EDITORIAL

Declining Visits to Primary Care Physicians?

THE GREAT VALUE of the National Ambulatory Medical Care Survey (NAMCS) is revealed again by Stafford et al[1] in this issue of the ARCHIVES. These investigators characterized trends in the practice of primary care by analyzing more than 136 000 office visits by adults to general internists, general practitioners, and family physicians reported from 1978 to 1994. The investigators coped with variations in the data collected by NAMCS during their study period by analyzing some data for shorter periods, based on availability. They relied on the weighting system and standard error figures provided by the National Center for Health Statistics to extrapolate to national patterns of practice, thereby offering a national portrait of primary care patients and practice by primary care physicians (PCPs). They made good choices in using diagnostic clusters to profile diagnoses, by not distorting their results with visits to obstetrician-gynecologists, and in reporting findings based on higher-than-customary *P* values. As good descriptive reports should, this one tells us a few things we can believe and leaves us wondering what it all means.

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The profile of patients and practices by this nationally representative sample from nearly 2 decades is provided in some detail. For example, these data show that patients visiting PCPs are older as a group, are more ethnically and racially diverse, and have had a shift in their insurance coverage toward health maintenance organizations (HMOs); but their clinical problems did not change much, and women consistently accounted for about 60% of visits. The physicians' practices changed, a conclusion that should not go unnoticed, given our proclivity to complain about the difficulties of changing practice. For example, they provided more dietary counseling and blood pressure measurements, prescribed different medications, and increased the amount of time spent with patients. This last finding was noted for both HMO and non-HMO visits after adjustment for patient characteristics. Most readers will probably find something they consider particularly interesting in the results and commentary of this article. The authors emphasize in their conclusion the increasing role of managed care, but the evidence about managed care and its effects is relatively weak and not entirely consistent in this analysis. What was most provocative was the finding that, during the period reported, the number of adult visits to PCPs probably declined.

According to this report, the rate of visits to physicians per person per year increased overall from 4.7 to 6.1 between 1980 and 1994. However, despite this increased level of visitation to physicians, between 1978 and 1994, the number of adult visits to PCPs decreased from 236 million to 219 million. The confidence intervals overlap, raising the possibility that, in fact, there was no change. Whether there was a decrease or no change, this estimate is surprising, in part, because of what is known to have happened to the PCP workforce during the study interval. Between 1970 and 1994, the number of general pediatricians increased 133%; of general internists, 113%; and of family physicians, 26%, yielding a combined increase in the number of PCPs of 73%.[2(pp152-155)] Although the proportion of active physicians in primary care actually declined from 37% to 32% from 1970 to 1994, the fact remains that a major increase in the number of PCPs was associated with no change or a decrease in the number of visits by adults to PCPs!

This report cannot explain why the number of visits to physicians has increased, but not to PCPs. Readers will have many ideas about what this means. For example, perhaps these data are the result of the relocation of specialty care from hospitals to the ambulatory setting, and the distribution of visits between PCPs and specialty physicians shown in Figure 1 of the Stafford et al article is appropriate. Maybe the general practitioners who were present in larger numbers at the beginning of the study period practiced differently from the general internists and family physicians trained during the study period. Perhaps in later years of the study period, NAMCS sampled enough capitated PCPs lacking financial incentives to do more visits, resulting in fewer visits than would have otherwise occurred in fee-for-service medicine. During the study period, there was a steady to explosive growth in the number of specialist physicians, nurse practitioners, and physician assistants[2(pp152-155,160-164)]; these clinicians, instead of general internists and family physicians, could be the locus of growth in primary care thought to be associated with the managed care era.

Among the interpretations of this report is the possibility that the US health care system and US physicians are actually moving away from primary care. This possibility is disconcerting because of what we have learned about the effects of primary care, such as the following[2(pp52-75)]:

- Primary care improves the overall performance of health care systems.
- With access to primary care, treatment occurs before evolution to more severe problems.

- Emergency department use and hospital admissions decrease when people have primary care.
- Primary care clinicians use fewer tests and spend less money.
- Particularly for the poor, access to primary care is associated with improved vision, more complete immunization, better blood pressure control, enhanced dental status, and reduced estimated mortality.
- Countries with health systems oriented toward primary care generally achieve better health status (eg, in low birth weight, neonatal mortality, life expectancy, and years of potential life lost), and this better health status is achieved with higher patient satisfaction, lower per capita expenditures, and lower medication use.
- Primary care clinicians and subspecialty physicians fail to achieve preventive service guidelines, but people with a regular source of primary care receive more preventive services.
- Higher levels of primary care in a geographic area are associated with lower mortality rates, and this holds after controlling for the effects of urban-rural differences, poverty rates, education, and lifestyle factors.

This function called primary care appears to be of great benefit to individuals, communities, and health care delivery systems. It is not well understood and begs for discovery by curious primary care clinicians. An enterprise so ready for scientific exploration and so poised to help people should hold enormous appeal to physicians.

Nonetheless, primary care possibly has yet to be embraced in the United States. Its intrinsic value to people may have been lost in gatekeeping and coping with an oversupply of subspecialized physicians. The article by Stafford et al, at a minimum, should jar PCPs into reflection about just what has been accomplished to date and what needs to be done now to install a foundation of primary care in the United States. When the NAMCS is reviewed again 20 years from now, will there be further declines in the number of visits to PCPs? Or, alternatively, will there be a vibrant physician community dedicated to the discovery and implementation of outstanding primary care? People await the benefits of improved primary care. Who will do it?

Larry A. Green, MD
Department of Family Medicine
University of Colorado School of Medicine
1180 Clermont St
Denver, CO 80220
(e-mail: larry.green@uchsc.edu)

REFERENCES

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2. Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. *Primary Care: America's Health in a New Era.* Washington, DC: Institute of Medicine, Division of Health Care Services Committee on the Future of Primary Care, National Academy Press; 1996.

Clinical Pearl

Endoscopy Prevents Colon Cancer Deaths

Proctosigmoidoscopy, colonoscopy, and polypectomy are associated with lower mortality from colorectal cancer (odds ratio, 0.41; 95% CI, 0.33-0.50), with the protective effect lasting about 5 years. (*Arch Intern Med.* 1995;155:1741-1748.)