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The Crisis in the Primary Care Physician Workforce

Testimony to the Senate Committee on Health, Education, Labor and Pensions

February 12, 2008

Senator Kennedy, Senator Enzi, and members of the Senate Committee on Health, Education, Labor, and Pensions, thank you for inviting my testimony today on this hearing on the health care workforce. My name is Dr. Kevin Grumbach. I am a family physician and Professor and Chair of the Department of Family and Community Medicine at the University of California, San Francisco. I also am Director of the Center for California Health Workforce Studies and Co-Director of the Center for Excellence in Primary Care at UCSF. My testimony today will focus on the crisis in the nation's primary care physician workforce.

There are three main points I would like to emphasize:

1. **Primary care is the essential foundation of a well-performing health system**

2. **The primary care infrastructure in the United States is crumbling, and patient access to primary care is suffering throughout the nation.**

3. **The federal government can address the crisis in primary care through:**

    a. **Targeted health professions primary care training programs such as Title VII programs,**
    b. **Reform of Medicare Graduate Medical Education funding,**
    c. **The National Health Services Corps, and**
    d. **Medicare physician payment reform.**

Let me review the evidence in support of each of these points.

1. Primary care is the essential foundation of a well-performing health system

A primary care home serves as the patient's door into the health care system and the patient's guide through the system. Patients and families can choose a family physician, general internist, or pediatrician to be their primary care physician. Working closely with these physicians, nurse practitioners and physician assistants also deliver primary care. When people say, "I'm going to see my personal physician," they are usually talking about their primary care physician. Primary care has the job of preventing illness; treating acute problems; caring for the millions of people with chronic conditions such as high blood pressure, arthritis, and diabetes; providing compassionate care at the end of life; and coordinating specialty and other referral services.

Research evidence makes it clear that health systems built on a solid foundation of primary care deliver more effective, efficient, and equitable care than systems that fail to invest adequately in primary care:

- Costs

  Patients with a regular primary care physician have lower overall costs than those without. Compared with specialty medicine, primary care provides comparable quality of care at lower cost for a variety of conditions such as diabetes, hypertension, and low back pain. In comparisons of regions and states in the US, increased primary care physician to population ratios are associated with reduced hospitalization rates and lower overall health care costs.

- Quality

  States with more primary care physicians per capita—but not specialists—have better population health indicators such as total mortality, heart disease and cancer mortality, and neonatal mortality. Medicare patients in these states also receive better quality of care, including more appropriate care

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for heart attacks, diabetes, and pneumonia. Patients with a primary care home are more likely to receive appropriate preventive services such as cancer screening and flu shots.

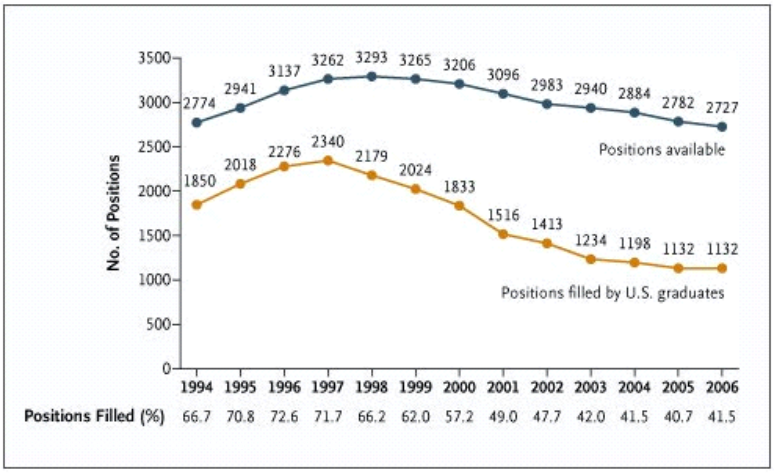
- Equity

  Racial disparities are reduced when patients receive care from a well-functioning medical home.

2. The primary care infrastructure in the United States is crumbling, and patient access to primary care is suffering throughout the nation.

