KFF

Headquarters
185 Berry Street
Suite 2000
San Francisco, CA 94107

650.854.9400
650.854.4800 fax

Washington Office &
Barbara Jordan
Conference Center
1330 G Street, NW
Washington, DC 20005

202.347.5270
202.347.5275 fax

April 3, 2024 | Virtual Event Transcript

The Health Wonk Shop: Primary Care Check Up: Why It Can Be Hard to Get an Appointment and How to Fix It

Larry Levitt: Hello, I'm Larry Levitt from KFF. Welcome to the latest episode of The Health Wonk Shop. About once a month, we dive into timely and complex health policy topics with experts from a variety of perspectives. Today, we're diagnosing the primary care shortage and what can be done about it. There may be no healthcare issue more tangible for people than the challenge in getting a timely primary care appointment. The issues behind the primary care shortage are complex, involving the financial incentives throughout our healthcare system, the way doctors get paid, and the way medical students get trained. But the frustration for patients is real and immediate. The US spends double what other high-income countries spend on average on healthcare per person, yet we have fewer physicians per capita, and our system is much more heavily skewed towards specialty care. We often talk about trying to get better value for our healthcare dollar, and the lack of value is no more apparent than in the lack of resources we put into primary care.

We're joined today by a smart panel of experts, as always. All of them happen to be physicians, so know how things work from the inside, but they also have deep expertise in systems and policy issues beyond their white coats. Yalda Jabbarpour is director of the Robert Graham Center for Policy Studies and an assistant professor at Georgetown. Asaf Bitton is executive director of Ariadne Labs and an associate professor at Harvard. Candice Chen is an associate professor at George Washington University, and Erin Ney is an expert partner at Bain.

A little bit of housekeeping before we jump in. If you have questions, submit them at any time through the Q&A button in Zoom, and we'll get to as many of them as we can. Also, note that this session is being recorded, and an archived version should be available later today. Yalda, let me start with you with a very basic set of questions. Do we have a primary care shortage in fact, and is it getting worse? And what data and indicators do you look at to measure that?

Yalda Jabbarpour: A simple answer is yes. We do have a primary care shortage, and yes, it's getting worse. And in terms of data and indicators, I'm a researcher, so this is almost blasphemous to say, but the data that you can look at is just your own trouble getting a primary care appointment. In the last several years as a primary care

physician, I'm seeing more patients than ever, but my patients on their end are telling me that it's harder than ever to get in. So why does that mismatch exist? I really think it's because we have a shortage in terms of actual data. We looked at this in the Milbank Scorecard a decade ago when we were sounding alarms that we have a primary care shortage.

We had about 68 primary care physicians per 100,000 people. And today, a decade later where there is more demand for primary care, instead of that number going up, it's gone down to 67 per 100,000. And is that enough? The answer is no. I mean, you said it, Larry, when you opened this up, other high-income countries have much better access. In fact, Canada is around 120 to 130 primary care physicians per 100,000, and even they complain of a shortage. So we're not doing so great.

Larry Levitt: And Asaf, let me turn to you. We know that primary care docs make less than specialists. How did we get here? I mean, what's behind this disparity in what we pay for primary care versus specialty care? And talk a little bit about some of the innovations you're seeing to shift payment to promote primary care.

Asaf Bitton: Well, thanks so much, and thanks for having me on here and join this wonderful panel. The problem starts, but doesn't end, with money. And I think that the workforce shortages, which we see the result in by what our patients tell us, they can't see us tomorrow, they can't see us next week, but we also see the results in the fact that the potential of primary care to realize its outcomes is not being made available. Primary care is the only part of the health system in which investments in it routinely result in longer lives and more equity. You can invest in other parts of the healthcare system for very good reasons, but you won't get the same improved outcomes with equity that you do in primary care. And yet the problem is really in the form and the level of money that we provide. We have a unit-based payment system that for a lot of historical and idiosyncratic reasons, which we can get into, pays by generally visits or small procedures.

