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Obstetrics-Gynecology As Primary Care: A Market Dilemma
by Lucy Johns

The managed care market in California, for a decade a maelstrom of creative adaptations to the pressures of competition, shows a new pattern of interest for designers of health reform proposals: small-area variation among plans in their selection of primary care physicians. In major health maintenance organizations (HMOs) in the northern California urban markets of Sacramento and the San Francisco Bay Area, obstetrician-gynecologists (OB-GYNs) have virtually disappeared as primary care physicians available to patients. Of course, experimentation with the provision of primary care has an honorable history, including use of nonphysician practitioners and advocacy of self-care. This variation, however, is inconsistent with state policy, unsettling in light of recent studies related to quality of care, and contrary to historical preferences of those most in need of OB-GYN services (females ages fifteen to forty-four). It raises a number of issues important to providers and consumers as major participants in health reform.

Importance of the primary care physician. The designation of primary care physicians assumes unprecedented importance in a competitive, managed care market. Traditionally the first source of care, the primary care physician now also plays “gatekeeper,” controlling access to any other needed health services. A monthly capitation fee that includes the potential cost of specialty and other services reinforces parsimonious use of such other services. Thus is primary care infused with a new sensitivity to cost containment. As HMOs and gatekeeper-centered hybrids come to dominate a local market, selection as a primary care physician becomes a prize. It guarantees a patient base, a flow of revenue, and-sweetest to some-the ability to deprive hospitals and specialists of both. The power to bestow this prize now resides with the managing physicians in physician groups competing for HMO contracts and, in theory, with the managers of HMOs. These individuals now decree, far from public scrutiny, the characteristics of the caregiver closest to the patient.

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Variations in the primary care concept. The first issue implied by the absence of OB-GYNs as primary care physicians concerns the integrity of the concept of primary care. A subject of study, professional concern, and law for several decades, the ideal of primary care has not produced a universally accepted definition. However, the widely used definition from the Institute of Medicine (IOM) invokes the nature of the service, rather than the specialty of the provider:

Primary care in medicine is distinguished from other levels of care by the scope, character, and integration of the services provided. The services, not the specialty of the provider, form the basis of this definition of primary care.¹

In the IOM definition, primary care physicians represent an emphasis, not a particular discipline:

Because services define primary care, good practitioners can be trained in a variety of disciplines. Many more primary care practitioners graduate from family medicine programs than from surgery programs, but it is possible for a graduate of either to practice exemplary primary care.²

In California, theory is more precise, and law adds additional weight. The 1980 State Health Plan defines primary care as

that level of personal health services which meets the routine and basic health needs of most of the people most of the time. . . . [It] is defined to include well care . . ., diagnosis and treatment of common acute and chronic illness . . ., psychological support . . . [and] referral, coordination and followup.³

The plan counts OB-GYNs and family practitioners as physicians available to provide primary care services.⁴ The California Business and Professions Code provides the state’s legal definition of “primary care” services: “those services involving the specialties of general practice, family practice, general internal medicine, obstetrics, gynecology, and general pediatrics.”⁵ OB-GYNs are included in California’s latest attempt to increase the number of primary care physicians in the state through its educational pipeline at the University of California.⁶

Variations in quality of care among specialties. More disturbing than deviations from theory are data indicative of a second issue: a difference in the quality of care provided by OB-GYNs, internists, and family practitioners. Although “outcome” indicators of differences are not available, recent studies address some “process” markers that figure prominently in quality guidelines emerging from payer groups. The National Committee for Quality Assurance, for example, scrutinizes several process indicators related to
obstetrics-gynecology: regular mammography screening for women age forty and older, Pap tests for women age eighteen and older, low birth-weight, and first-trimester prenatal care.7

A study of the first two indicators in a Twin Cities HMO showed that OB-GYNs were more likely to perform preventive gynecological services (regardless of their or their patients’ age) than were family practitioners and internists combined.8 Rates for female family practitioners and internists were higher than those for their male colleagues but still below the rates for OB-GYNs of either sex. The value of routine Pap tests and mammograms has not been controversial: They can be lifesaving. Differences in their provision for no reason other than physician specialty signals a problem.9