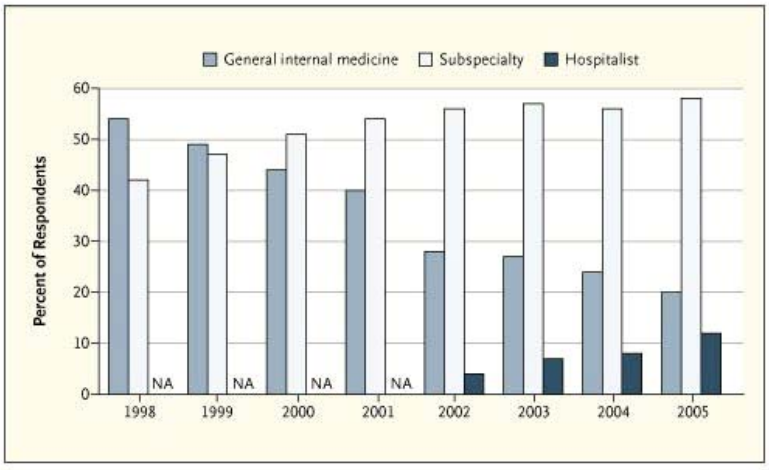
From 1997 to 2005, the number of US medical school graduates entering careers in family medicine residencies dropped by 50%.

Family Medicine Residency Positions and Number Filled by U.S. Medical School Graduates

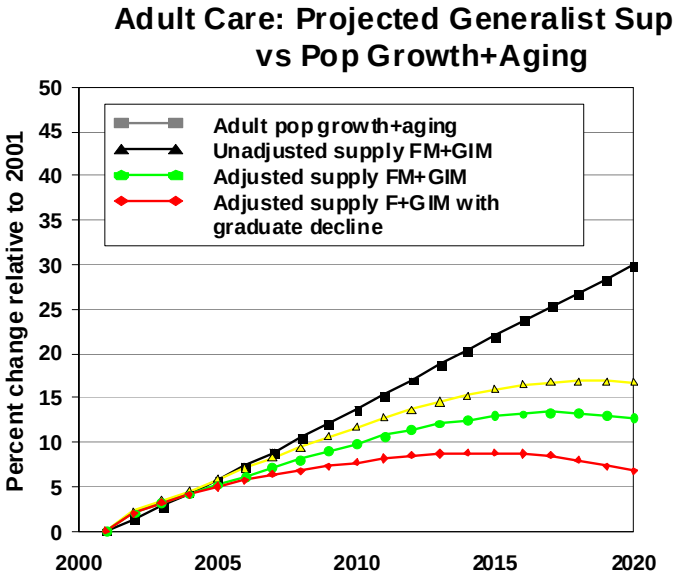


A similarly large decrease has occurred in the number of internal medicine residents planning careers in primary care rather than specialty medicine.

Proportions of Third-Year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists



An analysis performed by Dr. Jack Colwill and colleagues at the University of Missouri indicates that the growth in the supply of primary care physicians for adult patients is now lagging behind the rate of growth in the adult population, with the gap projected to widen dramatically over the next decade.



SOURCE: J Colwill, unpublished data, 2007
NOTES: "aging of pop" based on visits per age group; "Adjusted supply" - adjusted for age and gender. Graduate decline"- extends the 2001-2004 rate of decline of graduates through 2007.

The human resource crisis in primary care is apparent in the difficulties faced by health organizations in recruiting primary care physicians. In a 2006 survey of 92 large or medium-sized physician groups, 94% of the respondents ranked internists or family physicians as the most difficult to recruit. Federally funded community health centers reported more than 750 vacant positions for primary care physicians in 2004.

These workforce trends are having a deleterious effect on patients. Lack of access to primary care physicians is becoming an alarming problem in communities throughout the nation, not just in traditionally underserved rural an inner city communities. In 2007, 29% of Medicare beneficiaries reported a problem finding a primary care physician, up from 24% in 2006. Soon after Massachusetts began implementing its universal coverage plan, it confronted the glaring deficiency of having an insufficient supply of primary care physicians to provide medical homes to the patients newly insured by the state health plan.

