TESTIMONY BEFORE

The House Committee On Education And Labor

Fitzhugh Mullan, M.D.

Murdock Head Professor of Medicine and Health Policy
Professor of Pediatrics
The George Washington University

2121 K Street, N.W. Suite 210
Washington, D.C. 20037

Tel: (202) 994-4312
Fax: (202) 478-2772
fmullan@gwu.edu

On

The Tri-Committee Draft Proposal for Health Care Reform

June 23, 2009

TESTIMONY FITZHUGH MULLAN, M.D.
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Background Perspectives on Health Workforce

- **Improving access to health care in the United States will require modifications in the structure of the US health workforce, the foremost of which will be the construction of a strong primary care delivery base.**

- **The distribution of physicians (and other health professionals) in the U.S. heavily favors urban areas. Metropolitan areas have 2-5 times as many physicians as non-metropolitan areas. Economically disadvantaged areas have significant physician access problems.**

- **Two-thirds of the U.S. physician workforce practice as specialists. The number of young physicians indicating an interest in primary care is declining. Approximately 100,000 nurse practitioners (NPs) and 70,000 physician assistants (PAs) are practicing in the United States today. This represents an important asset for service delivery.**

- **Today's physician-to-population ratio is in the zone of adequacy and should be maintained with appropriate growth in the number of physicians trained to parallel growth in the population. Increased requirements for patient care due to the aging of the population or the inclusion of more Americans as a result of health care reform legislation should be met by more strategic distribution of physicians, both geographically and across the primary care – specialty spectrum, and the expanded use of physician assistants and nurse practitioners. The role of PAs and NPs should be in both the generalist and specialist sectors of the care delivery system.**

- **Medical schools – The current expansion of medical schools is welcome but Title VII legislation needs to be reinvigorated and up-funded to augment primary care training in medical schools.**

- **Graduate Medical Education – The current number of Medicare funded slots is sufficient to maintain workforce numbers. However, reforms need to be made in current legislation to prioritize and incentivize community-based and ambulatory training. Support for Teaching Health Centers would significantly advance this goal. Beyond that, serious consideration needs to be given to aligning Medicare GME with the workforce needs of the country.**

- **Medical Practice – Primary care payment reform, support for new practice organizations such as primary care medical homes, and investment in health information technology are all important reforms that will help to promote a strong primary care practice base in the country.**

- **Data and leadership in the field of U.S. health workforce development is insufficient. A National Center for Health Workforce Studies and a National Health Workforce Commission would both be important assets at the federal level in managing health care workforce reform.**

Summary of Testimony

The Tri-Committee draft legislation takes a significant step towards establishing a health care workforce which will sustain a high-quality, cost-effective, fully accessible health care system. Moves to establish an Advisory Committee on Health Workforce Evaluation and Assessment, re-invest in the National Health

Service Corps and Title VII of the Public Health Service Act, redistribute unused Medicare GME positions to primary care programs and establish teaching health centers, and address payment and practice challenges to primary care through the medical home and accountable care organization pilot programs are all positive moves towards a sustainable health care workforce. However, to fully achieve workforce reform, the following are recommended:

- **Promoting the Advisory Committee on Health Workforce Evaluation and Assessment to a "National Commission on the Health Workforce", providing it with an authorization and clarifying its role in reporting to Congress, including addressing Medicare GME payments.**

- **Fully supporting the Teaching Health Centers program, converting it to at minimum a pilot program rather than a demonstration project and creating a Teaching Health Centers Development Grant within Title VII.**

- **Further increasing National Health Service Corps authorization for appropriations to maximize the program's full potential to provide health care in the most underserved areas.**

- **Increasing primary care bonus payments and SGR target growth rate to ensure effective maintenance and incentives for primary care.**

- **Invest in a primary care extension program to provide technical assistance and training programs for strengthening primary care practice.**

Introduction

Thank you Mr. Chairman for this opportunity to testify today. During the 40 years since I graduated from medical school, I have been a member of the health care workforce of the United States working as a pediatrician; I have directed workforce programs such as the National Health Service Corps while serving as a member of the United States Public Health Service Commissioned Corps; and I have been a student of and commentator on U.S. workforce policy in my current role as a Professor of Health Policy at The George Washington University.

Therefore, it is with experience as a practitioner, administrator, and scholar that I come before you this morning.

Background

The Health care workforce is a necessary component to any health care system and addressing the deficiencies in the current workforce is critical to ensuring any form of health care reform succeeds.

