

Pay primary care more: Kennedy may be getting this one right!

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I have recently written strong criticisms of Secretary of Health and Human Services Robert F. Kennedy, Jr. and his positions on a number of issues, including most importantly vaccines (see RFK, Jr.: The Secretary of Health and Human Services is Dangerous to Your Health!). Not only is he wrong about vaccines being dangerous, he is in fact creating major danger by discouraging their use. The polio vaccine essentially eliminated a disease that was a major scourge in the US as well as the rest of the world, as did the measles vaccine. Many other vaccines protect our children – and adults – from other serious viral diseases like influenza, COVID, mumps, chicken pox, rubella, shingles, and human papillomavirus (HPV) which causes cervical cancer, as well as bacterial diseases including diphtheria, tetanus, pertussis, and *Hemophilus influenza b*. The last is something most people have not heard of, but early in my career was a major cause of morbidity and death in infants and young children from meningitis, pneumonia, and epiglottitis, which caused their throats to swell rapidly and choke off their breathing. Many others have articulately expressed this concern, including the pediatrician Perri Klass in the *New York Times*. While these diseases affected people of all social classes, they were more prevalent among the poor and minority groups such as the people I cared for at Chicago's Cook County Hospital. Indeed, research has demonstrated tremendous benefits from vaccines on the health of children and other populations that go far beyond just the decrease in the specific diseases that they target to decreasing all-cause mortality!

Kennedy is wrong about many other things, if not all of as of such immediate potential danger as urging people to not get vaccinated. These include nonsense like suggesting that people who eat right and exercise won't get disease, that raw (unpasteurized) milk is better for you, and that "natural" is always better (which, even if we could agree on a definition of "natural," it isn't). One recent example is his arguing for Coke to use "natural" cane sugar rather than high-fructose corn syrup, both of which are sugar and have calories and in large amounts are bad for you.

But there turns out to be one area where Kennedy and I seem to agree, which is the need to take concrete action to increase the number of primary care physicians. Lots of people, including politicians, healthcare providers, and health policy experts, express concern about the shortage of primary care, but have done nothing to address the real cause of this problem – that primary care physicians (and the nurse practitioners and physician's assistants working with them) get paid a lot less than do physicians in other specialties.

Kennedy appears to be doing something other than wringing his hands. On several occasions I have written about the RUC, the AMA committee that decides how to divide up the pie of Medicare dollars among specialists by deciding how much each thing doctors do is worth relative to other things that they do. (Changes in the RUC: None. How come we let a bunch of self-interested doctors decide what they get paid? July 21, 2013, Doctors' incomes and patient coverage: both need to be more equal July 26, 2014, and most recently, Not enough primary physicians OR Nurse Practitioners: It's the money, stupid!, June 27, 2024).

Not to get too technical, there is a set amount of Medicare dollars and the RUC decides (or recommends to CMS, which almost always accepts those recommendations) how many physical exams, say, are equivalent to one gall bladder surgery, considering (theoretically) both difficulty and time. This makes a tremendous difference in physician income and, I would argue, specialty choice by medical students. And, over the years, the amount of time it takes for doctors to do some things, particularly procedures, changes. Colonoscopies used to be estimated to take an hour and a quarter, but now are routinely done in 30 minutes. Cataract surgeries take a fraction of the time that they once did. This can result in physicians billing for more procedures than the model assesses as possible in a day. In contrast, the time it takes for a physical exam, or to listen to an interpret a person's story, hasn't changed significantly. The composition of the RUC, according to the AMA, represents all specialties, but its membership has a low proportion of primary care doctors – five of the 32 seats. Unsurprisingly, then, specialist-performed procedures are valued more highly than cognitive work. And, very important, these rates (relative value units) do not affect only Medicare payments – virtually all insurers pay based upon Medicare rates, so it is the whole health system! Prior to this new regulation, alternative models for allocating payment have been developed, such as this 2025 publication from the National Academies of Science, Engineering, and Medicine (NASEM).

So, now, maybe, a change. The *NY Times* reports that, buried in an 1800-page HHS regulation, are proposed changes in the RUC methodology that would benefit primary care. This would be real action! In addition to reassessing these relative values, the action would also look at the current practice of reimbursing more for the same procedures done in a hospital than in a doctor's office, a major way that hospitals make money. And, for those who think "of course it costs more to do something in a hospital", this is a technicality; it simply means that the hospital *owns* the practice or clinic. So two, say, skin biopsies performed in similar doctor's offices across the street from each other are now reimbursed at very different rates if one is owned by a hospital. This is absurd and inequitable, and getting rid of it makes terrific sense!

The diffusion of medical services to people and communities is primarily driven not by the health needs of the populations in different areas but by the potential to

make the most money for health care providers. These are largely, and increasingly, hospitals and health systems, as well as enormous insurance-company and private-equity owned practices rather than individual or small group physician-owned practices. So, we get enormous hospital campuses and medical facilities in major cities and wealthy suburbs and little or nothing in poor neighborhoods and rural areas. This should change. The only reason for decisions about what healthcare services to provide and where to provide them should be the health needs of people, and not on how much profit can be made.

The new HHS regulation will be a big step in this direction if it redirects Medicare (and thus all insurer) funds to primary care, and does not preferentially favor hospital-owned practices. To the extent that he is responsible for it, Kennedy should be congratulated. However, while it is a

big step, it is not a solution. The next, necessary, step is a universal health insurance program where every single person is covered and covered by the same system, and where establishment (and closure) of health facilities, and the services that they provide or do not, is entirely based on the health needs of the people. Of course, there will be a lot of resistance – highly paid specialists will resist the proposed HHS reimbursement changes, and the institutionalized powerful insurance companies and other big players who are making lots of money from “healthcare” will oppose more comprehensive changes. Indeed, they already are, with highly funded social media campaigns against universal health care.

We are glad for this first step, but we need to keep fighting to get a comprehensive health program – like those of every other wealthy country!