Differences in physician training. If training influences the inclination to provide preventive OB-GYN care, a third issue is suggested by the primary care physician pattern in northern California. Are internists and family practitioners effectively trained in the type of primary care tradition ally provided by OB-GYNs? Residents in internal medicine incur a requirement under “Experience in Other Specialties” that “office gynecology . . . should also be available,” duration and content not further specified.10 Residents in family practice medicine must complete a three-month rotation that includes one month of gynecology and two months of obstetrics, in addition to, under “Elements of Family Care,” some training in “human sexuality” and “family planning.”11 By contrast, OB-GYN residents, for whom experience in “care of ambulatory patients is essential,” spend three (and sometimes four) years learning to prevent and when necessary to care for the unique problems of women.12 Such wide variations in educational preparation may well explain the observed differences among the three specialties in interest, familiarity, and comfort level with gynecological needs.

Historical use of OB-GYNs. The final issue derives from historical use of services by reproductive-age women unconstrained by managed care protocols. National longitudinal survey data from 1973-1990 indicate that these consumers use OB-GYNs extensively for primary care.13 Statistics for 1989-1990 include the following: (1) 29 percent of all physician visits by women ages fifteen to forty-four are to OB-GYNs (family practitioners account for 30 percent of visits by women in this age group, internists for 9 percent); (2) 95 percent of all visits to OB-GYNs are self-referred; (3) 60 percent of visits to OB-GYNs are classified as “diagnostic, screening, and preventive,” compared with 12 percent for all other specialties; and (4) pregnancy, the most frequent diagnosis reported by OB-GYNs, accounts for fewer than one-third of all visits (31 percent).

In southern California these very preferences tend to be viewed as a mandate. For example, the Mullikin Group, the largest physician organiza-
tion in the region, deems OB-GYNs to be primary care physicians because their services are "cost-effective" (that is, preventive care predominates) and because "quality of care is customer-driven" (that is, women want direct access to OB-GYNs). Pacific Physician Services, the only publicly traded physician organization in the state, lists OB-GYNs as primary care physicians for its HMO contractors.

To summarize, the omission of OB-GYNs from the primary care physician lists of some California HMOs raises significant conceptual, clinical, and consumer issues. Comprehensive health care reform should encompass appropriate remedies.

**Solutions**

Barriers to direct access to OB-GYNs could be challenged by three sources: the government, the market, and the concerned health professions.

**From government.** A governmental challenge would be the most direct, but such a strategy has not been included in existing proposals for health system reform at either the federal or the state level. President Clinton’s Health Security Act, however, recognizes the existence of the obstetrics-gynecology/primary care problem. In a section addressing reform of medical education, the act defines “primary health care” to include the following medical specialties: family medicine, general internal medicine, general pediatrics, and obstetrics/gynecology. Such a definition could provide a policy argument for those seeking voluntary revision of primary care physician selection criteria used by medical groups and health plans. However, as the California case demonstrates, definition in a statute is not a mandate for the practical design of health plans. Certification requirements for accountable health plans (or their state-defined equivalents) would provide the strongest basis for including OB-GYNs as primary care physicians.

**From market pressures.** Proponents of managed competition as the guiding principle of health reform maintain that “the market” will develop any needed remedies. Two current plan variations can be cited to support this position. The first, found in the Washington, D.C., area, is for plans to permit women to choose two primary care physicians, an OB-GYN and an internist or a family practitioner. This tactic institutionalizes the choices reflected in the federal survey data but also encourages access to more generalized primary care. The second, from northern California, shows the effect of *ex post facto* pressure exerted by an irresistibly large purchaser. Relaying complaints from female beneficiaries suddenly barred from their OB-GYNs, California’s largest health benefits administrator, the Public Employees Retirement System (CalPERS), prompted some HMOs in northern California to establish the “well-woman visit,” a yearly gyneco-
logical visit to an OB-GYN that does not require a primary care physician referral. In effect, the plans bypassed their contract physician groups by creating a new benefit that the groups must buy out of their contract revenue. These variations imply that there is some promise in a laissez-faire approach to elimination of access barriers where sufficient pressure can be brought to bear.

