The future of primary care in an ACO model

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Primary care is a unique field of medicine.

Primary care physicians (PCPs) are the gatekeepers to specialized care, provide preventative care, and most importantly, they have the ability to manage patients with multiple chronic conditions. Thus, primary care physicians are in prime position to become the point men in the accountable care organizations (ACOs).

Accordingly, the value of PCPs will increase, and their salaries will rise. Moreover, the goal of establishing patient center medical homes seems obtainable. The key tenets of medical homes, which include long-term personal care, integrated team-based care, and increased access to health care, will improve patient health.

But a medical home without foundation is not a home at all. Currently, there are not enough PCPs in the U.S to address the increase of the U.S population, the retiring of the baby boomers, and the increasing number of patients with chronic conditions. So despite a likely increase in prominence, one must wonder if health care reform, particularly the ACO model, can help revamp the field of primary care.

The solution is clear either increase the number of PCPs by increasing the number of foreign PCPs or increase the number of U.S medical graduates going into primary care. But are there enough incentives to instigate the change necessary to meet the increase of people entering the health care system? Simply, the answer is no. Sadly, for many medical students, good intentions are not enough. This is an issue beyond financial considerations. Rather, it is a matter of lifestyle. For many students, primary care is not “sexy.” Ear infections, back pain, diabetes, and hypertension just are not as interesting at coronary catherization and advanced MRI studies. But the lifestyle concern expands beyond the day-to-day care provided; it is about the lives of physicians once the white coat comes off. The grueling demands of medical education and a generational shift towards prioritizing a more controllable lifestyle has resulted in medical students seeking specialties with a better work-life balance.

It is questionable whether primary care can provide this lifestyle. By 2025, the workload for PCPs is expected to increase by nearly 30% relative to the workload in 2005. Being the prime players in ACOs could possibly further increase the workload of PCPs. However, if team-based care really does take hold in ACOs, the workload for PCPs may decrease. Currently, if one used the ACO model, there would have to be more assistance from mid-level providers and/or from specialties to help relieve the burden on PCPs. Of course, the affect of ACOs on PCP workload will depend on if ACOs have an economic of scale to adequately distribute and/or decrease the amount of work-per-provider.

The current trend of an increasing number of medical students going into primary care allows for cautious optimism. Nevertheless, the past trend of a shrinking number of PCPs will leave its mark. That is to say, any increase in the number of medical students going into primary care will not offset the dearth of PCPs necessary to address the health care dilemma. In addition, if the ACO model does not decrease the workload of PCPs, then medical students may shun away from going into primary care. Based on past patterns, current PCPs may move
to other fields of medicine. Finally, with the recent shortening of work hours for resident physicians, the medical culture of endless devotion and extremely long hours will take another step towards oblivion.

It is hard to predict the story will unfold, but if ACOs come to fruition, primary care as we know it will never be the same.