

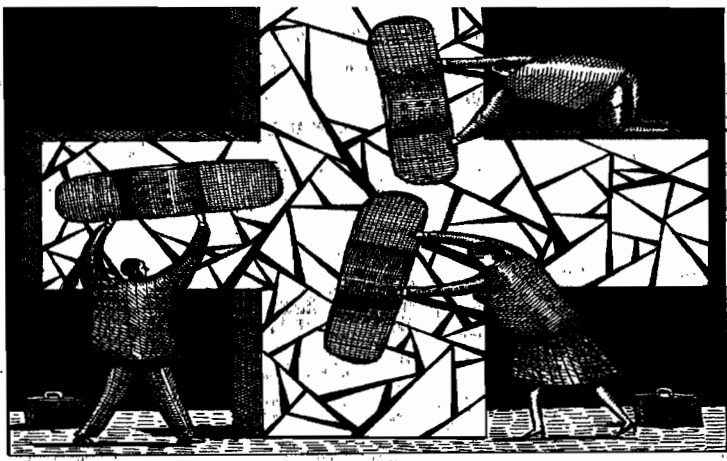
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Are you ready for today? CLOUDY, HIGH 44, LOW 42 / PAGE B8 ROCKETS GO FOR FOUR IN A ROW / PAGE C3

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Focus reform on shortage of primary care providers

■ Establish 'medical homes' to effectively treat patients

By CLIFFORD C. DACSO, LYNN JONES AND MATTHEW DACSO

OVER the next few days, there will be a national conversation about the country's health care crisis and how to respond to it. The Obama transition team has asked that Americans participate in a discussion and report back on how they feel and what they think workable solutions might be. In the guide for the discussion, the team outlines what they consider to be the big problems. On everyone's list must be the solution to the problem of underinsured people and underresourced communities. No one disagrees with this. Less often discussed, but close to the surface of the problem, is the question of who will take care of the people, even if the lack of payment capability is solved.

Among the many crises facing American medicine is the rapidly diminishing number of primary care physicians presently at work and in training for the future. It is instructive to see how we got to this point, since the identical problem faced the country in the 1960s.

Anticipating a projected shortage of physicians, Congress enacted the Health Professions Education Assistance Act in 1963 with three major goals: increasing the number of graduates of American medical schools, increasing the number of physicians entering the primary care disciplines (internal medicine, pediatrics, general practice, and, in 1969, family medicine) and providing medical care to underserved communities by training physicians who grew up in those areas. The first goal was accomplished with uncommon success. The number of graduates of American medical schools increased from 9000 in 1970 to more than 15,000 by 1980. However now, 45 years later, we are still bemoaning the lack of access to medical care and the failure of primary care physicians to meet the needs of even the presently insured population, to say nothing of the additional 45-50 million who will have payment capability under any sane health care reform plan.

Changing the distribution and makeup of the physician work force has been a fond desire of social engineers for decades. Yet, there really has been no appreciable change; people in rural areas, inner city urban communities, and even wealthy urban areas are united by their frustrations in accessing medical care that is knowledgeable, compassionate, thoughtful, prompt and affordable. Palm Beach County, Florida, certainly not an economically deprived area, has had a 22% decline in the number of family physicians in the past two years. Despite the well-meaning programs increasing the number of medical school graduates, this trend will not reverse for many years, if ever. Let history be our guide.

The transition team has asked for public discourse on the issues of access to medical care. In response to that invitation, we have to address the issue of how we are to provide access to the best medical care for everyone and who will do it.

Primary medical care does not equal primary care physician care. The preponderance of pri-

mary medical care, at least for adults, involves prevention of illness, care of chronic diseases such as asthma, heart disease, diabetes, depression and chronic pain. The diagnosis of these illnesses is the province of the physician; however, their longitudinal care is often best accomplished by non-physician professionals in the context of what has been called the "medical home." In this setting, physicians, nurses, nurse-practitioners, physician assistants and others provide access for acute care and management for chronic illnesses, and they do this collaboratively. Although this may sound fanciful, just such a medical home is being piloted in Ontario, Canada, and is called the "Family Health Team."

Perhaps the most important collaborator in the medical home is the person who has the illness or is trying to avoid becoming ill. This person needs to be informed on alternatives in a clear and thoughtful way and be given the authority to make choices that are in his or her own best interest. That means that the information stream has to travel far from the hospital or the physician's office into the home, the school, the community center, and wherever else health care information is needed.

Physicians squandered the trust of the public when they became "gatekeepers" for insurance companies and managed care operations. People soon realized that the only time a gatekeeper is needed is when someone wants to close the gate and thus physicians became perceived not as advocates for health but as agents of the corporate entities that only made money when health care was not provided. However, managed care addicted the covered population to cheap health care as they competed on the "co-pay." A \$20 office visit totally insulated the consumer of health care from its true cost and reduced the perceived value of the physician-patient encounter to a dinner for two at McDonald's.

Now we have to get the medical care professions, doctors, nurses, therapists, nutritionists and many others on the same side as the patients and people trying to avoid being patients. It will take more than providing payment capability for additional tens of millions of people since they will be competing for already limited resources. It will take a concerted effort to build systems that promote information sharing among the health care professionals and between them and their communities. The medical home does that, and it does it at no appreciable incremental cost.

That the system (if we grace it with that name) is broken is indisputable. That we need to provide basic medical care for Americans regardless of geography, social group or payment capability is the only path compatible with our national ideals. That we need to reorganize how we pay for health care and prevention goes without saying. That this can be accomplished by our medical professionals working in concert with those that they serve is a lofty goal and one that we must attain.

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