Whether market pressures can entirely breach the barriers is uncertain, however. The rationales underlying the current pattern in northern California hint at some complexities. Foremost is a conviction among some physician group managers that care provided by OB-GYNs is expensive compared with that available from family practitioners or internists. This belief encompasses both the cost to the plan of fees or salaries and patterns of practice supposedly typical of OB-GYNs. Second is the distraction created by the clamor of physicians in physical medicine, rehabilitation, and emergency medicine who also are seeking a primary care role. Specialty certification is an easier guideline to follow in choosing primary care physicians than is the actual content of care provided by individual clinicians. A final factor is division among OB-GYNs themselves on the desirability of primary care physician status. Although their training aims to prepare them as “providers of primary care to women,” the market has rewarded the referral surgeons and subspecialty consultants (in infertility, for example). Physician managers now designating primary care physicians bring this stereotype to the current task and use it to dismiss those OB-GYNs who choose to seek primary care physician status. Such interand intraspecialty jostling is not easily diminished by payers pressing for change and could stall consumers indefinitely.

**From the health professions.** A final possibility is a professional response that builds on the functional focus of the IOM’s concept of primary care. Competency in primary care for women could be defined, taught, and tested to certify practitioners of any specialty to play the primary care physician role. This approach could in theory ensure high-quality care, help to recycle subspecialists no longer needed, relieve shortages of general internists and family practitioners (and combat monopolistic pricing), and ensure continuing professional attention to consumer concerns—a hallmark of primary care. This approach is long term in nature, itself facing numerous obstacles properly the subject of further studies.

The trend in northern California to reduce access to OB-GYNs for primary care shows the need for attention to delivery system design in the debate about health care reform. Concern for women’s health is at an all-time high. Placement of barriers between women of reproductive age and the specialty concerned exclusively with their health status should alert federal and state policymakers to yet another controversy embedded in
comprehensive reform. Acceptable quality and appropriate access for women may be too sensitive an aspect of managed care to be left entirely to the mercy of the market.

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NOTES

1. Institute of Medicine, Primary Care Medicine: A Definition (Washington: National Academy of Sciences, 1977).
2. Ibid.
4. Ibid., Table VII-6.
5. California Business and professions code, Section 2201(d), Chap. 1313, Statutes 1980; Chap. 886, Statutes 1989.
6. Office of the President, Changing Directions in Medical Education: A Systemwide Plan (Oakland, Calif.: University of California, 1993).
11. Ibid., 33-35. “Arrangements” for additional electives in obstetrics-gynecology must be available, expressly including high-risk obstetrics and surgery.
12. Ibid., 70-73.
14. A physician organization is a corporation that provides all support services needed by physicians to practice managed care. The physicians themselves are employed by or on contract to a physician-owned corporation that contracts with the physician organization and with the HMO (or preferred provider organization). This complex structure is entailed by California law prohibiting the “corporate practice of medicine.” California Business and Professions Code, Section 2400, Chap. 1313, Statutes 1980. Mullikin Group, personal communication, July 1993.
16. For example, see the Washington Health Services Act of 1993 (E2SSB 5304 and ESB
A.B. 2493, introduced 11 January 1994 in the California Assembly (J. Speier), proposed that OB-GYNs be “deemed” primary care physicians by regulated health plans and insurers.


19. No documentation in a managed care setting can be cited for this belief. Concerning the cost of OB-GYNs compared with other specialists, there is little excuse for failing to test the possibility that in a competition for primary care physician status, the price demanded by OB-GYNs for their labor will decline.

20. We do not even address the possibility of physician substitutes. The American Nurses Association maintains that half a million of the two million registered nurses in the United States could be trained to provide “the same” primary care that physicians do within “12-18 months.” Inside Health Care Reform 1 (1993): 3.


22. The price for family practitioners is now soaring in response to a perceived “shortage.” See B. Boughton, “Primary Care’s New Power,” Northern California Medicine 4 (1993): 1, 7. Note also the following declaration of the president of the California Academy of Family Practice: “[F]or the primary care physicians [that is, family practitioners] who are out in rural areas . . . doing the surgeries and the caesarian sections . . . cholecystectomies and bowel resections and mastectomies . . . I think they [the Health Care Financing Administration and other payers] are going to have to look at that.” “Interview with Mary E. Frank,” Northern California Medicine 3 (1992): 9.