And that has really not tracked with how primary care is provided. Primary care is a longitudinal, team-based sort of continuous healing relationship over time between teams of clinicians and individuals in their communities. And primary care is not principally a procedural-based specialty. So paying by visit aliquots and paying at low rates compared to specialists, especially proceduralists, is a problem. Primary care has, even if you were looking only at visits, it's about 35% of visits, but only gets about three to 5% of the total healthcare spend. And that's just one example of the discrepancy. What we see globally in effective health systems, I've never seen, and I do a lot of work globally, I've never seen

an effective health system not have a strong base of primary care at it's core and not pay at least 10 to 15% of its total healthcare spend on primary care.

But the good news is that a lot of other people, and a lot of payers, and a lot of provider organizations are seeing the wisdom of moving from visit-based, unit-based payment to more episodic or longitudinal, or hybrid payments, which pays more for a team to care with and for a patient and her family over time. And so this transition from fee-for-service to hybrid payment that includes prospective one-year-long, risk-adjusted hybrid payment is certainly what most people think is necessary to pay for a better kind of primary care over time.

Larry Levitt: Thanks. And we're definitely going to want to come back to these questions of team-based care and how you pay for it. Candice, let me bring you in and sort of step back a little bit. I mean, we've got this, I think a consensus that there was a shortage of primary care physicians that starts, at some sense, in medical school, where we train future physicians. What is it about our medical training that leads to more students choosing to go into specialties?

Candice Chen: Sure. I mean, first off, I think that we should recognize that how we pay relatively primary care versus specialty care is influencing what people choose to do and what people choose to specialize in. And I'll also say the pay differential also translates into what practice feels like for primary care versus specialty care. So that's another aspect of that. But if we step back into the educational pathway, there's a lot that education can be doing. First of all, we know that individuals from rural, from underserved, from historically marginalized underrepresented groups are more likely to go into primary care and more likely to serve in rural and underserved communities. One of the things that we haven't talked about is also the maldistribution of the workforce. And so where we're creating opportunities, the pathway programs where we're making investments to help people come up into the health professions training, what medical schools and other health professional schools, and we haven't talked about advanced practice clinicians, nurse practitioners, physician assistants, and all of the other really important people that make up primary care teams.

But what our recruitment and what our admissions look like then affects that and who ultimately comes into, whether it's medical school or there's other professions, and then influences the likelihood that people will again pick primary care and choose to serve different populations. How we train matters, and there's so much evidence, but it's like common sense as well, right? If we give people positive exposures to primary care, if we give people positive exposures to rural and underserved medicine, provide them role models,

they're more likely to pick those areas. And then a really, really important thing that I hope we spend a little bit more time talking about is residency training in the United States. And residency training, many people don't realize that this is where the federal government puts the most money in terms of developing the health workforce, and it's mostly to the physician workforce.

And residency training is absolutely critical in the United States because every state, with some developing policies that might change that, every state requires that you do residency in the United States to become an independent physician practitioner. And that means that the number of positions that we offer in terms of residency determines the overall number of physicians we have. And it's in residency that we differentiate into the different specialties. So it's in residency that people pick the primary care, or pick the specialty position. And so it's the distribution of those positions that ultimately determines how much primary care, how much specialty care we have. And right now, the Medicare program is putting about $18 billion a year into teaching hospitals to train residents. And then I also said something really important, teaching hospitals. So most of that money goes to hospitals; it's tied to hospitals in law, and then we say to hospitals, train the workforce that makes sense to you, and they're training a workforce that's ready to stock the hospitals of America. So there's a lot that can be done in this space, and people have recommended reform, particularly for Medicare.

Larry Levitt: So lots to unpack there that we're going to come back to. Erin, let me bring you in. So a lot of activity around primary care in the commercial sector, we've seen other retailers expand into primary care, not always successfully. Insurers like United have been buying up physician practices. Is this a trend you expect to continue? And I mean, just from a raw economic sense, is there profit in providing primary care commercially?

