FULL COMMITTEE HEARING ON THE PROJECTED PHYSICIAN SHORTAGE AND HOW HEALTH CARE REFORMS CAN ADDRESS THE PROBLEM

HEARING

BEFORE THE

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HOUSE OF REPRESENTATIVES

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FULL COMMITTEE HEARING ON THE LOOMING CHALLENGE FOR SMALL MEDICAL PRACTICES: THE PROJECTED PHYSICIAN SHORTAGE AND HOW HEALTH CARE REFORMS CAN ADDRESS THE PROBLEM

Wednesday, July 8, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 9:35 a.m., in Room 2360, Rayburn House Office Building, Hon. Nydia M. Velázquez [Chair of the Committee] presiding.

Present: Representatives Velázquez, Moore, Dahlkemper, Altmire, Bright, Griffith, Graves, Bartlett, Luetkemeyer, and Thompson.

Chairwoman VELÁZQUEZ. Good morning, everyone. This hearing is now called to order.

American health care is a complex system. To properly function, it requires a myriad of interworking components, from hospital infrastructure to insurance companies and drug researchers. But the most critical element cannot be built or tested in a laboratory. It is the men and women who make the system run.

General practitioners are the backbone of the medical field. They offer basic care and are responsible for half of all patient visits. But in many parts of the country these small business practices are becoming an endangered species.

Today, we will examine the current physician workforce shortage and discuss its potential impact on health care reform. This issue is of particular concern to our Committee, not just because most general practices are small firms. For one, it affects doctors in all areas, from surgeons to pediatricians. Physician shortfalls also hinder our efforts to control costs for entrepreneurs and have the potential to undermine our work towards universal coverage.

In overhauling health care, we are looking to provide coverage that is both affordable and accessible, but we cannot do that without the necessary workforce.

In the last decade the availability of doctors has dropped off considerably, even for those with gold-plated policies. If current trends continue, the gap between supply and demand may reach 125,000 by the year 2025. Fewer physicians mean longer lines in waiting rooms, greater difficulties scheduling appointments, and less time

with the doctors themselves. These challenges are more than an inconvenience. Some patients may choose to avoid checkups all together. That will be a dangerous consequence, one that could blunt the benefits of universal coverage and drive up costs over time.

Primary care is preventative care and an effective means for reining in costs. That is because a person who gets regular checkups is less likely to develop serious conditions down the road; and, considering that 75 percent of health care expenditures go towards treating chronic illnesses, primary care is critical.

The current physician shortage is already posing a significant threat to reform. Reform will bring more uninsured Americans into the fold, but it will not create more doctors to treat them. Take the 46 million newly insured, add an aging baby boomer population, and that could very well be a recipe for disaster.

As with anything related to health care, there is no silver bullet solution. Still, a number of possible fixes are under consideration, including provisions to expand health services in underserved communities, the regions suffering most from the current shortage.

This body will soon take steps to transform our broken health care system. I think most of us will agree that it is about time. But in moving towards reform, we need to be sure our foundation is strong. It is critical that we have a solid pool of medical professionals to see the process through. Today, I hope we can look for ways to make that happen.

I would like to thank all of today's witnesses in advance for their testimony, and I am so pleased that they could join us and look forward to hearing from all of you.

And let me say the hearing was scheduled to start at 10, but the Small Business Committee has a bill on the floor, and they sent a late note last night that the hearing needed to be much earlier.

With that, I will yield to Ranking Member Graves for his opening statement.

Mr. GRAVES. Thank you, Madam Chair, and thank you for calling this hearing on the supply of physicians here in the United States. And I want to extend a special thanks to all of our witnesses who are here today.

A 2008 University of Missouri study found that the U.S. Could face a shortage of up to 44,000 family physicians, general internists, and general pediatricians in the next 20 years. Many of these professionals operate solo or in small group practices, small businesses. It is underserved urban and rural areas, such as parts of my district in Missouri.

With our growing and aging population, there is an increasing demand for health care services, and there is a trend towards the coordinated and continuous care provided by primary care physicians and internists. However, during the past decade the supply of generalist physicians has fallen by 22 percent, partly due to the reliance on physician specialists, which makes our health care more expensive and less efficient. The decline in generalists continues as fewer medical students are choosing to practice in family care. In addition, there is evidence that physician assistants and nurse practitioners may also be choosing to specialize in fields such as cardiology and oncology.

According to the Government Accountability Office, conventional payment systems undervalue primary care compared to specialty care. There is a growing income gap between primary care physicians and specialists. Several physicians' organizations have recommended altering compensation structures to encourage medical students to become generalists.

The Kaiser Family Foundation reported that in 2007 U.S. health care expenditures exceeded $7,026 per person. Yet surveys on satisfaction with health care are mixed. Some experts believe that there is an over-reliance on specialists and a greater use of primary care providers and internists would lead to better outcomes at lower costs. These physicians focus on prevention, wellness, coordinated care, and chronic disease coordination. Studies show that these services can save money over the long term.

I want to add a final word about health care reform. I strongly oppose employer mandates and a government-run health care system. These alternatives could cause as many as 120 million Americans to lose their current coverage, drive companies out of the market, and require substantial tax increases on the small businesses we are depending on to create jobs. I hope Congress will consider these points during our debate.

Again, Madam Chair, thank you for holding this hearing. I look forward to hearing from our panelists.

Chairwoman VELÁZQUEZ. Thank you, Mr. Graves.

Chairwoman VELÁZQUEZ. Let me welcome Dr. Robert Harbaugh. He is a neurosurgeon at Penn State University in Hershey, Pennsylvania. He serves as the Director of the Penn State Institute of Neurosciences. Dr. Harbaugh is testifying on behalf of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. The Association is dedicated to advancing the specialty of neurological surgery.

Welcome, sir. You have 5 minutes to make your presentation.

STATEMENT OF ROBERT E. HARBAUGH, M.D.

Dr. HARBAUGH. Good morning, Chairwoman Velázquez, Ranking Member Graves, members of the Committee. Thank you for inviting me to appear today to discuss the current workforce shortage that is facing surgical specialty medicine and, specifically, neurosurgical care.

Recently and understandably, a great deal of attention has been paid to the shortage of primary care physicians, but little attention has been paid to the shortage of surgeons. The Association of American Medical Colleges estimates a shortage of 46,000 primary care physicians and 41,000 surgical specialists by 2025; and while plans are being considered to address the primary care deficit, little is being done to address the shortage of surgical specialists.

The Bureau of Health Professions projects a 19 percent increase in primary care physicians by 2020, based on some of the actions that are planned, but continued and significant decreases in the number of surgical specialists over the same time.

At present, there are fewer than 3,500 practicing board certified neurosurgeons in the United States serving a population of more than 300 million people. And as the population ages, more of our citizens face devastating problems such as stroke, degenerative

spine disease, Parkinson's Disease, and brain tumors that neurosurgeons treat. This supply/demand mismatch will become ever more acute.

In addition, the effectiveness of things like deep brain stimulation for treating movement disorders and obsessive compulsive disorders makes it very likely that we are on the verge of a minimally invasive and effective neurosurgical treatment for things like obesity and addiction; and because of the prevalence of these disorders, many more neurosurgeons will be needed to meet the demand for their neurosurgical treatments.

We already have an acute neurosurgical workforce problem in the subspecialty areas of pediatric neurosurgery and trauma and emergency neurosurgery. There are less than 200 surgeons certified by the American Board of Pediatric Neurological Surgery, and within the next 10 years more than 40 percent of the current pediatric neurosurgical workforce is likely to retire.

On the supply side, there are less than 10 trainees who enter pediatric neurosurgery fellowship training each year. There is also a shortage of neurosurgeons to provide neurosurgical emergency and trauma care. Closure of trauma centers in Pennsylvania, Tennessee, Missouri, Illinois, Texas, and Florida were due in part to shortages of neurosurgeons. And the National Foundation For Trauma Care reports that, after trauma surgeons, neurosurgeons are the specialists with the highest percentage of trauma care.

