

Primary Care, Private Equity, and Profit: How to ensure poor quality care for the American people

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I -- and many others -- have written (frequently and recently) about the abuses of for-profit companies, especially private equity companies and “non-profits” that act like for-profits in health care ([Private equity, private profit, Medicare and your health: They are incompatible](#), May 11, 2023; [Privatizing Medicare through “Medicare Advantage” and REACH: The Wrong Way to Go!](#), Jan 20, 2023; [“Private Equity”: Profiteers in nursing homes, Medicare Advantage, DCEs, and all of healthcare](#), Sept 16, 2022). But despite our efforts, it doesn't get any better. Indeed it gets worse.

Drs. David Himmelstein, Steffie Woolhandler, Adam Gaffney, Don McCanne, and John Geyman, leaders in the campaign for a national health insurance plan (e.g., Medicare for All), published an article 18 months ago in ‘The Nation’ (March 31, 2022) titled [‘Medicare for All is Not Enough’](#). They go through the ways in which the ownership of our health system has changed, particularly over the last decade, to focus on profit for the private owners rather than improving “health care”. That is to say, while a single-payer Medicare for All program would likely limit the considerable negative impact that for-profit insurance companies wreak on our collective health, as long as for-profit companies continue to increasingly own our actual health delivery systems (in the form of hospitals, nursing homes, pharmacies, and physician practices), those single-payer dollars from such a Medicare for All program would flood into investors' pockets rather than patient care.

Insurance companies like United Health and giant pharmacy firms like CVS own large portions of our practice and health delivery sector. At least as terrifying is the role of private equity companies and investors, with their “buy ‘em and burn ‘em” approach to acquisition and profit, in taking over our delivery system. As the authors state:

At least UnitedHealth and CVS plan to stay in business for the foreseeable future, and may be constrained by the worry that substandard care will damage their reputation. Private equity companies face no such constraints. They promise investors quick profits, and often sell off the businesses they've

bought within five years, often after stripping their assets and loading them with debts that hobble future operations.

On top of who will *own* our care provision, there also is the issue of who will provide the care. Most developed countries, with more rational health delivery systems, rely on primary care physicians and other clinicians far more than the US does. In those other countries primary care is at least 30-40% of the physician workforce, while here it is closer to 20% and dropping, an issue I have written about often (see, for example, [What is the problem with Primary Care? The US health system!](#), March 22, 2022). Primary care clinicians – family physicians, pediatricians, and general internists, and the NPs and PAs who work with them – can provide not only cost-effective care but care that is comprehensive, continuous, and reassuring to people and families because they know the person who is providing it and have a relationship with them. And the cost-effectiveness is not (only) about the fact that they earn less money (see below) but because they are in a position, as a result of taking care of the “whole person” and having a long-term relationship, to more wisely utilize resources when necessary. Nonetheless, there is a definite shortage of primary care clinicians, as anyone who has tried to find one recently can testify, because their physicians moved, or retired or had their practice bought out by a large company like Optum (a subsidiary of UnitedHealthcare, which has become UHC's major profit center as documented by former insurance executive Wendell Potter in his [“Health Care Un-covered”](#) substack), or, sometimes in response, their physician moved into a “concierge” or “boutique” practice. Elisabeth Rosenthal, editor of Kaiser Health News, notes in a recent piece in the Washington Post, [“The Shrinking Number of Primary Care Physicians is Reaching a Tipping Point”](#), that “fewer medical students are choosing a field that once attracted some of the best and brightest because of its diagnostic challenges and the emotional gratification of deep relationships with patients.” And she makes the important point that:

One explanation for the disappearing primary-care doctor is financial. The payment structure in the U.S. health system has long rewarded surgeries and procedures while shortchanging the diagnostic, prescriptive and preventive work that is the province of primary care.

Don't forget that one. Rosenthal discusses the terrible experience of colleague Bob Morrow, MD, who, under financial pressure, finally had to sell his decades-old practice and then left medicine, having watched how the new owner ran it (which he considered not in the best interests of the patients). Morrow is not a depressed person, but reading

about what has happened to him and thousands of other primary care doctors is enough to make one depressed.