Erin Ney: Yeah, thanks, Larry. I do expect that it is a trend that will continue. We can go into some of the reasons for that. Some of the challenges which others have already highlighted, right? As we start to increasingly shift towards value-based payment models, as Asaf pointed out, I think that is going to fuel a lot of the innovation because that actually provides a source of potential profits in primary care, at least at a higher margin than a fee-per-service model. So I do think we'll continue to see that. I think there's been a few different commercial models that we've seen, and some hold promise and some, like you mentioned, have challenges, particularly around execution. We've seen a lot of interest in advanced primary care providers, particularly in the Medicare Advantage space, or, I should say, in the Medicare space, serving largely Medicare Advantage population as well as now an ACO Reach population.

Those models, I think, and actually what I'll touch on for a few of the models, those models I think are interesting and have promise because they actually just narrow the focus of the population for providers and organizations. And I think that allows you to tailor and hone your capabilities for both providing care as well as thinking about how you manage and contract with payers. So those are models like Oak Street, like ChenMed, like CenterWell, some are owned now by retailers, some are owned by payers. But I think that's a model. I also think that model holds promise, and I think we're going to get into this a bit more, because of the usage of integrated multidisciplinary care team, which, when we talk about issues, primary care provider shortages, it allows you to have it and build a team that involves both physicians, advanced practice providers, and then you can think about other specialists, behavioral health, care managers, or case managers, nutritionists, pharmacists.

But that means that the primary care physician is not on the hook for providing all the care and owning all the touch points with the patient. And I think that ultimately leads to a better model and also gets patients better care. So we can talk about that a bit more. I think a couple other models are, so that's the Medicare space. Innovation in the commercial space is a little bit trickier and has been a little bit slower. We see employer-direct primary care providers like a Premise or a Marathon or a Crossover, and those are providing on-site and near-site care. And so that certainly improves access and improves convenience, and usually is a model where there are both physicians and advanced practice providers. And then finally, I would say retail. Yes, I spend a lot of my time with retailers, and thinking about their healthcare delivery and health and wellness strategies.

Retailers have really come at this from a really interesting position. They have a large footprint, quite often with thousands to tens of thousands of locations, physical locations across this country, so they can provide convenient location and access. They have quite trusted brands often with their consumers, and I think they also hold the potential for having both the opportunity to provide care delivery services as well as the products that our patients need to be well. And so that can range obviously from pharmacy and optical, but also OTC and grocery, and if you could connect the dots and connect the pieces on that, there's a pretty big potential, I think, to create an ecosystem of care and care delivery. The execution on that has been really challenging, and you can see that in the press right now across retailers, and we can talk about that more, but I think that there is potential there. The business of, as we all know, of healthcare is very different than the business of a retail company. And so that has been challenging, I think.

Larry Levitt: So each of your are physicians, but each of you mentioned the importance of team-based care and looking to folks other than physicians to help provide that care: nurses, PAs, physician assistants. Let's unpack that a little bit. Yalda, let me start with you. So, I mean, you talked about the primary care physician shortage. What about these other providers? Are there shortages there as well? So it's fine to talk about this team-based care, but if there aren't people that provide it, that's a challenge.

Yalda Jabbarpour: So I think one of the bright spots here is that there has been a growth of nurse practitioners and physician assistants over time, just that discipline overall, which is absolutely essential to building the primary care team. When I shared with you the numbers of us versus Canada, we are never going to reach that by training physicians alone, especially based on what Candice has already told us about sub-specializing and the way GME is set up. That's not a short-term solution, but being able to grow these other providers on the primary care team that can distribute the work based on what their training is, is absolutely essential. So yes, we've seen a growth in nurse practitioners, we've seen a growth in physician assistants. When you actually add them to the curve and count the primary care nurse practitioners and physician assistants, there has been a growth of primary care clinicians overall.

