Not enough primary physicians OR Nurse Practitioners: It's the money, stupid!

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"Like doctors, more nurse practitioners are heading into specialty care" is the title of a recent article in the Washington Post (June 17, 2024) by Michelle Andrews, a contributing writer for KFF News, and McKenzie Beard. It makes the point that

> Nurse practitioners have long been a reliable backstop for the primary-care-physician shortfall, which is estimated at nearly 21,000 doctors this year and projected to get worse. But easy access to NPs could be tested in coming years. Even though nearly 90 percent of nurse practitioners are certified to work in primary care, only about a third choose the field, according to a recent study.

That study, called 'No One Can See You Now: Five Reasons Why Access to Primary Care Is Getting Worse (and What Needs to Change)' was published by the Millbank Memorial Fund, and goes on at length to explain those reasons, and what needs to change.

> Spoiler Alert: Like physicians, primary care nurse practitioners make less money, often for more work, and far less restricted scope of practice. Or, borrowing from an old political mantra, "It's the money, stupid!" Or, as the WaPo article quotes Candice Chen, an associate professor of health policy and management at George Washington University, "We get what we pay for."

It is, of course, more than just the raw amount of money. It is also how much NPs – and physicians – are paid for the amount of work that they do. This work is undervalued for primary care, based upon the notion that, somehow, being expert in a narrow specialty and knowing a lot about a little, is worth more than having a broad knowledge and being able to help a lot of people, most people, a great deal. Thus, subspecialists dramatically limit their practices to what they feel most expert at and expect the primary care clinician to do everything else. This often includes preparing people for a procedure and following them up after, which are both completely the responsibility of the person doing the procedure. Subspecialists particularly like to send paperwork back to primary care. "Your primary care doctor (or NP) will have to take care of this." Implication: 'Unlike primary care clinicians, I do important things.'

I would argue that managing people's health is doing important things. Which is what the primary care clinician (family physician, general internist, general pediatrician, or the NPs that work in these fields) does. Managing the actual person, you, not just one of your diseases, or one aspect of one of your diseases; being knowledgeable about you, your life, and the interactions of all your conditions and the impact that they have on the rest of your life.

How might this manifest? Let's say you have knee pain. You go to your family physician, who examines it, and decides that you need an x-ray. They review the x-ray and the report, and decide that you might benefit from seeing an orthopedist. They fill out the referral. Then, after the consultation and recommendation from the orthopedist, they review it, and decide how to implement the treatment. That is a lot of work. The orthopedist was done in a few minutes. Guess who gets paid, altogether, more?

Like the physicians that employ them, NPs are often very expert in their limited area (say, heart failure management), but often do not know how to manage that problem in the context of a person whose other diseases or medications may complicate that. This is where the (underpaid) primary care clinician, physician or NP, has to come in. It is a lot of responsibility, a lot of work, and often a lot of extra hours. One NP profiled in the WaPo article is taking training to become a dermatological NP. This is one of the medical fields with the highest pay/work ratios. Most of its work is not emergent and can conveniently be scheduled during the day during the week, and is less likely than many other specialties' work to interfere with treatment for other conditions. And it is very highly reimbursed.

Should people be paid based upon the amount and difficulty of their work? If we did, people doing the most difficult work that everyone agrees needs to be done but that most people do not want to do (e.g., picking up the garbage, doing farm work in the hot sun) would be paid more than those who get fancy offices and lots of perks and boss folks around (e.g., CEOs). But difficult can have other definitions; this is really a separate discussion. In health care, for physicians (and now NPs) it should be how they contribute to the system. Currently the usual measure is money, that is, how much a given practitioner brings into the practice, or more commonly now, to their employer (often a health system), which is based on how much payors (insurers) pay for different things. That amount is not God-given, but a matter of policies that could be changed. Two mechanisms through which the amount of reimbursement is set are the RUC and the facility fee. The RUC is a group of non-governmental physicians appointed by the AMA that makes recommendations on how Medicare money should be divided up between specialists – like "one gallbladder removal is worth 6 complete examinations", or whatever. Medicare is not required to accept their recommendations, but they usually do. And – surprise – the RUC is mostly made up of subspecialists, not primary care clinicians!

The facility fee is an amount that Medicare (and other insurers, see below) tack on to the physician fee if the practice is owned by a health system rather than a physician,

and is often several times the fee for the procedure. To be clear, this means that if I receive a procedure today from a physician in his office and you get the same procedure in the same office by the same physician next week, but in the interim that practice has been acquired by a health system, the charge will be MUCH more. Medicare or your insurance may pay it, or most of it, but your co-pay will be much higher, and all of our premiums go up. This practice is hardly ever made apparent or explained in advance to patients ("Hi, thanks for calling. Just to let you know, Dr. Smith's practice was just acquired by the MuchProfit Health System, so you will be charged three times as much for your procedure as you would have been last week.") This is so insidious (not to say evil, but it is evil) that even doctors are often surprised, as revealed in the essay by Dr. Danielle Ofri in the New York Times (June 17, 2024) 'Even Doctors Like Me Are Falling Into This Medical Bill Trap' and the follow-up letters and comments from other physicians.

The fact that facility fees and the RUC are about Medicare does not mean that they do not affect the fees, cost, and reimbursement from other insurers. Almost all insurers payment rates are set as multiples of Medicare. That is, if Medicare pays $100 for something, they may pay $150 or $200 (and, more recently, those multiples are lower, with patient responsibility higher). Changing these two factors, facility fees and RUC allocations, for Medicare will affect all insurers and make a real difference in income (which is why most subspecialists and hospitals oppose them).

Should primary care clinicians be paid more, or subspecialists less, or somewhere in between? Whichever, by decreasing the difference more clinicians are likely to enter primary care specialties. And, whichever, the raking off of facility fees to increase the wealth of hospitals, not to mention the pocketing of huge profits by insurers, has to stop.