rely on “hospitalists” (usually internists who limit their practice to caring for hospitalized patients) to treat their patients who require hospitalization.

The reason for this is practical. Primary physicians have found it less and less feasible to handle both an office and a hospital practice since managed care has put both time and financial pressure on them. Hospital care has also grown increasingly complex. Consequently, American-style doctoring, in which the same physician follows a patient in the office, then in the hospital during acute illness or surgery, and once again in the office during convalescence is giving way to European-style medical care with a disconnect between inpatient and outpatient care. The lack of continuity of care is not ideal, but it suggests that shorter training to prepare for just outpatient medicine may be viable. For this to happen, however, both postgraduate training and state licensure laws would have change. Once implemented, another group of trainees could continue with three or more postgraduate years to qualify them as diagnosticians and experts in the care of chronic diseases and also offer them the possibility of working both in the hospital and outside.

The lack of continuity of care is not ideal, but it suggests that shorter training to prepare for just outpatient medicine may be viable.

Primary care physicians must also be allowed to work more sensibly than they are now. Consider the present situation. Primary physicians have involuntarily become intermediaries between patients and insurance carriers when it comes to obtaining authorization for expensive diagnostic services. Why is this the task of the primary physician and not, for example, of the surgeon who orders the test or the radiologist who performs it? The stated rationale is to obtain enough relevant (and less biased) information for the carrier to make sure money isn’t being spent unnecessarily. More than pure information is involved, however. The way in which a case is presented greatly affects the impression of how urgent and important the contemplated test really is.

Let me provide a real-life example. A man whom I had not seen in two years suddenly showed up with his wife in the middle of a busy day. He had just been released from the hospital after receiving four units of blood for internal hemorrhaging. Cancer was suspected and a major surgical procedure was tentatively scheduled. But first the man needed a pet scan, which is a nuclear imaging study that costs $10,000, to be sure the tumor hadn’t spread. He was in my office because his insurance carrier (one of the largest in the country) insisted that only the primary physician is permitted to apply for approval to do the test. Moreover, it was an emergency because unless I secured the approval by 6 p.m. the same day, the scan would have to be cancelled.

Thus, without having had any direct participation in the current problem, I called the carrier. Dispensing with any salutation or company identification, a peremptory voice demanded, “What is your tax id number?” There was no way around this initial roadblock. Once in the system, it then took conversations with five different people in two companies to supply both the requisite clinical and demographic information. I was so appalled by the abusive red tape that I invited the patient and his wife into to my private office to witness what was happening. Altogether, it took 50 minutes to secure an approval number. The couple was incredulous. As an afterthought, the reviewer let me know “how rare it is to win approval so promptly.” I thanked her, even as I seethed inside. By the time I was done, my next patient was at the front door, on the way out. His patience had limits too. Facing a choice between being bullied and allowing your patient to suffer harm is now par for the course in primary care. It does nothing for the doctor’s self-respect and, I fear, for the respect of others for the doctor. This must stop. Primary physicians cannot be expected to do other people’s menial work and still function at a high level. If the concern is excessive testing, then confirming the indication for the test is fine. That’s a medical opinion. The rest of the details can be supplied by the people who ordered or who personally stand to benefit from doing the test.

These may seem like tolerable annoyances, but they add up and the analogy to Gulliver is apt. Even giants can be rendered helpless when tied down by too many little strings. In medicine, it's counterproductive to use highly trained physicians to do simple chores — it actually turns rational personnel policy on its head. Yet the situation I described is both typical and deliberate. It's an example of what is called "rationing by inconvenience" — making it so hard to get things done that people give up. The climate is also adversarial and therefore abnormal, even though commonplace.

Will current efforts at health reform rescue primary care? Only in theory. Variations of national health insurance are more popular among primary physicians than specialists. In this sense, the U.S. is reminiscent of the period after World War II when socialized medicine was introduced in Great Britain. At that time, general practitioners were acquiescent to change, but the far more influential specialists were bitterly opposed. Prime Minister Aneurin Bevan found a way to overcome that opposition: "I'll stuff their mouths with gold," he said of the specialists. It took 50 years for British primary care to achieve anything resembling parity. Until then, improvements in the quality of primary care took a back seat to rationing and the imposition of price controls.

Co-opting opponents can be a powerful tool for gaining political control, but in the U.S., the price of buying off powerful specialist opposition to increased government control over medicine would be too high. It isn't likely to happen. Nonetheless, there is no current American plan for health care reform that will do much to change the fortunes of primary care. Reliance on foreign medical graduates and increased use of non-doctors will buy time. Yet, ultimately, more American-trained primary care physicians will be essential to enhancing the status of primary care and creating a better and less costly balance between primary and specialist care.

The nation is highly conflicted on this, but if better balance is what we really want, then half-hearted measures will not suffice. Real financial and professional incentives are indispensable in order to enlist and empower tomorrow's primary care providers.

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