Now we need to take that with a grain of salt because each member of the team has an important role, but each member of the team does not have the same role. So it's not a one-for-one swap. The other thing though that we are seeing now with nurse practitioners and physician assistants and the data is just like physicians, they are starting to sub-specialize and move away from primary care. And I think that has a lot to do with the primary care environment. So it's not something that just physicians face, the burnout in the primary care environment or the under-resourcing. The nurse practitioners and physician assistants face that too. And if they can move into a cardiology clinic where they're getting paid more with more resources to work the same amount of hours, why wouldn't they? So we're starting to see as the workforce grows there, we're starting to see that same pattern, unfortunately.

Erin Ney: Yalda, I'm really happy that you brought up the environment piece because I think the other piece that we need to think about is, yes, to Candice's point about how we can better train clinicians to become primary care providers, but I think we also need to think about what is the value proposition for not only becoming, but also then staying in primary care, and what are we asking of our primary care providers? What are we asking for them to do and what is sustainable? I think that's a really important part of the conversation.

Larry Levitt: And Asaf, I mean, you talked about the sort of unit-based payment, fee-for-service payment, not being compatible with how primary care should be provided. I mean, there's been a lot of talk of ACOs, capitation, we've been talking about capitation for as long as I've been in health policy, which is decades. Are we seeing now some movement towards a better way of paying to promote primary care and a team-based approach?

Asaf Bitton: Yes, and no. And the sort of top-line answer is there's no, as you know so well and have documented, there's no one system, one way of doing things in the US. And so we are seeing across the system, I think, and to some of the questions in the chat and to what Erin and Yalda just said, we as a country have to face the fact or ignore at our great peril to the health of our communities that the current majority form of providing primary care is not just unsustainable, people are voting with their feet, and that's the access and the inability to get appointments and have the people who have known you, care for you, and with you over time. So we see that, and primary care is a little bit like oxygen. You only start to notice it once the levels go critically low, otherwise, you take it for granted, or as an assumption, or as something you hope is there because if it's not, it's a real problem.

So are we seeing? Yeah, for sure. We are seeing it across federal states, commercial and innovator markets, and marketplaces. So in the ACO marketplace, even just last week, CMMI released news of a new model that really moves on to its SSP program and gives primary care providers in ACOs the opportunity to take their Medicare payments and get them capitated and boosted in a way that Medicare has never done before. This has been a big issue with ACOs, which take responsibility in a global budget for a set group of patients but have never been specified to make sure that they pay primary care the way that the consensus and the evidence suggests is the way the primary care should be paid.

Because, as you heard, it's a team sport over time with a lot of interstitial connections and things that happen between visits. So when you try to stuff everything into a visit, things fall through the cracks, people's needs don't get met, and that reactiveness doesn't play into the strength of primary care, which is the ability to proactively think about a person's individual health, the community's population health. We are seeing state, there are a variety of other CMS models that basically serve to try to move the dial from fee-for-service toward different types of hybrid population-based payments.

Some have worked better than others, they're incomplete. And there's a whole complicated story there. At the state level, there's actually a lot of state

Medicaid action going on. Many states, including Maryland, Vermont, Colorado, Massachusetts, New Mexico, Montana, and others, have a lot of activity in, again, capitating or finding new ways to pay prospectively for primary care. They are hampered by generally lower rates of Medicaid that state Medicaid programs can pay for primary care. And that's a big issue. And there are a variety of 1115 waiver demonstrations which we could talk about. And then, just to Erin's point, there's an incredible amount of activity in the private sector, and it's not all, as she rightly pointed out, just in the kind of models that we hear, which we tend to talk a lot about the segmenting models, the Oak Street, Iora, et cetera, et cetera, which take often high-cost, high-need patients often in Medicare Advantage, throw a lot of team services at them, and maybe are showing some early wins but are pretty narrow models.

There are other types, we talked about employer models that segment employees within and around the workplace. There are lots of membership models that range from direct primary care, where primary care docs and their teams come off of the employer-based insurance system and have brokerage of either direct payments or make a variety of deals to basically get paid for more continuous care over time. There's concierge care, which I think for those who are wealthy, is an opportunity to get the core functions of primary care met with smaller panel sizes. It brings up a very obvious point of both sustainability and inequity that is front and center, but we're seeing a lot of growth there. The convenience care models, because people will vote for their feet when they need to be seen, have grown, and I think that primary care as a traditional mode maybe could do more to figure out how to interface with these access-forward models that don't have a lot of comprehensive chronic care.