According to this same report, physician shortages, caused by a variety of factors, including medical liability expense, decreasing reimbursement, represent one of the major reasons for the closure of trauma centers. And with estimates that 10 to 20 percent of the Nation's 600 regional trauma centers may be forced to close within 3 years, it appears that neurosurgeon shortages are affecting the availability of trauma care in the United States, despite the fact that more than 90 percent of practicing neurosurgeons participate in emergency call coverage.

Many neurosurgeons must provide emergency care at more than one hospital at a time, and that places our citizens at risk of delayed care for neurological emergencies such as head, spine, and nerve trauma and cerebral hemorrhage from ruptured intercranial aneurysm and other causes.

While there are many complex factors that lead medical students to select one specialty over another, there are several reasons for the present and impending shortages in the neurosurgical workforce. One of these is medical liability. Neurosurgeons continue to face increased professional liability insurance costs, which in some areas of the country now approach $300,000 per year.

According to a survey we conducted a few years ago, medical liability issues contributed substantially to neurosurgeons limiting their availability for emergency and trauma care and eliminating treatment of high-risk patients; and medical liability reform would clearly help address this part of the physician workforce shortage.

Lifestyle issues must also be considered as a contributing factor in the shortage of surgical specialists. The AMC projects that physician practice patterns are likely to be different in the future because of a greater concern for lifestyle issues among young physicians and because of the intensity of the neurosurgical practice.

With frequent emergencies requiring long hours of neurosurgical care, lifestyle issues will contribute to a shortage of available neurosurgeons.

In some areas of medicine, physicians assistants and advanced practice nurses may be able to address a shortage of physicians, but there is no good substitute for well-trained neurosurgeons for patients with head, spine, and nerve injuries, brain tumors, stroke, hydrocephalus, and other neurosurgical emergencies.

After graduating from medical school, most neurosurgeons train for 7 years or more before entering practice; and there are less than 100 neurosurgical training programs in the United States, with many programs training only one resident per year.

Compounding this problem, the Accreditation Council for Graduate Medical Education has established work hour restrictions for residents; and due to the time and intensity required to adequately train a neurosurgeon, restricting weekly work hours will require lengthening the period of training if we want to continue to have well-trained neurosurgeons.

Over the past several years, we have heard repeatedly that reimbursement is contributing to the shortage of primary care physicians because more medical students choose higher-paid specialties rather than primary care. However, there is also a risk that reducing surgical specialty reimbursement in the face of medical liability and lifestyle issues that inhibit students from entering a surgical specialty will exacerbate the current shortage of surgical specialists.

In conclusion, the convergence of declining reimbursements, rising practice expense, less time for non-work-related activities may deter young physicians from becoming neurosurgeons. This will exacerbate already acute problems with access to neurosurgical care, and I think these problems will be compounded by effective neurosurgical treatments for common disorders and an aging population that requires more neurosurgical services.

Thank you for this opportunity to speak with you today. I would be happy to answer any questions.

Chairwoman VELÁZQUEZ. Thank you, Dr. Harbaugh.

[The statement of Dr. Harbaugh is included in the appendix.]

Chairwoman VELÁZQUEZ. Our next witness is Dr. George Sheldon. Dr. Sheldon is a Professor of Surgery and Social Medicine in the Department of Surgery at the University of North Carolina in Chapel Hill. He is also the Director of the American College of Surgeons Health Policy Research Institute.

Dr. Sheldon is testifying on behalf of the American College of Surgeons. The ACS is a scientific and educational Association of surgeons that was founded in 1913.

Welcome.

STATEMENT OF GEORGE F. SHELDON, M.D.

Dr. SHELDON. Thank you very much, Chairman Velázquez and Mr. Graves, ranking member, members of the Committee. We are also pleased to be here, and I would make several points on the going in.

Neither candidate during the last election could put forward any of the details about one of the big problems in health care that has

already been mentioned by Dr. Harbaugh is a shortage. And I think if we pick just one specialty to try to stimulate, it is sort of like putting a finger in a dyke that has got 10 holes leaking. We have got to do it for everybody.

And I know we hear a lot about the problems with American medicine and all the things, and we all agree, and we are all committed to health reform. But I would call your attention to a July 4 publication of Lancet, the respected British medical journal. They published a comparison of cancer deaths in the United Kingdom, 11 countries, and the United States, using World Health Organization databases. Cancer mortality in the United Kingdom, which has a federal program, as everybody knows, were 23 percent higher than six European countries and 31 percent higher than in the United States. So my hope, among other things, is that whatever we do for health reform, we don't throw the baby out with the bath water. There have been some good things happen over the years.

We are encouraged by the book by Ezekiel Emanuel. Dr. Ezekiel Emanuel, who is a White House advisor, has a very good outline of a plan that might be done.

In a similar void and on the other side, the June 2 publication by the Council of Economic Advisors of the White House embraced the concept of a 30 percent overage that could be money saved in health care costs by reduction in regional variation by what they call input changes and also by using the False Claims Act. This is, of course, based on the Dartmouth work, respected investigators.

But there is four other groups, including ours, that find different types of data. And that would be Dr. Robert Berenson of the Urban Institute, Dr. Richard Cooper of the Wharton School of Business for the University of Pennsylvania, and our data from Dr. Ricketts. In short, while there is some regional variation, they are only comparing Medicare; and Medicare is only 50 percent of the payers. So it is like comparing apples and oranges. It is not agreed upon enough to be a premise for health care reform.

The rest of my comments will deal with shortage of surgeons. There are shortages in every specialty of surgery today. We have done population maps and showed that some States are worse off than others, but there is not a single State in the Union that has more surgeons than they did 10 years ago, and that's also shown in the Dartmouth atlas.

One-third of all surgeons are over 55 years of age; and specialization of surgery, as instrumentation and other types of technology increased, has been monumental. But to give some data, the general surgeon is sort of the generalist in the group. He is usually head of the trauma centers, does a lot of the transplant surgery, does a lot of the cancer surgery.

And we have fewer general surgeons now practicing than we did in 1980. The American Board of Surgery, of which I was chairman at one time, in 1981 certified 1,047 people. Last year, it was 1,032. And, in the meantime, the population of the country has grown by 25 million each decade.

Rural America, with about 20 percent of the population, 59 million people, require on surgical services to keep their hospitals open. That is what allows the hospital to provide the other services. It is the backbone of the rural hospital.

There is 1,300 critical access hospitals in the United States, and 300 of them don't even have a surgeon living in the county. If a surgeon is not available, the other services pretty much go away.

A further example of the shortage is cardio-thoracic surgery. Cardiac disease is the commonest killer in the 20th century and will predictably be for the first part of the 21st.

Only 50 U.S. medical school graduates applied for training in cardio-thoracic surgery this past year. So who is going to do our heart surgery as we go forward? There aren't going to be people around to do it.

My closing comments would just say that I would believe that we have a shortage in all specialties, primary care and all the surgical fields. And we think that there ought to be access to the public programs like Title VII, the National Health Service Corps, of the dish provisions that are provided for primary care and others. These things ought to be made available for all specialties, not just primary care.

Thank you very much for your attention, and I am certainly available to provide maps of all these States and everything if you would like to see them. In fact, you have one map with you, I think.

Chairwoman VELÁZQUEZ. Thank you, Dr. Sheldon.

[The statement of Dr. Sheldon is included in the appendix.]

Chairwoman VELÁZQUEZ. Now the Chair recognizes the gentlelady from Pennsylvania, Mrs. Dahlkemper, for the purpose of introducing our next witness.

Mrs. DAHLKEMPER. Thank you, Madam Chair.

