We Need a “Marshall Plan” to Save Primary Care, Public Health Infrastructure

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Following the devastation of World War II, the United States enacted the Marshall Plan, providing more than $15 billion to help finance rebuilding efforts on the European continent. It was crafted as a four-year plan to rebuild cities, industries and infrastructure heavily damaged during the war, to remove trade barriers between European neighbors and to foster commerce between those countries and the United States.

Our war against this novel coronavirus is far from over, but we must start planning now so this type of public health crisis and the economic devastation it has caused never happen again. We need a Marshall Plan for our primary care and public health infrastructure.

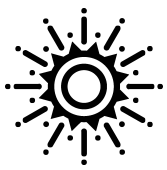
For years leaders in primary care and public health have been warning of the dire consequences of persistently underfunding our primary care and public health infrastructure. The coronavirus pandemic has vividly exposed gaping cracks in our siloed, fractured, and disconnected health care system. While it might be easy to point fingers and assign blame, this crisis is the result of system design failure.

Our medical supply chain has failed us. Our medical supply delivery distribution system has failed us. Our fee-for-service payment system has failed us, and our lack of health insurance coverage and complex benefit design have failed us. The consolidation that has occurred in various segments of our health care market has only compounded the felony and exacerbated these system failures.

Our independent, community-based primary care physicians constitute the foundation of our health care system, a foundation that has been neglected and deteriorating for years. We now depend on them to serve on the front lines of the battle against COVID-19, poorly outfitted with severely depleted supplies of personal protective equipment and facing the harsh economic reality of a steep drop-off in patient visits.

These practices are no different from other small businesses, and they are not immune to the sudden economic downturn caused by the COVID-19 outbreak. Many practices report visits are down 50 to 75% as patients stay at home, paralyzing revenue streams and hampering practices’ ability to make payroll, pay bills, and keep the lights on. These are business that operate on a tight margin and often only have two to four weeks of cash reserves on hand. Practices across Texas are already laying off staff.

Unlike other small employers, though, these independent practices can’t simply close up shop. People will continue to get sick. Patients with chronic disease still need ongoing care, and many more will seek mental health counseling as a result of isolation, job loss, and financial insecurities than ever before. We cannot afford to lose our primary care workforce.



Our Marshall Plan strategy includes investments across multiple sectors of the health care system to modernize care delivery so that it is focused on regional, organized systems of care committed to population health management that balances access and relational continuity.

We must immediately change the way primary care is paid for, from transactional fee-for-service to prospective payment that rewards care management, relational care, and continuity. We should make regulatory and payment changes to accelerate the adoption and use of telemedicine. We need to embrace new epidemiological strategies like digital pandemic tracking to detect global health threats sooner, and we must procure and stockpile necessary items like personal protective equipment to address public health crises and develop appropriate plans for proper distribution in times of need.

Finally, we need to expand and tailor our primary care workforce by producing more primary care and public health workers, and by implementing strategies to encourage their appropriate geographic distribution. We could forgive medical school tuition for graduates who choose primary care specialties and provide further loan forgiveness for those who practice in underserved communities. We can also increase graduate medical education funding for primary care residency positions to incentivize academic institutions to invest more in those programs.

The Marshall Plan was initiated three years after the end of World War II. With the current crisis threatening our frontline primary care physicians, we don't have the luxury of waiting that long. We need our state leaders working on this now, even as we continue the fight to contain this pandemic.

We have an unprecedented opportunity to redesign our health care system so that it truly serves Americans and the professionals who care for them. We must save our frontline primary care and public health professionals and in so doing, set the foundation for a better way of delivering and paying for care.

If we ignore the workforce crisis unfolding before us, the long-term consequences to our health care system will be dire.