Could there be an interplay? They are some of the largest employers of NPs and PAs in primary care that might be underutilized, especially for chronic disease and holistic management. So there's a lot of, I think, potential there. There are chronic disease-focused companies that are overlays to traditional practices to help up-ramp their ability to do work in a disease state or help augment a level of service, and then there are value-based care enablers. So there's a lot of innovation going on in primary care, whether and how that's spread equitably and distributed in such a way to get back to the core problem, which is that the work of primary care right now in its documentation, insufficient payment, and insufficient workforce is really not sustainable. So we probably need to throw and will throw a lot of things at the wall, we'll see what sticks.

Larry Levitt: So you raised about 15 issues there that we could spend several hours talking about. Let me focus on one, and it's what you ended with. These equity issues. So we think about concierge medicine, providing much better access for people

who can pay. Even some of these retail clinics, where you may have to pay out of pocket, great if you have the money to pay out of pocket, they may not interface with insurance particularly well. I'll throw it out there. I mean, are we moving towards a world where we will address some of these primary care access issues for people with resources and potentially make them worse for people who don't have those resources?

Candice Chen: Can I just offer? I think that we're already in that world. When you talk about the fact that we have, I think the current estimates is like 77 million people living in primary care health professional shortage areas. I think 120 million people living in mental health health professional shortage areas. There are people right now who are already experiencing this inequity, and I think that there is very much a concern that it's going to get worse. And one of the things I want to, I think as Asaf was sharing is is that there's a lot going on right now, and I think that so many of us have our fingers crossed and hoping that some of these payment innovations are going to flip the script specialty and primary care, but some of it is working, some of it is not working, and it's a highly volatile landscape right now. And on top of all that we're coming out of, I'll say we're coming out of COVID, and all of these things are just, it's put incredible pressure on the workforce.

We saw increased movement during that, I think, with the primary care workforce, with many other workplaces, the nursing workforce. We're really concerned that we're going to be losing even more workforce, and the environment was already challenging, and then COVID made it all worse with staffing turnover and making environments even harder to deliver care in. And it's such a changing landscape. I think about direct primary care, I think about concierge care, and I can understand why people are going to direct primary care and concierge care, where the model and the experience of delivering care is maybe a little bit better, but that then does have downstream effects. We did a study a couple of years ago just to get an idea, and there was this model called independent, freestanding emergency departments. They really popped up in Texas, and it was emergency rooms that weren't associated, that weren't physically located with a hospital, and they argued, Hey, we're going to increase access.

And some of the early researchers went, Oh, that's great, but you're only located in high-income, highly insured populations. You're not really equitably increasing access. And let us look at one more kind of downstream ripple effect of these kinds of models, a model that arguably might be like direct primary care/concierge care. And because they advertise, we were able to pull all of the physicians that they staffed with, the emergency room physicians, off of their

websites, and we just looked where did they come from. Not surprisingly, they overwhelmingly came from rural hospitals, and they came from disproportionate share hospitals, hospitals that were serving low-income populations. So there are downstream effects that we need to be watching.

And then I also want to just add, we've talked about all these innovations. There are also entries into the market that are concerning private equity entry. Not that private equity is all bad, but there is a rising body of evidence that suggests that there are concerns about access, quality of care associated with private equity entering the marketplace. And while private equity started with some of the more specialized care, and hospitals, and health systems, we're seeing an increase of private equity in primary care. And so what is that going to do to quality, to access, to the workforce?

Yalda Jabbarpour: I'll just add, Larry, before we get on private equity, to talk about the equity question a little bit. I think there are, maybe it's not innovations, but there are bright spots in terms of providing equitable care, and that is the community health center program. So that program is located in areas of most need. It's federally funded and probably not funded at levels that are needed. But if you look at what they do in those community health centers, it's amazing. They have multidisciplinary teams. They have social services. They have legal services. They have pharmacy, it's a one-stop shop. They're located in areas where many primary care offices are not located, including rural and frontier areas. So there's an innovation there that maybe we need to not reinvent the wheel but start putting more funding into to grow in order to increase health equity in the United States.