Primary care, in particular, is essential to a cost-effective, quality, fully accessible health care system. This is supported by:

- The Dartmouth group – examined differences in Medicare spending in different regions in the U.S. Found regional differences largely explained by more inpatient and specialist-oriented practice in higher spending regions.
- Barbara Starfield et al – showed primary care is associated with improved health outcomes
- Massachusetts example – MA health care reform increased coverage but failed to address workforce and therefore access, featured in the New York Times article, "In Massachusetts, Universal Coverage Strains Care"
- GAO report February 2008 – "Ample research concludes in recent years that the nation's over reliance on specialty care services at the expense of primary care leads to a health system that is less efficient…research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve better health outcomes and cost savings."

Primary care is declining (Figure 1) due to:

- Large payment disparities between primary care and specialties – Median annual salary of a primary care physician is $190,000 compared to a dermatologist ($345,000), a cardiologist ($380,000), a radiologist ($462,000) and an orthopedic surgeon ($450,000) (Figure 2).
- Practice conditions which make primary care less attractive to future physicians – 2/3 of primary care practitioners work in practices of 4 or fewer physicians and the institutional infrastructure to drive practice improvements doesn't exist.
- Declining support for primary care educational and pipeline programs, such as Title VII of the Public Health Service Act (Figure 3).

The Career Lifecycle of a Physician

Before considering questions of the sufficiency of the workforce or policy options to modify its direction, I would like to suggest a framework for considering physician careers. I call this the career lifecycle of a physician. It has three phases --- one of which is educational, one of which is transitional and the final one of which is vocational (Figure 4). The phases are medical school, graduate medical education, and practice. The first two might be considered "pipeline phases" since they determine the quantity and nature of physicians

prepared for practice. The final phase is the "payout" phase when the physicians are actually providing health care to the nation.

This framework allows us to consider capacity, cost and performance in three separate but interlinked longitudinal phases of the career path of physicians.

The Tri-Committee Draft Bill

The House Committees on Education and Labor, Energy and Commerce, and Ways and Means are to be commended on the Tri-Committee Draft Bill that we are discussing today. It proposes legislative action that would go a long way toward providing a floor of access to quality health care for all Americans -- a major unmet American agenda. The workforce components of this bill will do a great deal to rebalance the health professions training systems of the country to produce a healthcare workforce more aligned with the needs of the American people and the coverage envisioned in this bill. The particularly important issues that this bill addresses are: (1) the need for expanded incentives and support for primary care education and practice, (2) strong measures to build the health workforce in areas of chronic need and underservice, and (3) support for a broad spectrum of health workers, including physicians, nurses, physician assistants, and public health professionals. Finally, this bill envisions better deliberations on the future of the workforce through the Advisory Committee on Health Workforce Evaluation and Assessment and better information through the National Center for Health Workforce Analysis.

Tri-Committee Draft Legislation Recommendations

Advisory Committee

The draft legislation proposes an Advisory Committee on Health Workforce Evaluation and Assessment. Given that the health workforce of our country staffs 1/6 of our national economy, it is an area where we need to be smart, agile, and prescient. Virtually all health professional education programs receive public support, and as such, we have a particular responsibility to manage those human and financial resources with prudence and intelligence. At the present, there is no national deliberative body that looks ahead at national needs and informs the Congress or the Administration on a regular basis about broad directions and preferable investment strategies. Therefore, the National Advisory Committee proposed is a major step ahead.

However, the term "Advisory Committee" connotes a body whose influence is considerably less than that of a "National Commission". Moreover, the details of this Advisory Committee do not distinguish it substantially from a number of other advisory committees (listed in the legislation) whose reach is generally modest. The legislation provides no specific authorization level for its work. Consideration should be given to making the Advisory Committee on Health Workforce Evaluation and Assessment to a "National Commission on the Health Workforce", providing it with an authorization, and clarifying its role in reporting to Congress.

National Health Service Corps

The draft legislation increases National Health Service Corps scholarship and loan repayment funding levels to $300,000,000 annually, effectively maintaining the ARRA funding for NHSC and increasing the total NHSC from approximately 4,000 providers to 8,000 providers. However, the NHSC has the potential for further growth. Last year, over 4,500 health care providers applied for NHSC positions. Only 950 positions (20% of applicants) were awarded due to funding limitations.