In a data-driven [“Scorecard” on primary care in the US](#), the Milbank Memorial Fund ranks it poorly on all fronts, although not based on the quality of the physicians:

This first national primary care scorecard finds a chronic lack of adequate support for the implementation of high-quality primary care in the United States across all measures, although performance varies across states. The scorecard finds:

- 1. Financing: The United States is systemically under-investing in primary care.*
- 2. Workforce: The primary care physician workforce is shrinking and gaps in access to care appear to be growing.*
- 3. Access: The percentage of adults reporting they do not have a usual source of care is increasing.*
- 4. Training: Too few physicians are being trained in community settings, where most primary care takes place.*
- 5. Research: There is almost no federal funding available for primary care research.*

The Scorecard, created for Milbank by the Robert Graham Center (the policy arm of the American Academy of Family Physicians, AAFP) not only identifies these deficits, but also the importance of solving them for the health of the American people. One hundred million people without a primary care doctor who are only able to see a physician (if they can see *any* physician) who has a narrowly focused, disease-based practice is a real problem. We need those specialists for when we are diagnosed with a particular condition that requires their expertise, but they are often not knowledgeable about conditions outside it. Moreover, the primary care clinician does not only care for many conditions; much more important is that they care for the *person* who has those conditions.

The report also endorses the conclusions from the National Academy of Science, Engineering, and Medicine (NASEM) from 2021, recommending that the US:

- 1. Pay for primary care teams to care for people, not doctors to deliver services.*
- 2. Ensure that high-quality primary care is available to every individual and family in every community.*
- 3. Train primary care teams where people live and work.*
- 4. Design information technology that serves the patient, family, and interprofessional care team.*
- 5. Ensure that high-quality primary care is implemented in the United States.*

Finally, for the moment, an effort is being made in

Congress to try to increase the number of primary care clinicians. In an uncommon bipartisan effort, the bill is cosponsored by Bernie Sanders (I, VT), chair of the Senate HELP Committee, and Roger Marshall, MD, an OB/GYN and conservative Republican from Kansas, [as reported by Jake Johnson in Common Dreams](#), Sept 14, 2023. Although bipartisan support is nice to see, the bill would, sadly, be unlikely to have a major effect on increasing the primary care physician supply. Funding in the bill – about \$6 billion – would go mainly to Community Health Centers (CHCs), especially Federally-Qualified Health Centers (FQHCs). These centers provide care to lower-income people and communities where access to other clinicians is difficult. Republicans like them because they are not actually “government” programs, but responsible only to their boards of directors. These centers often rely heavily on primary care, and expanding them will increase the number of jobs for primary care clinicians. However, such an expansion would do nothing to increase the supply of those clinicians, such as by convincing medical students to enter family medicine, pediatrics, and general internal medicine instead of much higher-paying subspecialties.

This problem is a lot about money, as the Milbank report also mentions. Convincing students to enter fields where their income is likely to be a fraction of that of subspecialists (even if much better than that of most Americans) has become increasingly difficult, especially in the context of huge educational debt borne by these students (frequently over \$250K), and in view of the lack of respect given by the medical profession and often society at large to primary care. And, not at all to be minimized, the takeover of so many practices by for-profit corporations and private equity, with situations like Dr. Morrow’s becoming the norm rather than the exception. [Some subspecialties make 2-3 or more times that of primary care doctors](#), which makes it increasingly difficult for students to decide to enter primary care. While some of these subspecialties have grueling work hours (e.g., general surgery) others have much more circumscribed work hours, often characterized by shift work with little call.

There IS certainly something the federal government could do. The Center for Medicare and Medicaid Services (CMS) sets the relative reimbursement for physician services (office visits, procedures, etc.) and virtually all private insurance companies reimburse based on multiples of the Medicare rate (traditionally more, but now often less). So, CMS could revise its fee schedule, increasing the relative value of primary care visits relative to procedures. Of course, there would likely be great opposition from other specialists; indeed the “RUC”, a non-government committee that advises CMS on this ratio is completely dominated by subspecialists ([Changes in the RUC: None.. How come we let a bunch of self-interested doctors decide what they get paid?](#), July 21, 2013). CMS is not required to follow the recommendations of the RUC, although it

usually does; CMS could ignore or adjust what the RUC recommends or reconstitute the membership of the RUC to have more primary care doctors. Primary care physicians do not need to make as much as the highest-paid subspecialists (indeed, neither do those subspecialists!), but the difference needs to be decreased. Studies have indicated that if primary care doctors earned 70% of what subspecialists do, income would no longer be a significant factor in specialty choice. [CITE]

Addressing this income gap is critical to increase the number of primary care clinicians. Of course, there is a lot more to do to improve healthcare, like getting for-profit corporations and private equity out of healthcare altogether.

For a "humorous" depiction of the takeover of primary care by for-profit companies like Optum, check out this short piece by the brilliant Dr. Glaucomflecken: <https://twitter.com/i/status/1706339952857149895>