Candice Chen: And I'll just add, I think the number one issue that community health centers have is recruitment and retention of their workforce.

Larry Levitt: And I would say community health centers are maybe the one place in healthcare where there's actually bipartisan support as well. So we've had a ton of questions coming from the audience, and we will certainly not get to all of them. There are a whole bunch about technology, and we all know that healthcare has been somewhat backwards technologically. What are some ways that technology is being used or could be used to help the system work better, whether that's making appointments easier or telehealth? And Erin, maybe I'll start with you. What are you seeing in terms of some investments or innovations in technology that are making things better?

Erin Ney: Yeah, I'll speak to telehealth first, and then we can speak to certainly some other areas of innovation. I think because of the pandemic, we saw our

telehealth utilization rise out of necessity, and I think at least both in the corporate world as well as with financial investors, there was an idea of: is this now the new model of care? Particularly in primary care, particularly as we talk about access issues, is this the new model of primary care? I feel really strongly, as a former practicing primary care provider, and we have some data to back this up, that the interpersonal relationship with your own doctor and the value of physical exam, and the value of actually laying hands on a patient cannot be replaced by the convenience of telehealth longitudinally. I think telehealth has its place, and what we've seen in our own work, in our own surveys is that tends to bear out with both consumers as well as physicians where if you ask consumers their preference for seeing any doctor quickly versus seeing my doctor, the preference is very strongly towards seeing my doctor.

And for all of those reasons, again, someone who knows you, someone whom you have existing relationship with, and for someone who you actually also see probably in person in clinic. And so while we saw, again, telehealth usage ramp up out of necessity in COVID, but because of that we also saw not just pure-play telehealth companies have increased utilization, but primary care providers had to do that as well. Most providers had to do that. And so now more traditional primary care providers have that capability and can offer that. And so we now see the shift, and so we expect that telehealth ends up being roughly settling out at roughly like 20% of visits, and you can think about what visits are most appropriate for that, but that's one. I do think there's a lot of buzz, and rightly so, around generative AI, and the promise that it holds, and the technology that it holds.

I think there are lots of opportunities there. And we can think about within primary care models, certainly on the administrative side, and I think administrative to reduce the administrative burden and think about how we improve the experience for both patients and clinicians. I think there's tremendous potential there. Through ambient listening models to help with documentation. Through ambient listening models to actually assess our patient's experience as they move through our systems and to be able to address their pain points as they come up. And then I think we are seeing, and we'll continue to see AI support for clinical decision making, and I know that's going to be further out. I mean, it's in process, but it's going to be further out. So I think those are probably the biggest ones. I think there's a lot of technology employed around data aggregation as we think about participating in alternative payment models as well as proactively gathering insights from our patients and highlighting when we think someone's going to get sick so that we can intervene before they do. So I think those are some of the areas where I see problems.

Yalda Jabbarpour: I want to pick up on one thing Erin said about the telehealth models. I think the telehealth models are absolutely improving access for our patients. I saw that during the pandemic where some patients who never came in to see me because of work, because of transportation, because of childcare, were actually seeing me, and that's great. Where I have a concern, particularly in this world of we're already in a primary care shortage, is these telehealth, these primary care telehealth only models. Because just watching, I work with residents, I work with trainees, and just watching, the workforce almost get fragmented even further in primary care. And not because people are going into specialty care, but because they're like, you know what?

I'm going to work for one of these telehealth-only companies and not do continuity primary care, which I was trained to do. And that just takes down the primary care shortage even more, right? So there's good and there's bad on that side. And then on the generative AI, Erin, yesterday was my first day using ambient listening in clinic, and oh my goodness, was it amazing. I really see promise there because I didn't have to write a single note. I could just see my patients, and I think that's great.