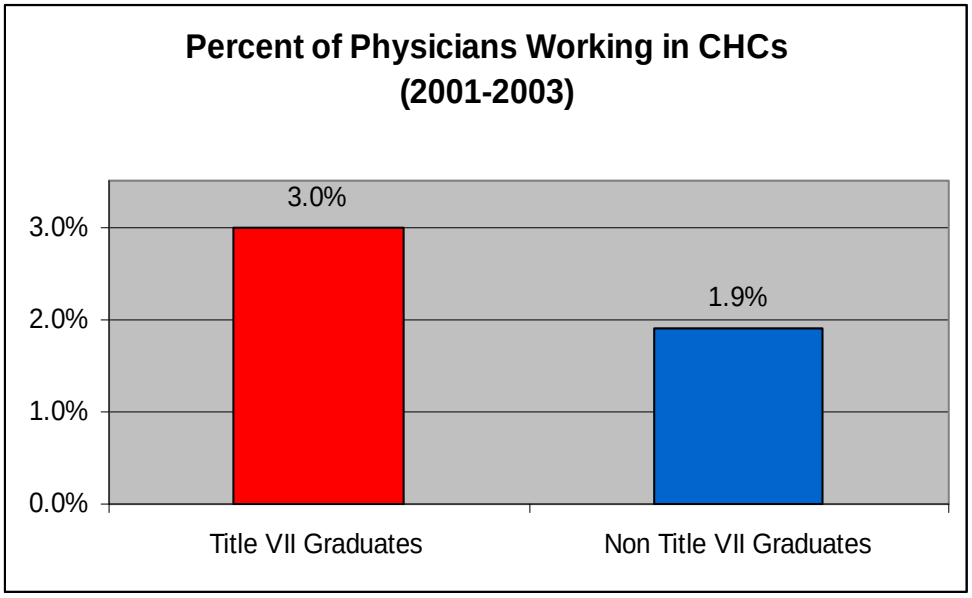
3. Federal policies to address the primary care workforce crisis: An evidence-based approach to effective policy

Research evidence supports the critical influence of federal policies on the state of the nation's primary care workforce, and points to effective interventions to address the current crisis.

a. Targeted health professions primary care training programs: Title VII programs

Title VII Section 747 Primary Care Training Grants are intended to strengthen the primary care educational infrastructure at medical schools and residency programs and to encourage physicians-in-training to pursue careers working with underserved populations. Research shows an association between Title VII grants to medical schools and increased production of primary care physicians and a greater likelihood that graduates will practice in underserved areas. In addition, a study of Title VII grants to family medicine residency programs in 9 states found that graduates of Title VII residencies were more likely to practice in rural and low-income areas than their counterparts trained at residencies that did not receive Title VII grants.

Recent research conducted by our own team at UCSF, led by Dr. Diane Rittenhouse, has documented the importance of Title VII grants for strengthening the educational pipeline producing primary care physicians who work at federally qualified community health centers and join the National Health Service Corps. Physicians who graduated from Title VII funded US medical schools were 50% more likely to be practicing at a CHC in 2001-2003 than physicians who graduated from medical schools that did not receive Title VII funding. As the figure below indicates, 3.0% of graduates of Title VII funded medical schools were working at CHCs in 2001-2003, compared with 1.9% of graduates of schools not funded by Title VII. Similar results were found for Title VII funded residency programs. 6.8% of family physicians who trained at Title VII funded residencies worked at CHCs in 2001-2003, compared to 5.0% of family physicians who trained at residencies not funded by Title VII.



These same patterns were found for the association between Title VII funding and physician participation in the National Health Services Corps. For example, family physicians who attended Title VII residency programs were 50% more likely to participate in the NHSC Loan Repayment Program than family physicians who trained at residencies not funded by Title VII.

This recent research provides evidence that the Title VII Section 747 grant program supports the training of primary care physicians who are more likely to staff CHCs and participate in the NCHS. These findings have important implications for federal policy decisions, including the recent major reduction in Title VII Section 747 funding. Reductions in Title VII destabilize institutions that disproportionately serve as the pipeline for producing primary care physicians who participate in the NHSC and/or work at CHCs, undermining the federal effort to improve access for the underserved through CHC expansion. Ongoing federal investment in the medical education pipeline to prepare and motivate physicians to participate in the NHSC and to work in CHCs should be considered an integral component of efforts to improve access to care for the underserved.

b. Reforming Medicare Graduate Medical Education funding

Medicare GME funding policies tie funds to hospital-based settings emphasizing specialty training and hospital service priorities, rather than the public's workforce needs. Medicare GME funding needs to become more aligned with primary care workforce needs and less rigidly tied to hospital-based training sites. The minutes of the September, 2008 meeting of the Council of Graduate Medical Education summarize draft recommendations on GME funding that are consistent with the priorities identified by many medical educators as fundamental to more rational GME funding that corrects current disincentives for primary care training. These include:

- Broadening the definition of "training venue" beyond traditional training sites,
- Removing regulatory barriers limiting flexible GME training programs and training venues, and

- Making accountability for the public's health the driving force for graduate medical education, including by:
    - developing mechanisms by which local, regional or national groups can determine workforce needs, assign accountability, allocate funding, and develop innovative models of training which meet the needs of the community and of trainees
    - linking continued funding to meeting pre-determined performance goals.

Deliberations about altering the current funding formulae for Medicare GME allocations to reduce overall Medicare GME funding must carefully consider the potential impact on vulnerable primary care residency training programs. Funding formulae should not be revised without considering the types of principles under discussion by the Council of Graduate Medical Education to create a more accountable and rational approach to GME funding.

c. National Health Services Corps

National Health Service Corps physicians comprise a substantial proportion of physicians staffing CHCs. Research indicates that after completing their NHSC obligation, a large proportion of NHSC participants remain in service to the underserved. In addition, temporary placement of NHSC physicians in rural underserved areas positively impacts the long-term non-NHSC physician supply in those areas. Unfortunately, the demand for NHSC physicians far exceeds the supply. In 2006 there were over 4,200 vacant positions in underserved areas for NHSC physicians, yet only 1,200 NHSC physicians available to fill these slots.

The NHSC is an effective strategy to provide incentives to physicians in training to enter primary care and provide service where it is most needed.

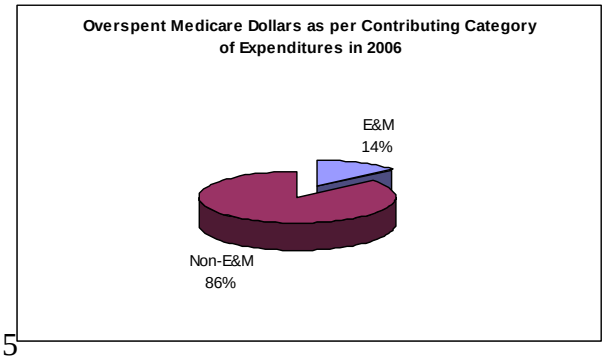
d. Medicare physician payment reform

One of the major disincentives for physicians in training to pursue careers in primary care is the widening gap in earnings between primary care physicians and physicians in subspecialty fields. The income of primary care physicians, adjusted for inflation, decreased by 10.2 percent from 1995 to 2003. Median specialist income in 2004 was 180 percent of primary care income. Unadjusted for inflation, specialist income grew almost 4 percent per year from 1995 to 2004, while primary care income grew 2 percent per year. A specialist spending thirty minutes performing a surgical procedure, a diagnostic test, or an imaging study is often paid three times as much as a primary care physician conducting a thirty-minute visit with a patient who has diabetes, heart failure, headache, or depression.

Although Medicare is only one payor among many in the US health system, Medicare has a dominant influence on physician payment policies for all payors. Most private health plans base their payment policies on Medicare's relative value unit system. Thus, Medicare physician payment policy is physician workforce policy. Changes to Medicare physician payment policies that reverse the financial disincentives for primary care practice can play a powerful role in addressing the crisis in the primary care workforce.

i. Splitting the Sustainable Growth Rate (SGR)

From 1997 to 2006, Medicare expenditures for specialty-oriented physician services (e.g., surgery, imaging studies) increased 36% faster than expenditures for primary care-oriented evaluation and management (E&M) services. In 2006, non-E&M services accounted for 86% in the overage in Medicare physician expenditures above the overall SGR target.



Although there are valid reasons for Medicare to use some type of SGR approach to control overall physician expenditures, the specific manner in which the SGR has been implemented has had a disproportionately adverse impact on Medicare payments to primary care physicians. Because there is one conversion factor for all services, primary care physicians are essentially penalized when large increases in expenditures for specialized services drive down the conversion factor that is applied to E&M and non-E&M services alike.

A simple policy that could mitigate much of this unintended effect of the SGR that disproportionately penalizes primary care physicians would be to use a split SGR system for E&M and non-E&M services, such that the conversion factor for each category of service would rise or fall based on expenditure trends within that category of service.