It is my pleasure to welcome Dr. Carlo DiMarco to the Small Business Committee today. Dr. DiMarco is from my hometown of Erie, Pennsylvania. He is the 112th President of the American Osteopathic Association. He is also a Professor and Regional Dean of Clinical Medicine and Director of Ophthalmology Residency Program at the Lake Erie College of Osteopathic Medicine in Erie, which we call LECOM.

Aside from his duties at LECOM, Dr. DiMarco is part of Medical Associates of Erie, a network of multi-specialty physicians who practice throughout Erie County and teach in affiliation with LECOM.

Welcome, Dr. DiMarco.

STATEMENT OF CARLO J. DiMARCO, D.O.

Dr. DIMARCO. Thank you, Chairman Velázquez and Ranking Member Graves and Representative Dahlkemper and members of the Committee. I thank you for the opportunity to testify today.

As President of the American Osteopathic Association, which represents 67,000 osteopathic physicians across the country, and as Professor and Regional Dean of the Lake Erie College of Osteopathic Medicine, I am acutely aware of the challenges of addressing our Nation's physician workforce shortage, particularly in the field of primary care.

At LECOM, our mission is to educate physicians in the osteopathic tradition of competent and compassionate whole person care. The percentage of our graduates who pursue careers in primary care is 67 percent, placing LECOM at eighth in the Nation for

training primary care physicians. But despite this commitment to primary care, the challenges facing our profession and our students are increasingly prohibitive.

Three central factors contribute to our current and projected primary care workforce shortage, and these factors also apply to general surgery: the Medicare physician payment system, graduate medical education, reimbursement policies and time-consuming administrative burdens that shift attention away from patient care.

With respect to physician reimbursements, studies show that income disparities have a significant negative impact on the choice of primary careers over specialties among the Nation's young physicians. This is not surprising, given that the average of income of a primary care physician is approximately one-third of a specialist, while practice costs are often even higher.

Unless Congress takes immediate action to establish a more equitable physician payment system, a predicted workforce shortage can only worsen. We urge Congress to enact financial incentives for primary care physicians to provide a bonus of at least 10 percent for primary care services, with mandated annual increases to achieve market competitiveness.

As you know, the instability of the current physician payment system stemming from the flawed sustainable growth rate formula results in the threat of annual costs and cuts. We appreciate Congress's yearly interventions to avert these drastic cuts, but a Band-Aid approach does nothing to alleviate the underlying systemic problems driving physicians out of medical practice. The unpredictability forces small primary care practices with limited revenues and narrow margins to make difficult decisions about whether to lay off staff, reduce their Medicare patient population, defer investments or retire early.

Medicine is calling, but the business of medicine, in general, is a small business. No business can survive when its expenses exceeds its revenues.

Administrative burdens create additional strains on primary care physicians, resulting in the significant decline in professional satisfaction and hampering recruitment efforts. In fact, 60 percent of primary care physicians would not recommend a career in medicine.

While physicians in all other specialties face unnecessary and costly administrative hassles, the burden on primary care physicians in small practices is particularly excessive, detracting from the time available for patient care. Primary care physicians' role in coordinating care and making needed referrals to specialists typically involves frequent interaction with Medicare and other third-party payers to obtain required approvals, services, and payments, and resulting in paperwork and overhead expenses at almost twice that of other physicians.

A typical primary care physician must coordinate care for Medicare patients with 229 other physicians working in 117 different offices, yet receives no compensation for these care coordination services. The AOA supports the development of a new delivery and payment model such as the patient centered medical home that will allow primary care physicians to provide comprehensive, continuous patient care.

Reforms to the graduate medical education training system are also an essential component of workforce development.

First, the current graduate medical education system is not capable of meeting increases in enrollment in the Nation's colleges of osteopathic medicine and colleges of medicine. We support a modification of current limits on the number of funded residency training positions through a one-time increase in the number of funded positions by 15 percent.

Additionally, we support modifications that allow for collaboration through consortiums, such as the Osteopathic Postgraduate Training Institutes, or OPTIs. These consortiums allow several teaching locations to share resources, thus enhancing the educational opportunities for the resident physician.

Finally, research has shown that physicians who are trained in the community health centers, for example, are twice as likely to work in underserved settings and four times more likely to work in health centers after completing their residencies. However, Medicare does not reimburse for most time spent in outpatient settings. We urge Congress to enact legislation that will create new training opportunities in non-hospital settings and clarify existing regulations governing such training.

Providing residents with the opportunities in real-world settings offers greater exposure to primary care specialties and increases the likelihood that residents will choose to practice in these settings and in small physician practices that make up the backbone of our primary care system.

On behalf of the AOA, I would like to thank you for drawing attention to this important issue, and we look forward to continuing to work with you in addressing the physician workforce shortage. Thank you very much.

Chairwoman VELÁZQUEZ. Thank you, Dr. DiMarco.

[The statement of Dr. DiMarco is included in the appendix.]

Chairwoman VELÁZQUEZ. Our next witness is Dr. Lori Heim. She is President-elect of the American Academy of Family Physicians. Dr. Heim advocates on behalf of family physicians and patients nationwide to inspire positive changes in the U.S. health care system. The American Academy of Family Physicians is one of the largest national medical organizations, with more than 93,000 members.

Welcome.

STATEMENT OF LORI HEIM, M.D.

Dr. HEIM. Thank you, Chairwoman Velázquez and Representative Graves and members of the Small Business Committee.

I am Lori Heim, President-elect of the American Academy of Family Physicians, which now represents over 94,000 members across the U.S.; and I am pleased to be here to testify on physician workforce needs as Congress considers health care reform.

As you know, the vast majority of family physicians themselves are small businesses, delivering care in communities across the Nation. Nearly 38 percent of family doctors practice in solo or two-physician practices. Studies indicate that more Americans depend on family physicians than on any other specialty. We see up close the hardship of the uninsured, and we struggle along with those patients who are insured but then who face coverage denials.

We consider an expanded primary care physician workforce essential to the success of health reform. Unfortunately, while the supply of primary care physicians is far from adequate, the projections are truly alarming. Primary care has been described as the base of the health care workforce pyramid. But the U.S. physician profile is only 31 percent primary care and 69 percent specialty.

The AAFP supports the steps necessary to build the primary care workforce to at least 45 percent of all practicing physicians. To restore stability, we must adopt workforce policies that ensure an adequate number of primary physicians who are trained to practice in the comprehensive patient-centered primary care medical home model. That model of care provides patients with preventive care, as well as coordinates their chronic disease and appropriate care for acute illness.

To realize the quality and efficiency benefits of the patient-centered medical home, we must have an adequate supply of primary care doctors, particularly family physicians.

The reasons for the inadequate supply of primary care are many, and we must address each one of these. The first and most critical step has already been mentioned, and that is to increase the payment for primary care. This will encourage more student interest in primary care, as well as allow for the redesign of existing practices to improve quality and access.

Next, Congress should provide targeted incentives such as scholarships, loan forgiveness or other forms of debt relief for medical students who choose primary care and family medicine.

Also, we are recommending opportunities in programs such as the National Health Service Corps. Congress should reauthorize and adequately fund Title VII health professions training grant programs for primary care medicine.

AAFP has also called for reforms to graduate medical education payments to ensure that we are training the primary care physician workforce that we need. However, we would suggest caution with respect to the expansion of residency slots. We recommend that unused residency slots be dedicated to primary care before an overall expansion of the number of residency slots is considered.

We are grateful to the House discussion draft that addresses the primary care physician workforce shortage with provisions including the bonus payment for primary care services provided in health profession shortage areas, reauthorization and mandatory funding for Title VII section 747, the Health Professions Primary Care Medicine Training Program, and the National Healthcare Workforce Commission to study and recommend appropriate numbers and distribution of physicians.

We look forward to continuing to work on workforce and other key elements of health care reform. Now is the time to provide affordable, high-quality health care coverage. The status quo is not working, neither for the physicians nor for the patient. We urge Congress to invest in the health care system that we want, not the one that we have now.

Thank you very much.