Physician Assistants and Nurse Practitioners

The United States is a global pioneer in the creation of new categories of health professionals who contribute to the delivery of clinical services. Separate pilot programs in the 1960s introduced the world to the idea of the nurse practitioner (NP) and the physician assistant (PA). Since those early programs, both professions have grown enormously in size, stature and public acceptance. Approximately 125,000 nurse practitioners have been trained in the United States, the majority of whom are engaged in clinical practice. There are almost 70,000 certified physician assistants in the United States and more than 100 training programs.

Both of these professions are associated with primary care and practice in rural and underserved areas. About 25% of all nurse practitioners are located in non-metropolitan areas and an estimated 85% of them practice primary care. Physician assistants are active across the spectrum of medical specialties with more than one third of them working in primary care practices and approximately one fifth of them working in rural areas.

The Tri-Committee bill addresses the importance of these two professions, and this is particularly important in the context of the current workforce shortages in primary care. Specifically, I commend the bill's support to expand nursing education, practice and retention programs, nursing faculty loan repayment programs, and the training of advanced practice nurses who will deliver care in shortage areas. The bill also supports and gives preference to the development of physician assistantship training programs with demonstrated success in producing primary care providers and providers from underrepresented racial and ethnic groups and disadvantaged backgrounds. Additionally, the bill provides grants to programs that promote interdisciplinary and team-based models of care as well as coordination with academic health centers and across health professions settings for training and practice. Building out the nursing and PA workforce will, in the face of the primary care crisis, help support a robust primary care delivery system.

Diversity in the Workforce

Diversity in the physician workforce is critical to adequate, accessible, and culturally responsive care. Health professionals from racial and ethnic minority groups are more likely to enter primary care, practice in health profession shortage areas, and care for minority, poor, underinsured, and uninsured individuals than their white counterparts.[1] One national survey reported that while African American physicians comprise only 4% of the workforce, they serve more than 20% of African American patients in the U.S.[2] Another study found that African American physicians practice in high density African American communities, and Hispanic physicians practice in high density Hispanic communities.[3] Finally, diversity among physicians help with efforts to improve cross-cultural training and competencies throughout the profession by broadening physician perspectives regarding racial, ethnic and cultural differences.

The Tri-Committee bill recognizes the unique importance of training a diverse health professions workforce to meet the expanding and evolving needs of the current health system and the population it serves. It supports the development of primary care training programs that have a record of training individuals from underrepresented groups as well as disadvantaged backgrounds, strengthens existing programs that promote diversity in the health care workforce, and increases funding to support the training of individuals from disadvantaged backgrounds.

[1] Council on Graduate Medical Education, *Twelfth Report Minorities in Medicine*, 1998.
[2] S. Saha et al, "Do Patients Choose Physicians of Their Own Race?" *Heath Affairs* 19, no. 4 (2000): 76-84.
[3] M. Kamaromy et al. "The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations," *New England Journal of Medicine*334, no. 20 (1996): 1305-1310.

Teaching Health Centers

The proposed Demonstration Project for Approved Teaching Health Centers represents an important preliminary step towards aligning our graduate medical education system with our nation's primary care workforce needs. Through this Demonstration Project, teaching health centers including FQHCs and rural health clinics would be eligible for direct Medicare GME funding to train medical residents in community-based clinical settings. Not only will these programs better prepare the next generation of physicians to cost-effectively serve our nation's health care needs and expand access to primary care services, they have also been shown to improve recruitment and retention of physicians in underserved areas. [4,5]

Medicare Graduate Medical Education

The Committee also deserves great credit for resisting pressure to lift the Medicare cap on graduate medical education. By dedicating the reassignment of unused residency positions to primary care, the Committee has sent an important signal that smart growth in federally funded graduate medical education should focus on primary care specialties. Any expansion of Medicare-sponsored GME should, at a minimum, be tied to medical school expansion and focus future support on carefully documented national needs.

The $8.6 billion that Medicare currently pays to teaching hospitals in the United States for Graduate Medical Education represents by far the largest federal investment in medical education at any level. This system is of great value for hospitals since it provides stable funding for their residency workforce with minimal reporting requirements. Moreover, the program is an entitlement under Medicare legislation driven by formulas for direct and indirect payments. Hospitals have been able to train the types of residents that meet their needs without either application or outcomes reporting. Since the teaching hospitals of the country are the training grounds for the physician workforce, the workforce of the country is effectively determined by the staffing needs of teaching hospitals. This circumstance has resulted in a workforce that is, by all measures, highly subspecialized and weak in primary care. It tends to be located closer to medical centers and areas of advanced technology, and not as well represented in rural and financially disadvantaged areas of the country.