We have modeled the implications of a split SGR. In our modeling scenario, we allowed total Medicare physician expenditures to increase from 1997 to the actual observed 2006 level of $93.7 billion. However, instead of allowing total expenditures to increase more rapidly in the non-E&M service category than in the E&M category, as historically occurred, we kept the 1997-2006 rate of expenditure increase (90%) equivalent within each of the E&M and non-E&M SGR pools. Under this scenario, E&M spending in 2006 would have been $37.5 billion rather than $34.4 billion, and fees for E&M services would have been 9 percent greater in 2006 than they actually were. Non-E&M spending in 2006 would have been $56.2 billion rather than the actual $59.3 billion. The conversion factors in 2006 under the high growth scenario would have been 41.3 for E&M services and 35.9 for non-E&M services. These compare with the actual 2006 conversion factor of 37.9 for both E&M and non-E&M services. This modeling exercise indicates how implementation of a split SGR could allow Medicare to provide more incentives for primary care services without increasing overall Medicare expenditures.

ii. Adding a medical home care coordination payment, in addition to fee-for-service payments

Providing comprehensive care to patients with chronic illnesses and complex medical problems requires that physicians spend considerable time coordinating services, communicating with patients and caregivers by phone and email, and devoting effort to similar types of activities not reimbursed under the traditional “piecemeal” payment approach of fee-for-service. The Patient Centered Primary Care Collaborative, a coalition of large employers and primary care physician associations, has called for payors to add a monthly care coordination payment “for the physician work that falls outside of a face-to-face visit and for the heath information technologies needed to achieve better outcomes. Bundling of services into a monthly fee removes volume-based incentives and promotes efficiency. The prospective nature of the payment recognizes the up-front costs to maintain the required level of care. Care coordination payments should be risk-adjusted to ensure that there are no inherent incentives to avoid the treatment of the more complex, costly patients.”

An example of the cost-effectiveness of such a care coordination payment is illustrated by the experiences of North Carolina's Medicaid management program, known as Community Care of North Carolina. To qualify for a monthly coordination payment of $5.50 per Medicaid patient per month, primary care practices must agree to use evidence based guidelines for at least 3 conditions, track tests and referrals, and measure and report on clinical and service performance. The program spent $8.1 million between July 2002 and July 2003, but saved more than $60 million over historic expenditures. In the second year of the program $10.2 million were spent but $124 million was saved. In 2005 the savings grew to $231million.

iii. Subsidies for capital investment to modernize the medical home through EMR installation and related IT, training and hiring of primary care office staff for innovative chronic and preventive care programs, and other infrastructure needs

Specialist physicians who spend a large amount of their work time in hospitals benefit from the capital investments and staffing paid for by hospitals. Hospitals pay for installation of hospital-based electronic medical records, operating room equipment, and the nurses and other personnel to staff operating rooms and intensive care units. Primary care physicians are largely on their own when it comes to finding resources for capital improvement and staffing support. The work of primary care occurs mainly in the physician’s office. Investments in purchasing an EMR or hiring a health educator to assist patients to

learn how to manage their chronic illnesses come out of the physician's own practice earnings. In an environment where real net income for primary care physicians is falling, there is little margin in practice revenues to pay for such practice improvements.

Conclusion

Primary care is essential, and it is in crisis. Decisive action is required by the federal government to avert the collapse of primary care and its catastrophic consequences for the public. Many leaders in the private sector, such as large employers, are already taking action on issues such as physician payment reform to support new models of primary care.

Research provides evidence of strategies that are of proven effectiveness in strengthening the primary care workforce and providing incentives for primary care practice. Some of these strategies, such as implementing a split SGR for Medicare physician payment or reforming Medicare GME payments, do not require new funds but rather a reconsideration of how existing funds are allocated. Other strategies, such as a reasonable level of funding for the Section 747 Title VII Primary Care Training Grants Program, require small investments. For example, restoring Title VII Section 747 funding to its 2003 level of $92.4 million would represent an annual investment equivalent to 0.02% of the annual Medicare budget. Such investments in the future of the nation's primary care physician workforce are a cost-effective investment in the nation's health care infrastructure and in the health of the public.

Thank you.