Chairwoman VELÁZQUEZ. Thank you, Dr. Heim.

[The statement of Dr. Heim is included in the appendix.]

Chairwoman VELÁZQUEZ. The Chair recognizes the ranking member, Mr. Graves, for the purpose of introducing our next witness.

Mr. GRAVES. Thank you, Madam Chair.

Madam Chair, I am pleased to introduce Dr. Bruce Kauk, M.D. He is a fellow Missourian from Gladstone. Dr. Kauk has been in private practice with Northland Internal Medicine in Gladstone since 1979. He is board certified in internal medicine and geriatrics. A graduate of the University of Nebraska Medical Center in Omaha, Dr. Kauk served his internship and residency at Southern Illinois University in Springfield.

Dr. Kauk has been President of the Clay County Medical Society and President of the North Kansas City Hospital Medical Staff Credentials Committee, and he is a founding member and chairman of the Clay County Senior Services in Gladstone.

Thanks, Doctor, for coming in all the way from Missouri.

STATEMENT OF BRUCE A. KAUK, M.D.

Dr. KAUK. Good morning. Thank you.

Madam Chairman, Ranking Member Graves, members of the Committee, I appreciate this opportunity to talk to you. I do not represent any society or any other specialty group. I think I come to give you the passion and the soul of what we all do every day, which is not quite the flavor of what my other colleagues have told you. They are more concerned about the facts, and there are other issues to this issue.

I am particularly glad to come to this Committee because most physicians traditionally have been small businessmen. One of the issues is, though, that we are seeing that change dramatically. In my community, we are down to about a 50/50 mix of internal medicine and family practice being self-employed. Most of them have joined some organization.

Again, I say I am a traditional internist. That means I do everything. I go to the hospital. I have an office practice. I have a nursing home practice. Recently, because of some of the budget issues, I have added a long-term acute care practice.

So I know you are all aware that physicians are in evolution and internists are in evolution, particularly. We have hospitalists. We have people who just do office work. We have people who do none of that, who don't practice active care. There are many things that physicians can do now. There are many other opportunities competing for active practice.

Again, I think it is important to focus that we traditionally have been businessman, that we employ four to five people per practice. We pay taxes. We pay insurance for those people. For a two-man practice, my health insurance costs for my employees are $72,000 a year.

I bring evidence to you that this shortage has been going on since the 1950s, when my retired partner got a call after the funeral of one of his patients saying, one of your patients died. Can I come to your practice?

So that brings us to the shortage. I think we all agree there is a shortage—I am happy to hear that—in all parts of medicine but particularly primary care.

Why has that happened? I think there are a number of factors: the evolution, the competition, other venues, the number of hours worked. I would give you mine, but you wouldn't believe them.

Quality of life becomes an extremely important issue for all of us. We look at comparison to medical peers. That has been talked about. The difference between primary care and such specialty reimbursement is $3.5 million over your working lifetime.

You look at comparison of my neighbors. They all work a 40-hour week. I work a 60-hour week, and then I am on call. I am responsible every minute, 80 hours. That is a great difference in quality of life. Then we wonder why people don't want to go to medicine, don't want to go into primary care.

On top of that, we are asking people in primary care to do a great deal of gate-keeping. I have to personally sign numerous documents allowing other people to be paid. This takes approximately 30 minutes every day. I have to employ one full-time employee to take care of medicine issues, pre-authorization with insurance companies. A study has been done that shows each primary care physician expends $60,000 to deal with these kind of issues. That is one-third of my salary. It cost me 1 percent of my salary to come here today on my own dime.

So how do we fix that? What do we do about it?

We have said that physician extenders haven't been helpful. They go on into subspecialties. We are working on equalizing reimbursement, but the budget is an issue.

How do we retain present physicians? One of the things is decreasing costs. Primary care can do that. They have been shown to do that. Maintaining quality, again, primary care has been shown to do that. There are multiple studies documenting that, that those communities with more primary care physicians have a longer life span, fewer re-admissions, all the things that increase costs.

Prevention is another major issue in our society, in our country. I listened to Tommy Thompson, previous Health and Human Services Secretary, some 10 to 12 years ago say, we are missing the boat. We have got to do preventive care. Well, we are still missing the boat. There is a lot of work to be done there; and, from my point of view, that is the major area where cost savings can be entertained.

Chairwoman VELÁZQUEZ. Dr. Kauk, time has expired. And since we have a bill on the floor, I would like to go to the questions. And then in the question and answer period, if you want to expand on any thoughts that you might not have been able to share, you will be welcome to do so.

Dr. KAUK. Thank you.

[The statement of Dr. Kauk is included in the appendix.]

Chairwoman VELÁZQUEZ. Thank you very much.

I would like to address my first question, if I may, to Dr. Heim. You note that more medical training, must have greater flexibility if we are going to increase the presence of primary doctors in our health care system. How do we go about accomplishing this goal in a balanced way without creating new challenges for our medical education system?

Dr. HEIM. Thank you. If I understand your question, are you asking how do we balance the number of slots or the types of specialties that people go into, ma'am?

Chairwoman VELÁZQUEZ. Well, you are saying that we need more medical training and, in order to achieve that, that we must have greater flexibility if we are going to increase the presence of primary doctors. What I am asking is, how can we achieve that goal without impacting or dismantling or affecting or posing new challenges for our medical education system?

Dr. HEIM. The slots that we have right now, we have asked that those—the numbers of slots available for training in residency programs, those right now are, as you noted in your remarks, being—primarily, most of the education is done in the hospital. So there are a couple of factors.

One is, we have to realign the actual slots for training so that more of those go to primary care. That is a redistribution issue.

The other component is then paying for the care that is done in the community. Part of this is a regulation change that can occur at CMS having to do with voluntary preceptors.

The third component is that we believe that, right now, funding for training is primarily through government products—Medicare, Medicaid. Our policy is that everybody should contribute to that, whether or not it is funding for any of the GME slots; and in that way then I think it becomes much more balanced.

Chairwoman VELÁZQUEZ. Dr. Sheldon, do you have any thoughts on that?

Dr. SHELDON. Well, I think the Balanced Budget Act of 1997 froze reimbursement under Medicare, and that needs to be taken off.

It is important to note that there are only four specialties that had more applicants than they do slots. And when you talk about unfilled slots, most of those are in primary care fields; and redistributing back to primary care, I don't know if that would solve it or not.

Chairwoman VELÁZQUEZ. Dr. Harbaugh, the shortage of physicians is expected to intensify if health reform passes. As we learned in Massachusetts, there is no guarantee that patients will be able to see a doctor if they have health insurance. How do we avoid these problems to ensure access to care doesn't become a major problem?

Dr. HARBAUGH. I think all of us have addressed that. There clearly is a shortage of physicians, and that includes primary care physicians but certainly is not restricted to primary care physicians. There are acute shortages of surgical specialists, and we can't simply say we have to shift everything to primary care and that will take care of the problem, because it will exacerbate the surgical shortages.

Some of the things that I think would be very helpful, one would be to revise the cap on Medicare support for resident training, and that is an important issue. We are creating more medical students right now. There is a lot of investment going into new medical schools and enlarging medical school classes. But if we don't enlarge the residency training pool, we are simply going to take students that are trained in the United States and they will displace

students that are trained in other countries' medical schools that now do their residency training here, and at the end of the pipeline we will have the same number of doctors coming out.

So increasing the number of medical school slots without residency slots doesn't help, and I think we have to recognize that that increase must go across all specialties. We can make things worse by focusing solely on primary care and now having an exacerbated crisis in the surgical specialties, a crisis that already exists.

Chairwoman VELÁZQUEZ. There is no easy solutions, right?

I would like for any of the members of the panel to respond to this question.

Medical liability is a major concern for the medical profession. It seems clear the health reform cannot be achieved without addressing this issue. Short of placing a cap on medical claims, the President has stated he believes this should be addressed as part of reform. What measures should Congress consider to reduce the costs of malpractice insurance? Dr. DiMarco?