This situation is not new and has been subject to increasing calls for scrutiny and reconsideration. While no single alternative to the current GME funding system has gained a consensus among medical educators and policy makers, the Medicare GME system needs a thoughtful reexamination at the highest levels of government. This task might be specifically assigned to the Advisory Committee on Health Workforce Evaluation and Assessment, to MEDPAC, or to a specially constituted commission. The Tri-Committee draft bill would be greatly strengthened by addressing this important issue.

National Health Service Corps

The draft legislation increases National Health Service Corps scholarship and loan repayment funding levels to $300,000,000 annually, effectively maintaining the ARRA funding for NHSC and increasing the total NHSC from approximately 4,000 providers to 8,000 providers. However, the NHSC has the potential for further growth. Last year, over 4,500 health care providers applied for NHSC positions. Only 950 positions (20% of applicants) were awarded due to funding limitations.

[4] Morris CG et al. Training Family Physicians in Community Health Centers: A Health Workforce Solution. Fam Med. 2008 Apr;40(4):271-6.
[5] Ferguson WJ et al. Family Medicine Residency Characteristics Associated With Practice in a Health Professions Shortage Area. Fam Med. 2009 Jun;41(6):405-10.

Practice Reform

A number of provisions in the House draft legislation support primary care through programs which will promote practice and payment reform. The conversion of the Medicare Medical Home Demonstration Project to a pilot program and the establishment of a Medicaid Medical Home pilot program further patient-centered, comprehensive, coordinated and accessible health care which is largely primary care focused. The establishment of a Medicare Accountable Care Organization pilot program promotes accountability in the health care system and provides an incentive for high quality, efficient care – and recognizes the importance of primary care through requirements of qualifying ACO groups to include "sufficient number of primary care physicians" and "patient-centered processes of care."

Draft legislation includes a Medicare primary care bonus for designated services provided by primary care practitioners – 5% in general or 10% if the practitioner practices in a health professional shortage area. The Medicare Sustainable Growth Rate (SGR) is also rebased at the 2009 level for calculating future update adjustments and divided into 2 "service categories" – one including evaluation and management services (including primary care services), the other including all other services – with a separate target growth rate increase of 2% annually rather than 1% for all other services.

These changes begin to address both the practice and payment disparities which have contributed to the decline of primary care in the U.S. However, recent work done by the Robert Graham Center indicates a 5% primary care bonus will translate to only a $2,500 annual revenue increase for family medicine physicians.[6] When faced with primary care to specialist payment gaps over $200,000, this primary care bonus is unlikely to influence future physician career choices. A 50% primary care bonus, or a $25,000 annual revenue increase, is more likely to achieve the desired effect. Additional analysis by the Graham Center evaluating separate service categories for SGR calculations indicate that a target growth rate of GDP+2% will be insufficient to maintain current trends in increasing evaluation and management payments, which will surely increase even more with increasing health care coverage. GDP+3% for primary care services will prevent future cuts to primary care payments.

Finally, while medical homes and accountable care organizations provide incentives for strengthening primary care practice, they do little to provide the technical assistance and training needed to transform the current struggling primary care system into a high-functioning quality care system. A primary care extension program modeled off of the agricultural cooperative extension program would link the Department of Health and Human Services to State level hubs and local extension offices which could then provide the technical assistance and training programs needed to establish a higher quality and more cost-efficient primary care health care service network in the U.S.

Conclusion

The Tri-Committee draft legislation takes a significant step towards establishing a health care workforce which will sustain a high-quality, cost-effective, fully accessible health care system. Moves to establish an Advisory Committee on Health Workforce Evaluation and Assessment, re-invest in the National Health Service Corps and Title VII of the Public Health Service Act, redistribute unused Medicare GME positions to primary care programs and establish teaching health centers, and address payment and practice challenges to primary care through the medical home and accountable care organization pilot programs are all positive moves towards a sustainable health care workforce. However, to fully achieve workforce reform, the following are recommended:

[6] The Robert Graham Center. Effects of Proposed Primary Care Incentive Payments on Average Physician Medicare Revenue and Total Medicare Allowed Charges: White Paper. May, 2009

