Regarding the Oliver Wyman report:

As I understand it, the primary charge from Act 167 was to develop recommendations for a more sustainable hospital system. In preparing their report, I asked Dr. Harmony and his colleagues to include and emphasize the need for immediate steps to be taken towards increasing the number of primary care physicians in Vermont. Unfortunately, this did not occur.

While hospital transformation was the focus of the engagement process, three of the five listed objectives include: "improve population health outcomes, increase access to essential services, and reduce health inequities". Applied to the community at large, all of these would require a significant increase in primary care physician availability.

Dr. Hamory seems comfortable dismissing concerns about the primary care workforce with a passing mention of the HRSA assessment of Vermont's current and future needs. In response I spent some time wandering around the HRSA website. As expected, it's definition of the primary care workforce includes mid-levels as well as physicians. I have nothing against NPs or PAs, but they cannot make up for the deficit in primary care physicians. HRSA also has some data and predictions on supply and demand for various professions for the country as a whole. Currently, the supply of family physicians and primary care internal medicine docs does not come close to meeting the demand. By 2030, it is predicted that this gap will increase. They also acknowledge that family physicians and internists will likely be taking on an increasing role in managing patients' mental health needs, as we have been doing these past many years. This will of course require more time per patient.

The Association of American Medical Colleges projects a nationwide shortage of up to 48,000 primary care physicians by 2032.

Closer to home, the Vermont Department Of Health *2022 Physician Census Statistical Report* (the most recent available) has the following information: between 2012 and 2022 the number of primary care physicians in Vermont (FM, IM, Peds) decreased from 521 to 505. This downward trend is consistent with a 2018-2019 workforce study presented to the Green Mountain Care Board, and which I sent to Dr. Hamory. A most significant finding was the dramatic drop in the number of primary care physicians during that time, contrasting with the stability or significant increases in the numbers in other healthcare professions. It is difficult to reconcile this data with his assertion that we will be fine well into the future.

Aside from being an essential component of an optimally functioning healthcare system, a robust primary care physician workforce can alleviate some of the burden on hospitals by reducing emergency room visits and hospital admissions (and readmissions), particularly for patients with numerous chronic conditions. This would help ameliorate the staffing shortage with which most hospitals are grappling, since fewer staff would be needed. There would be a reduction in the backlog in scheduling for hospital employed specialists, since much of what is currently referred out could be managed in a primary care setting.

The medical literature is replete with studies going back decades demonstrating how patients with a regular primary care physician are healthier overall, have reduced mortality, improved end-of-life care, and all at a lower cost in overall medical expenses.

While these academic studies are compelling, with increasing frequency there are reports in the popular press of the real world impact of this shortage on patients. Some recent examples: a news item from one of the local Boston TV networks with the announcement that the

Massachusetts General/Brigham Hospital conglomerate, the owner of the largest network of primary care offices in the area, is no longer accepting new patients to these practices because they do not have an adequate number of primary care physicians; a newspaper article from Michigan relates how it is instituting loan repayment to persuade more physicians to practice primary care in that state to deal with their shortage; an ABC News description of New England physician shortages, includes a specific note of a difficult experience in Vermont; a FOX news item reports on the declining number of graduating medical residents pursuing primary care careers; and NPR describes of how family physicians, in particular, can help alleviate shortages in obstetric and pediatric care in underserved areas.

The charge from act 167 was to investigate means by which Vermont could improve “health system sustainability" as well as “hospitals' financial health”. The inclination to focus on hospital improvement is understandable, because so many are in trouble, and, paradoxically, because that is still where much of the money goes. However, important as they are, hospitals are not the entirety of a medical system. Attempting to address “health system sustainability“ without at least an acknowledgment of the importance of, and need for, more primary care physicians is an egregious omission. Fostering the growth and health of this component of the workforce is at the crux of any attempt at health system reform with the objectives of improving quality and lowering cost.

I think I can speak for family physicians, and probably most others in primary care, in affirming that our desire is just to take the best possible care of our patients, both individually and as part of their community, and to assist them in taking care of themselves, We aim to do this in a manner that is comprehensive, respectful of the economic resources of society, and of the highest quality permitted by the current state of medical science. This has become impossible at present. Some have even questioned whether it is medically ethical to practice medicine in the United States, given the numerous constraints on our ability to do so. It is a nationwide problem; Vermont has to start taking it seriously.

Rob Penney MD
Family Physician
Middlesex VT