Dr. DIMARCO. Next to caps. Except for caps. Well, unfortunately, the caps are a great part, because industry knew right away in the early days that Workmen's Comp—they knew how to deal with the—set their prices the way they needed it for those injuries.

But without caps, in Texas, for instance, when they passed a law on caps, the malpractice insurance dropped by 12-1/2 percent the next day. Now it is down by 25 percent since the passage of caps. So I think that caps are an important part of physician liability reform, and that is necessary to attract students into specialties that reimburse less.

Chairwoman VELÁZQUEZ. Okay. Dr. Sheldon.

Dr. SHELDON. I think the only answer is a cap like the California law. Three years ago, West Virginia's liability got so high that all the acute patients with trauma had to be transferred to Pennsylvania by helicopter. The same thing happened in Nevada. An emergency session of the legislature was called to provide some.

It won't work unless you cap like California did. And we appreciate the House has passed this many times. It is the Senate that doesn't seem to like it.

Dr. HARBAUGH. I think the caps are an important piece. Other things that could be considered would be alternatives to civil litigation, early disclosure, compensation offers, administrative determination of compensation where you have a health court model that would determine compensation.

I think we can also do things like provide medical liability protection for physicians who follow established evidence-based practice guidelines. If you are practicing to the standard of care, even if there is a bad outcome, then that shouldn't be a liability issue.

Some minor things would be to protect physicians who volunteer their services in a disaster or local emergency situation. And I think, going back to the cap, some reasonable cap on noneconomic damages, not on the economic damages to the patient but a cap on noneconomic damages is a very important piece of the puzzle.

Chairwoman VELÁZQUEZ. Dr. Kauk.

Dr. KAUK. The other piece is that, in Kansas, there is as equalization pool, my neighboring State. In Missouri, it is present but not funded. I pay as much doing no procedures as a gastroenterologist

who is licensed in Kansas who does procedures all day long. There needs to be more equity in the way the premiums are determined.

Chairwoman VELÁZQUEZ. Thank you.

Now I recognize Ranking Member Graves.

Mr. GRAVES. To kind of dovetail on medical malpractice, is it—is medical malpractice insurance more expensive for—and anybody can answer this—for general practitioners than it is for specialists? No?

Dr. HEIM. No, it is not. But one of the things goes to also what you were saying. I used to do vasectomies in my practice. However, when I applied for medical malpractice they gave me the same rate, doing that one procedure, as if I were doing urology with very extensive urological operations in the OR. That made no sense. So I had to stop doing that service for my community because I simply couldn't afford it.

So, in some ways, if we do the full gamut of what we have been trained to do, then, actually, we are bound by the higher cost, even though our rate of negative outcomes is obviously then far less.

Dr. HARBAUGH. I would like to address that from a local standpoint. I mean, the private practice model of neurosurgery in the Philadelphia area has gone away and it has gone away because neurosurgeons are asked to pay $300,000 per year for minimal liability coverage. That is their insurance fee. So by the time they pay office rent and secretarial help and nurses and record keepers and $300,000 off the top for an annual insurance fee, they can't make ends meet. So they have become hospital employees. They have joined large academic groups. There are ways that they have adjusted to this. But the malpractice premiums for some of the surgical specialties are truly astonishing.

Mr. GRAVES. Next question. And, Dr. Harbaugh, you touched on it. But is the shortage for all doctors? Is it interest? Is it students? Or is it because what you said was it is residency. It doesn't matter if we have bigger medical schools. If we don't expand our residency programs, the outcome is going to be the same. But do we have the students or the kids that are interested in medicine out there? Do we have the numbers?

Dr. HARBAUGH. I think there are always a lot more people who apply to medical school than get accepted, so—and many of the people who don't get accepted I think would make very fine physicians and are qualified. So if we expand the number of medical school training spots, we will turn out more medical students who have gotten their M.D.

The problem right now is, in order to practice independently, all of those students then need to go on and do a residency. If we don't increase the number of residency positions, we simply displace foreign medical graduates with American medical graduates, but the number of practicing physicians at the end of the day stays the same.

Dr. SHELDON. We studied this when I was chairman of the Association of American Medical Colleges. Right now, only 64 percent of the doctors practicing in the United States actually went to medical school here. There is 32 percent more position physicians in residency than there are graduates of U.S. medical students. Most of them come from India. The second commonest group come from

our offshore Caribbean schools. Those eventually get licensed; and if they go to a health services underrepresented area, 3 years they can get citizenship.

So if we leave the residency group alone right now, we will—and not get some of the funding changed—that is the bottleneck in the system at the moment.

Mr. GRAVES. Dr. Kauk.

Dr. KAUK. I think we have to make each subspecialty appealing to people. There have been studies done that show the amount of medical school debt implies one of the more likelihood to go to a subspecialty. Most physicians come out of medical school owing at least $100,000; and the kids these days are smart enough to figure that math out and do what works out economically, rather than maybe works for their heart.

In internal medicine 10 years ago, the number of people going into primary care was 54 percent. Now it is down to 26 percent. So that is a dramatic change in the last 10 years.

How can we change the reimbursement, the quality of life, the hassle factors? You know, at my hospital now, I have to talk to two people before I can decide whether they can be admitted or an observation. That has nothing to do with what I do. It has to do with Medicare reimbursement. So it takes me about twice as long to make hospital rounds now as it used to.

Mr. GRAVES. Dr. Heim.

Dr. HEIM. I think there are two other components when you are talking about students and medical school. One of it is we know from prior studies that there are certain types of medical students who are more likely to go into primary care and there is actually ways that States have incentivized more students going into primary care. Their demographics are known. Medical school admissions committees who are aware of this can, thus, increase the number of students who are interested in primary care.

And, secondly, going to the mismatch, the currently unfilled slots in family medicine and in primary care is true. We have not been filling, which I think just highlights the fact that we need to turn around those incentives for students to go into primary care. But I would say that the current proposals are such that you have made changes that will start making students interested in primary care. So I would encourage you to continue to move those unfilled slots to primary care.

You have created the incentive for them to want to be there. So don't then pull away the slots just at the time when you are telling them that they have a right to be interested and enthusiastic about primary care. Please keep those slots available for them to go into.

Dr. HARBAUGH. I appreciate the shortage in primary care, but we have acute shortages in surgical care as well, which will only get worse if we say that new residency spots must be restricted to primary care. We may make primary care better. I believe that would happen. But we will exacerbate what is already a shortage of surgical specialists. And if you look at the projections, the projected shortage of surgical specialists by 2025 is almost identical to the projected shortage of primary care physicians, and we can't make one problem dramatically worse at the expense of fixing another one.

Chairwoman VELÁZQUEZ. Mr. Griffith.

Mr. GRIFFITH. Listening to this—my mentors were neurosurgeons, David Klein and Peter Jannetta and George Tindall at Emory, et cetera, but I am a radiation oncologist, although I did 2 years of neurosurgery.

I must say that you are pointing out a real sensitive area for me and where we as physicians have been asleep at the switch. We show up only in Congress to be sure our reimbursements are okay, but for the last three decades, we have said nothing about the fact that we were in charge of—not you, but we generic, us—have been in charge of recognizing that the baby boomers were going to come through the system. We were delivering them, but we didn't—it made no difference to us in our medical schools. We didn't increase our numbers; we didn't increase the number of medical schools, the number of kids coming out, and now we are faced with an acute shortage. We have got an acute shortage of general surgeons. We have got an acute shortage of neurosurgeons, orthopedic surgeons, because as they practice, they begin to cut back on their trauma, their quality of life, they are ready in their 50s to slow down a little bit. Our residency programs are full of non-U.S. Graduates. And so we as a group, we M.D.s as a group, have let us all down by not making enough noise, not participating in the political system.