- Promoting the Advisory Committee on Health Workforce Evaluation and Assessment to a "National Commission on the Health Workforce", providing it with an authorization and clarifying its role in reporting to Congress, including addressing Medicare GME payments.
- Fully supporting the Teaching Health Centers program, converting it to at minimum a pilot program rather than a demonstration project and creating a Teaching Health Centers Development Grant within Title VII.
- Further increasing National Health Service Corps authorization for appropriations to maximize the program's full potential to provide health care in the most underserved areas.
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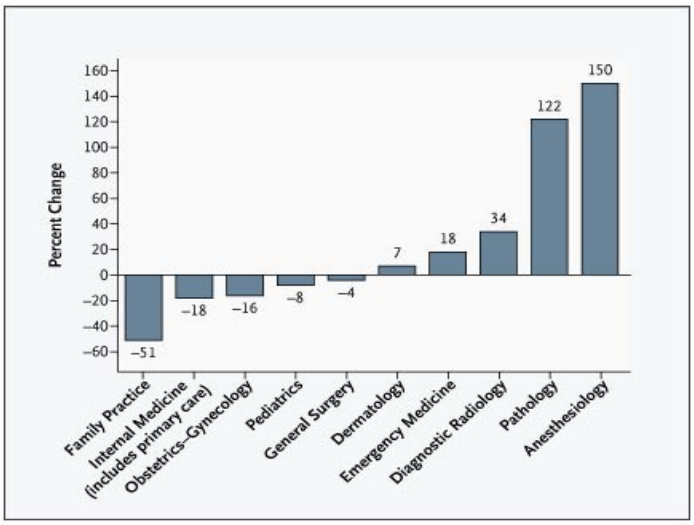
- Invest in a primary care extension program to provide technical assistance and training programs for strengthening primary care practice.

Thank you.

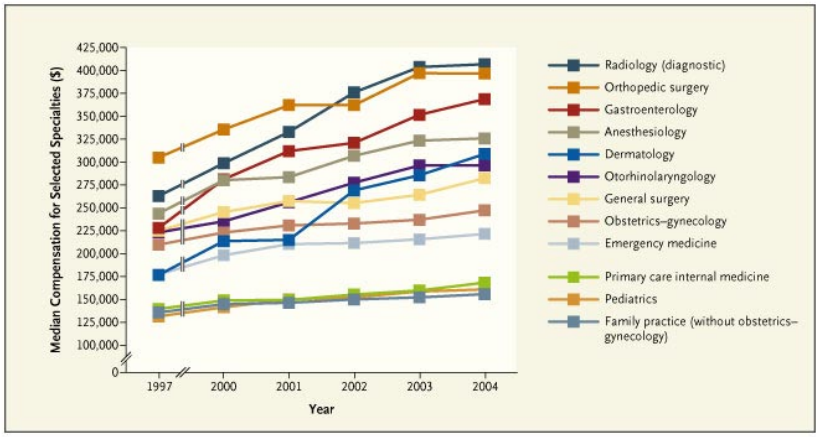
FIGURES

Figure 1: Percent Change between 1998 and 2006 in the Percentage of U.S. Medical School Graduates Filling Residency Positions in Various Specialties.



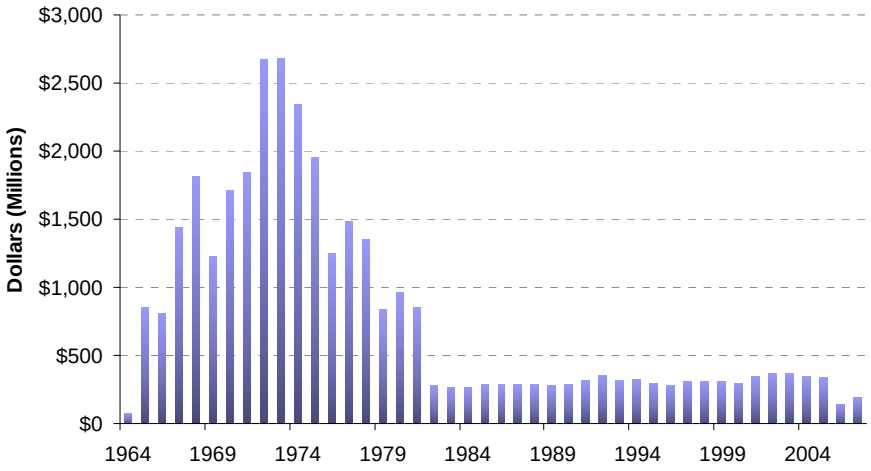
Source: Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005. From: Woo: N Engl J Med, Volume 355(9).August 31, 2006.864-866.

Figure 2: Median Compensation for Selected Medical Specialties



Source: Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005. From: Woo: N Engl J Med, Volume 355(9).August 31, 2006.864-866

Figure 3: Title VII Funding Levels, Adjusted to 2008 Dollars.



Source: Data provided by HRSA

Figure 4: Primary Care Workforce Reform