Larry Levitt: I want to come back to something Candice said earlier about training, and so much of our residency system and money is oriented towards hospitals and specialties. What are some ways to shift that? What are some ideas to shift those resources to more specifically give people, medical students interested in primary care, an opportunity to do those residencies?

Candice Chen: I know Yalda knows a lot about this, but I'm going to go first, if that's okay, Yalda. There is actually a great program. It's called the Teaching Health Center Graduate Medical Education Program. It was created in the Affordable Care Act, and what it did is it provided explicit funding in a very different mechanism solely for primary care physicians. It includes dentists, it includes psychiatry, and primary care, and then it said that the residency programs effectively have to be based out of outpatient primary care settings. So it flipped that model of attaching the payment to the hospital to say, We're going to instead require the payment, go to the primary care site effectively.

Now, the components of the primary care training still requires hospital and outpatient, it doesn't matter if it's hospital-based or whether it's a primary care site-based, but it changes the mission, it changes the focus, and a lot of those teaching health centers actually went to community health centers, and then they can build the residency programs in very different ways, in ways that are embedded in communities, in ways that are exposing the residents not only to, often in community health centers, a much more full scope of practice of

primary care. Primary care that is in community health centers, often guided by community boards with a lot of community engagement.

And the organizations themselves do a lot of partnerships, and community engagement, and think about population health. It's just a different model of training, and it required shifting the way that we pay for residency programs. Now, I mentioned that Medicare GME is putting out $18 billion a year in payments to teaching hospitals. Medicaid puts out another almost $5 billion and has a tendency to model how Medicare pays. The Teaching Health Centers program is being funded at about 120 million, million, M not B, million dollars a year. I know it's going to sound terrible, but compared to the Medicare investment, it's like dust. But if we could be much more intentional about what we're investing our training dollars in, we might be able to, in that way, start to turn and shift the tide.

And like I said, many people, in 2014, the National Academies of Medicine then the Institute of Medicine put out an entire report recommending a major reform of Medicare GME, and their conclusion is basically how we pay for Medicare right now completely disincentivizes an accountable training system that is producing a workforce that we need. So there's a lot of recommendations, I think, around taking that $18 billion and trying to do something a little bit different with it. And you could model it off of a program like the Teaching Health Centers program, which, by the way, also has to be funded right now.

Larry Levitt: Yalda, you want to jump in and add?

Yalda Jabbarpour: I think Candice did a great job. I mean, the only thing I'll add is not only is the Teaching Health Center program underfunded relatively, it's also unstable funding. So that's really hard when you think about how programs have to recruit. It's hard to recruit residents to your program when you're like, I know it's a three-year residency, but we only have funding for the next two years, and then we'll see what Congress decides. So it's a really tough thing the way that their funding is set up. But I agree with Candice, all the data shows that that program is creating primary care physicians, clinicians that work in high-needs areas and that are staying in primary care.

Larry Levitt: But let me follow up on that. We've had a lot of questions about rural areas specifically, and we talked a little bit about that, but so what evidence do we have of primary care shortages being worse in rural areas, and how do we approach that problem?

Yalda Jabbarpour: Yeah, I mean, I think the evidence is clear that primary care shortages are worse in rural areas. How we approach that problem is maybe a little bit more complicated. I know Candice has studied this and talked about it a little bit, but we know that the types of students, residents, that are going to go back to rural areas are not only coming from rural areas but also had robust training in rural areas. And so both recruiting from rural but also growing rural training tracks within residencies medical schools is really important. There's obviously a lot more factors outside of medical training and outside of healthcare that impact people going back to rural areas. A lot of, at least, physicians these days have dual working spouses, and so the other spouse needs to have economic opportunity.

They have children, the children need to be in good schools, et cetera. There's a lot of things outside that are of health and healthcare and health education that are really impacting the rural workforce shortages. So it is a difficult problem. What we know, though, is that primary care, compared to every other clinician's specialty, does a much better job of distributing ourselves in rural areas. And within primary care, family medicine representation almost matches exactly geographic distribution of the population. So X percent of the population is in rural areas, X percent of family physicians are also in rural areas.