I am through preaching. What I will say is this: I don't think we can pass any sort of health care reform without malpractice reform. There is always four people in your room when you are examining a patient. It is you, the patient, the nurse and the plaintiff's attorney unseen is there, and if we do not fix that, all of this reform, all of this reform, will be for naught because we will not control costs, because as Madam Chair said, if everyone has an insurance card, they still can't see a doctor, because if we don't reform the number of providers, and we continue to try to reform a system around a scarcity, we create the black market, or we create—we create the concierge medicine, and everybody else is over here fighting to see someone.

So we have got a real problem on our hands, and I am afraid that this rush to meet an artificial deadline on health care reform may have some severe unintended consequences. So my question to you or my plea to you is when you go back to see your people that you represent, that have got to get interested in the political process, you have got to tell them to get interested because your fate is going to be sealed by those of us on a panel like this who know very little about what you do.

But thank you each for coming. We really appreciate it.

Chairwoman VELÁZQUEZ. Mr. Thompson.

Mr. THOMPSON. Well, first of all, I thank the Chairwoman and the Ranking Member for this hearing. This is extremely important. I came to Congress after 28 years as a health care manager. And I appreciate the words my colleague just shared in terms of the issue with medical liability, the cost of that out of pocket for physicians; but the cost of the system with frankly having a medical record to be able to defend yourself with; that plaintiff attorney that is not seen but always present; and the workforce issue, which is significant. And I appreciate the panel being here.

It sounded a little bit like a family feud here the past couple of questions, and there is a lot of competition for future professionals, future providers.

I will start with Dr. Harbaugh, and then we will see if any others have a good handle on—frankly, instead of competing—right now it sounds like you are competing for these folks. What is the estimated shortfall over the next 10 years of the actual need of practitioners versus the supply given the current trends in enrollment that are out there?

Dr. HARBAUGH. Well, the numbers that I have heard is that if you look by 2025, there is an estimated 46,000-person deficit in primary care and about a 41,000 deficit in surgical specialties. And I think nobody here is questioning the need to support primary care physicians. The concern from the surgical specialties is that if that is done at the expense of the surgical specialties, which is what happens if you restrict residency training and give special relief of debt repayment, et cetera, et cetera, if you say we are only interested in primary care, primary care is where all the focus has to be, then I think you really run the risk of fixing that problem, great, but exacerbating another problem.

And I think the surgical specialists are as important as primary care for the overall health of the Nation, particularly in areas like trauma, where it is not going to go away and you need surgical specialists to be there right away, you know, a life-threatening situation that to exacerbate the one problem to fix the other doesn't make sense to me.

Dr. SHELDON. We had publications in Health Affairs about 2 years ago, and the numbers go between 20- and 40,000 of doctors across the board. These numbers aren't going to be right looking back, because medical schools are a target of 13 percent increase with now 130 medical schools as just the last few years.

The problem, though, is at the residency level, because if we don't get something fixed there, changing the Balanced Budget Act and that, we are just going to be robbing countries that can't afford to give us their people. I have worked all my life in public hospitals, and that is what we are going to be doing, and we ought to be able to have our workforce funding be self-sufficient.

Mr. THOMPSON. That is a good segue to kind of part two of my question, which is how do we fix this so we are not competing back and forth; that we are growing enough future professionals to meet all the needs? Because the need is significant with the aging baby-boomer population, the attrition of retirements that has been happening for some time now, and it is going to intensify, plus the amount of need that is going to be out there as the population ages.

Dr. SHELDON. Let me make one more comment. Dr. Griffith's comments are germane in that if the number of medical schools and residency growth had continued beyond 1997 at the pace that it was before, we would probably be okay right now. But we froze everything at that period of time with the Balanced Budget Act and with the voluntary cap done by the medical schools.

Mr. THOMPSON. Dr. DiMarco.

Dr. DIMARCO. Yes, the graduate medical education, no one has mentioned about the fact that Medicare—right now the residents are reimbursed through the hospital in its convoluted formula of di-

rect and indirect payments. And meanwhile the last two decades, Medicare funds have been going through independent insurance companies, who don't contribute back to the graduate medical education system. It is only on the back of Medicare and Medicaid.

And I think that would increase the GME slots tremendously, because at the medical school level we are all doing our job trying to increase the class sizes by 15 percent on the allopathic side, and we have doubled our schools on the osteopathic side. But if you can't place your residents when they are done—and the students vote with their feet. They are not stupid. They see what is going on. They know business a little bit. They can figure it out, and they say, I don't want to do this because I can't make ends meet, but I can do this. But if the GME slots were more available, some of the ones that don't get filled, there would be others that would get filled.

Right now there is an understanding that the GME slots are dedicated to certain specialties. They are not. They belong to the hospital, and they can divvy them out any way they want. And if you don't use them in 3 years, you lose them.

Mr. THOMPSON. Thank you, Madam Chairwoman.

Chairwoman VELÁZQUEZ. Mrs. Dahlkemper.

Mrs. DAHLKEMPER. Thank you, Madam Chair. I want to thank you for holding this very important and timely hearing today. As we move towards universal coverage and health care reform, it is essential that we address this future physician workforce shortage.

The Council on Graduate Medical Education has predicted a 10 percent shortfall of physicians by 2020, and as we have seen in Massachusetts, health care reform will only exacerbate this impending decline. And health care reform must strive to not only to expand health insurance coverage, but also to provide everyone access to physicians.

These physician shortages are particularly troublesome in rural areas such as my district in western Pennsylvania since less doctors tend to be attracted to fill those positions in the rural areas. In this vein I was pleased to see the additional funding for the National Health Services Corps, which was already mentioned today. And we also need to address the debt which the students carry, which we just talked about.

But I wanted to ask you, Dr. DiMarco, if there is 2,500 hospitals in the United States that do not have a teaching program, amenities are located in those rural and suburban communities. As a solution to our workforce shortage problems, the American Osteopathic Association recommends expanding the number of teaching programs. What steps should be taken to achieve this goal, and what kind of support would hospitals need to build these programs?

Dr. DIMARCO. Of course it is a brain-drain issue, but the thing is that in the country today, with six States that are responsible for 80 percent of the training, one of the advantages we have noticed in the osteopathic professions, we have opened schools in rural areas where there are hospitals that never had interns and residents. Fortunately there is a loophole in the Balanced Budget Act that says if it is a hospital that has never had an intern or a

resident, you can cap that hospital at a new number first time, And that is what we are achieving at this time.

We have hospitals in Colorado—in Colorado, in Denver; in Mississippi; Yakima, Washington; in California where there have never been residents and interns. And all our new schools have all their slots already preordained prior to the first graduating class, And that can be done across the whole country.

Mrs. DAHLKEMPER. Would anyone else like to address this?

Dr. Sheldon.

Dr. SHELDON. I was a charter member of COGME, and, candidly, they have been a part of the problem. They have said there is a cap—there was a study done the second year of COGME that not only talked about the primary care shortage, but about six stress specialties, which included two in surgery. And COGME is late coming around to recognizing the projected needs for the future. There are a number of other groups that were way ahead of them on that.

Mrs. DAHLKEMPER. Dr. Heim, did you want to—

Dr. HEIM. I practice in actually the poorest county in North Carolina right now and certainly appreciate the need to have more attention paid to the rural areas. When I discharge a patient from the hospital, I often cannot find anyone to take care of that patient. So simply having insurance, even if their bill gets paid, there is nobody there for me to refer to.

We also, as part of the Patient-Centered Medical Home Demonstration Project, where we are looking with residencies in a demonstration project to see new ways of doing training, likewise have been moving residents from the traditional tertiary big hospital out to small community hospitals as an innovative way of improving their training, providing some workforce to the rural, and also decreasing costs.

We also think that you have to change the payment system and make sure that health care insurance is available for all, because otherwise it is the small rural hospitals that are really struggling when you have a very high proportion of your population that gets admitted or comes to the emergency room for which there is no then adequate reimbursement for them.

Mrs. DAHLKEMPER. Thank you.

I have one last question. Dr. Harbaugh, you were talking about the foreign medical graduates, or maybe Dr. Sheldon was addressing this, too. What percentage of those who take these residency spots, what percentage of those are staying here, and what percentage are actually leaving?

Dr. HARBAUGH. To my knowledge, the vast majority stay in the United States. Dr. Sheldon may have more accurate—

Dr. SHELDON. It is well over 60 percent. India now has more medical schools than we do, and they will often send people here with a plan to go back, and probably more of that is happening now. But the number is way, way up.

Mrs. DAHLKEMPER. I was wondering just with the change in kind of the global climate, and some of these countries may be attracting more of their students back.

Dr. SHELDON. Like, sub-Saharan Africa has a real problem. Guiana had, I believe, 1,200 graduates; half of them practice in the

United States today. And their ratios, if you look at the World Health Organization chart, is just dismal. We shouldn't be robbing the other countries to fill our own residencies.

Mrs. DAHLKEMPER. Thank you very much.

Chairwoman VELÁZQUEZ. Time has expired.

Mr. Luetkemeyer.

Mr. LUETKEMEYER. Thank you, Madam Chairwoman.

With regards to the proposed health care plan that is being discussed, part of that plan is rationed health care, and I was just curious as to whether you had an opinion on this or whether you would give us some insights as to what the feeling of your group, Dr. DiMarco, would be. Or I see Dr. Kauk held his hand up first. Why don't you go ahead.

Dr. KAUK. That is fine.

I work in internal medicine and geriatrics, so I deal with hospice patients all the time. I have had multiple patients tell me that this is not the American way. We do not limit care, we do not ration care. If I get sick—Mom, I had this, I want this—may have a revolt of our patients. I have had the strongest outpouring from patients about this, And this is an issue I deal with every day with my patients. Sixty-five percent of my patients are on Medicare, and they are very concerned about this very issue. The patients are. Physicians are as well.

The impact upon myself and other peers, if we go to saying, okay, I spend too much money, and I won't be in the program anymore, this is what I do. How is that fair?

Mr. LUETKEMEYER. Very good.

Dr. DiMarco.

Dr. DIMARCO. We concur also. We do not support rationed care in this country. It is just not the American way.

Mr. LUETKEMEYER. Okay. I have a medical school in my district, by the way. So, welcome.

Dr. Heim, everybody has got their hand up here. I must have hit a hot topic here. Thank you.

Dr. HEIM. I would just like to point out that I think under our current system we do ration care. If you do not have health insurance right now, you oftentimes delay or do not get care. That is rationing.

I also think, though, that even those people who have insurance currently, I see a disparity, and we all know that there are disparities of care in this country. So I think that when we develop health care reform, we have to look at whether the disparities right now, what is the rationing that is currently going on as we move forward to a different program. But, sir, it exists out there right now, and I face it every day in my active practice.

Mr. LUETKEMEYER. Okay.

Dr. SHELDON. We have a safety net hospital. Eighteen percent of our work is uncompensated, coming close to $300 million a year. Rationing is common in the public programs in England and on the continent, and it is often pegged at a patient's age. And unfortunately, with all of the patients, everybody getting older in this country especially, that is when most of the diseases come along that need care. And the cancer statistics that I quoted earlier in my comments may well in part be due to the fact that they have

limitations what care you can get at certain ages. It is hard to get it right. I think if we follow the advisory of Council of Economic Advisors that was in that June 2nd document from the White House, the inevitable result will be losing public money and probably will make this worse.

Mr. LUETKEMEYER. Dr. Harbaugh.

Dr. HARBAUGH. I think the specter of rationing is that someone who doesn't know an individual patient will make a determination that this particular patient cannot receive care that may in that case be life-sustaining, and that scares people to death. I don't think we need to go there. If we had better research on what care is truly effective and what care was futile or ineffective, we could take care of a lot of the expense problems that we have now.

If you look at the Dartmouth health care maps—and I spent a long time at Dartmouth, and it was part of their surgical outcome s group. And if you look at the variability in the number of surgical procedures done from region to region, what you find is that where the indications for surgery are ambiguous, you have a great deal of variability, and it tends to follow the number of surgeons. On the other hand, when you have very clear-cut indications for surgery, you find that the rate of those operations is the same all over the country.

So we can do a much better job of finding out clear-cut indications for surgical care, and I am sure the same is true for other types of care, and the comparative effectiveness approach, I think, if done right, has a lot of merit.

Mr. LUETKEMEYER. Thank you very much.

Thank you, Madam Chairman.

Chairwoman VELÁZQUEZ. Thank you.

Mr. Bartlett.

Mr. BARTLETT. Thank you very much. Sorry that I was late.

I think in moving forward, we need to recognize that we really do not have much of a health care system in this country; we have a really, really good sick care system, the best in the world probably. I hope that in moving forward that we are focused a bit more on—a whole lot more on health care. Maybe if we had a better health care system, we wouldn't need to have such a big sick care system.

One of the problems that we have in rural areas, and I guess in some of our inner cities, too, is that the government now controls the health care for almost 50 percent of our population: all of our military, all of our veterans, SCHIP children, Medicare and Medicaid. And by design, the government intends to pay less than the cost of health care. Obviously you can't do this, or you can't stay in business. So there is a lot of cost shifting going on.

How are you dealing with this problem in rural areas where frequently large percentages of your patients—I have some rural areas in my district, and I know that some of their nursing homes are 90-odd percent all Medicaid. Tough to run an institution when the person who is paying the bill intends to pay less than the full cost of health care. How are you dealing with this?

Dr. HARBAUGH. Well, at a large academic medical center, this is an acute problem because we do not refuse care to anyone because

of ability to pay. We are—our trauma patients very frequently are Medicaid patients.

Now, we are luckily to live in a part of Pennsylvania that also has a pretty good payor mix in other parts of the population, and it is clearly cost shifting, that people who have insurance are paying enough to care for the people who don't cover their expenses with Medicaid.

Mr. BARTLETT. You have to do this, or you are out of business. Yes.

Dr. KAUK. I think it is really becoming an issue. I deal with 65 percent Medicare patients, and realistically it is coming to a point where I cannot any longer be a private physician running my own business. After 30 years of doing this, 30 years of being a very good, efficient, busy physician, I have not been able to give my employees a raise for 5 years, I have not funded my pension profit-sharing plan. I am looking at other options for my practice at this point. I will probably become an employed physician and will probably lose another small business, and this at a time where I should be doing well, not suffering.

And that is a personal story, but that is the way I think most people are struggling with it, not very well, hoping they get enough of the private insurance people who pay a little better that they can keep going or looking for other people to pay those bills. Studies have shown the average primary care physician loses 80-some thousand dollars a year.

Mr. BARTLETT. Dr. Heim.

Dr. HEIM. There are a few things that I think we can look to for models. One is in North Carolina we have the North Carolina Community Care, which actually is built around Medicaid patients right now, and as you said, you lose money on your Medicaid patients. And so simply filling up your practice usually with Medicaid, like any small business knows, that volume doesn't work when each time you lose more money. But in the North Carolina, the Community Care, what they have done is it is a patient-centered medical home model, and the State has paid the primary care physicians an additional payment per Medicaid payment in order to coordinate the care specifically across certain disease States. What that has done is it has increased the payment for the primary care physician to a point that they can afford to not only see these patients, but do the coordination of care, and, in fact, to save the State over 250 billion in the length of the program.

The other thing that I agree, I think what we are seeing is a change in primary care practices. They are starting to do more procedures, which is not what we want, because the system has driven people to simply do more things, rather than looking at health outcomes. And we have also seen that there are a lot of our members who are now selling out their practices and starting to work for hospital systems, or they are starting to leave and go into other practices.