Larry Levitt: So we are unfortunately coming to the end of our time and have only scratched the surface here. I just want to give each of you an opportunity to talk about one thing that you think could be done quickly to improve access to primary care. Asaf, I'll start with you.

Asaf Bitton: Quickly is the hard part. But I think, as we've come to understand, change can happen with a combination of community mobilization and political will. To me, the way into solving the primary care morass starts but doesn't end with paying primary care more and differently for the care that it delivers with communities. There's no one actor, there's no one magic lever, but there is a pathway that makes sense, and it makes sense because we know, and there've been lots of questions in the chat, a lot of people have said, Well, this sounds like stuff that Barbara Starfield and others said 20 years ago or 30 years ago. Look, we do actually know a lot about primary care that works. Primary care that provides first contact access, that provides comprehensive care, that provides continuity, and that really provides care over time for the whole person is care that reduces mortality, improves outcomes, and improves equity.

The way to do that is to create the fiscal space and the work environments to make that a reality. And in a system that has multiple parts of payment that come from employer-based and sponsored health insurance, state and federal

insurance programs, and private entities that provide care, people will run if they have access, and resources, and awareness to models like concierge, and DPC, and others that provide that kind of core functions of primary care. But the question before us is how do we make that kind of care that people want available for all? And not get sort of confused by augmentative solutions like telehealth, which are great, but they're not going to, as the other speakers eloquently spoke to, replace the core relationships that people need and want with their teams. Now, I think we spend too much time in primary care worrying about whether it's the NP, or the PA, or the doctor that's providing the care.

I think we could spend much more time wondering how do we make the roles, and lives, and work conditions of the people providing that care with and for communities better? And the way into that is to start paying them more and to start paying them in a form that's conducive to the kind of longitudinal relationships that they aim to build. And the way to do that can be done through employer contracts, can be done through commercial insurers finally realizing the value of primary care, through employers and purchasers finally realizing that the health of their employees is going directly through their ability to access these relationships, and the federal and state insurance mechanisms continuing to dial up the incremental reforms to something more profound.

Larry Levitt: Great. Erin?

Erin Ney: I mean, you might just want to end on that. I think most of us would agree, but I was going to just say, and I will echo, I think what needs to be done is that provider organizations need to recognize that I will say for all of us, and I'm the one here who has left clinical practice, but I went into primary care to take good care of my patients because that's what matters. And that is what I think most clinicians want to do, but particularly primary care physicians and clinicians, I should say more broadly, want to do. And I think organizations really need to look at, again, the work environment, certainly the payment environment that's broader, but just how we can better support our clinicians so that they can take good care of their patients.

Larry Levitt: And Candice?

Candice Chen: I mean, I have to, just to echo Erin, I don't practice that much. I'm a primary care pediatrician, but being a primary care provider is beautiful when you have the space and the resources to provide the care that you came into healthcare to provide. And then I'm just going to echo Asaf. You have to fix the payment. But then, because you gave us all the opportunity to say what else, I'm going to go for the long-term. As you fix the payment, you also have to start fixing the

educational pipeline because there are things that will act as an anchor and hold you still if we don't start to address that as well.

Larry Levitt: Yalda, you get the last word.

Yalda Jabbarpour: Well, I'm just going to say that I completely agree with Asaf. It starts with payment. And the reason that it starts with payment is that, the way our payment system is currently set up, we are not supporting primary care teams. We may be paying for primary care clinicians to deliver care, but we are not supporting teams to deliver care. And what we need to get out of this crisis is robust teams.

Larry Levitt: Well, I will say that almost every one of these long shots I've moderated and, frankly, almost every healthcare issue I've worked on starts and ends with payment. It is the story of healthcare, and it is what drives the incentives in the system and we get the outcome we pay for. So it's been a tremendous discussion [inaudible 00:50:38] for helping make it and our audience for great questions as well. I apologize we didn't get to all of them. We will certainly have to come back to this issue because we really did only scratch the surface. But thanks again for a terrific discussion.