Dr. HARBAUGH. I would like to point out that I think not only primary care physicians practice preventive care. Much of what I do is preventive care. The patient with the symptomatic carotid stenosis who is at risk of stroke, there is a very effective surgical intervention to prevent a stroke and all of the costs that go with

that. The patient with the unruptured intercranial aneurysm who is at risk of a devastating hemorrhage, if that aneurysm is fixed before the hemorrhage occurs, that saves an immense amount of cost in the system. And as I have mentioned briefly in my system, I think there are neurosurgical procedures just around the corner that would offer a minimally invasive and effective treatment for things like addiction, And that means addiction to tobacco and alcohol and et cetera, and obesity. And that would be a neurosurgical example of very effective preventive care that could save immense amounts of money.

So when we talk about prevention, let us be clear that many of us practice preventive medicine, even if we are surgical specialists.

Dr. SHELDON. I was going to comment that colonoscopy and early removal of polyps has a great impact on lowering colon cancer mortality, which has already seen progress since that has become more common.

Similarly, one of the differences that the United States has led the world in is frequency of mammograms. Instead of diagnosing a breast cancer at Stage 3, we are getting it at Stage 1.

As far as programs that have been authorized by Congress, they have a program in our State that has also been very effective in helping with some of these things and making access good.

Chairwoman VELÁZQUEZ. Time has expired. Let me take this opportunity to thank all of you for taking time to be here today. This is a very important issue, and there is no doubt in my mind that, as you stated, each one of you, you know, there are—most medical practices are small businesses, and that is why we wanted to hold this hearing today.

The House will be introducing its health care reform bill this week, and it is expected to be marked up next week. I have been meeting with some of the leaders dealing with the committee of jurisdictions discussing some of the important issues related to health care reform with small businesses. The shortage of physicians is a very important issue. There is no way that we can accomplish the goal of health care reform without addressing this important issue.

So with that, let me say that I ask unanimous consent that Members will have 5 days to submit a statement and supporting materials for the record. Without objection, so ordered.

Chairwoman VELÁZQUEZ. This hearing is now adjourned. Thank you.

[Whereupon, at 10:55 a.m., the Committee was adjourned.]

NYDIA M. VELAZQUEZ, NEW YORK
CHAIRWOMAN

SAM GRAVES, MISSOURI
RANKING MEMBER

Congress of the United States

U.S. House of Representatives

Committee on Small Business

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STATEMENT

Of the Honorable Nydia M. Velázquez, Chairwoman

United States House of Representatives, Committee on Small Business

Full Committee Hearing: *"The Looming Challenge for Small Medical Practices: The Projected Physician Shortage and How Health Care Reforms Can Address the Problem"*

Wednesday, July 8, 2009

American health care is a complex system. To properly function, it requires a myriad of interworking components, from hospital infrastructure to insurance companies and drug researchers. But the most critical element cannot be built or tested in a laboratory—it is the men and women who make the system run. General practitioners are the backbone of the medical field. They offer basic care, and are responsible for half of all patient visits. But in many parts of the country, these small business practices are becoming an endangered species.

Today, we will examine the current physician workforce shortage, and discuss its potential impact on health care reform. This issue is of particular concern to our committee, and not just because most general practices are small firms. For one, it affects doctors in all areas—from surgeons to pediatricians. Physician shortfalls also hinder our efforts to control costs for entrepreneurs, and have the potential to undermine our work towards universal coverage.

In overhauling health care, we are looking to provide coverage that is both affordable and accessible. But we can't do that without the necessary workforce. In the last decade, the availability of doctors has dropped off considerably—even for those with gold-plated policies. If current trends continue, the gap between supply and demand may reach 125,000 by 2025.

Fewer physicians mean longer lines in waiting rooms, greater difficulty scheduling appointments, and less time with the doctors themselves. These challenges are more than an inconvenience—some patients may choose to avoid checkups altogether. That would be a dangerous consequence, one that could blunt the benefits of universal coverage, and drive up costs overtime.

Primary care is preventative care, and an effective means for reigning in costs. That's because a person who gets regular checkups is less likely to develop serious conditions down the road. And considering that 75% of health care expenditures go towards treating chronic illnesses, primary care is critical.

The current physician shortage is already posing a significant threat to reform. Reform will bring more uninsured Americans into the fold, but it won't create more doctors to treat them. Take the 46 million newly insured, add in an aging baby boomer population, and you could very well have a recipe for disaster.

As with anything related to health care, there is no silver bullet solution. Still, a number of possible fixes are under consideration, including provisions to expand health services in underserved communities—the regions suffering most from the current shortage.

This body will soon take steps to transform our broken health care system. I think most of us will agree that it is about time. But in moving towards reform, we need to be sure our foundation is strong. It is critical that we have a solid pool of medical professionals to see the process through. Today, I hope we can look for ways to make that happen.

Opening Statement of
Ranking Member Sam Graves
House Committee on Small Business
"The Looming Challenge for Small Medical Practices: The Projected Physician Shortage and How Health Care Reforms Can Address the Problem"
July 8, 2009

Madam Chairwoman, thank you for calling this hearing on the supply of physicians in the United States. I want to extend a special thanks to the witnesses who have come to Washington to share their expertise on this subject, especially Dr. Bruce Kauk, a fellow Missourian from Gladstone.

A 2008 University of Missouri study found that the U.S. could face a shortage of up to 44,000 family physicians, general internists and general pediatricians in the next 20 years. Many of these professionals operate solo or small group practices – small businesses -- in underserved urban or rural areas, such as parts of my district in Missouri.

With our growing and aging population, there is increasing demand for health care services. And, there is a trend toward the coordinated and continuous care provided by primary care physicians and internists. However, during the past decade, the supply of generalist physicians has fallen by 22%, partly due to reliance on physician specialists, which makes our health care more expensive and less efficient. The decline in generalists continues as fewer medical students are choosing to practice in family care. In addition, there is evidence that physician assistants and nurse practitioners may also be choosing to "specialize" in fields such as cardiology or oncology.

According to the Government Accountability Office, conventional payment systems undervalue primary care compared to specialty care. There is a growing income gap between primary care physicians and specialists. Several physician organizations have

recommended altering compensation structures to encourage medical students to become generalists.

The Kaiser Family Foundation reported that in 2007, U.S. health care expenditures exceeded $7,026 per person. Yet surveys on satisfaction with health care are mixed. Some experts believe that there is an over-reliance on specialists, and that greater use of primary care providers and internists would lead to better outcomes at lower costs. These physicians focus on prevention, wellness, coordinated care, and chronic disease coordination. Studies show that these services can save money over the long term.

I want to add a final word about health care reform. I strongly oppose employer mandates and a government-run health system. These alternatives could cause as many as 120 million Americans to lose their current coverage, drive insurance companies out of the market, and require substantial tax increases on the small businesses we are depending on to create jobs. I hope Congress will consider these points during our debate. Again, thank you, Madam Chairwoman, for holding this hearing. I look forward to hearing from of our panel of experts, and yield back the balance of my time.

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Statement of

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on behalf of the

American Association of Neurological Surgeons

and the

Congress of Neurological Surgeons

before the

Committee on Small Business
U.S. House of Representatives

July 8, 2009

On the Subject of:

Physician Workforce Shortages

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Testimony of Robert E. Harbaugh, MD
Before the House Committee on Small Business
Hearing on "Physician Workforce Shortages"
Wednesday, July 8, 2009

Good morning Chairwoman Velazquez, Ranking Member Graves and members of the committee. Thank you for inviting me to appear today to discuss the current workforce shortage crisis that is facing surgical specialty medicine, specifically neurosurgical care.

My name is Bob Harbaugh and I am a practicing neurosurgeon, the Director of the Penn State Institute of the Neurosciences and Chair of the Penn State Department of Neurosurgery. I am here today on behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), organizations that represent nearly all neurosurgeons in the United States. I currently serve as the Chair of the AANS/CNS Washington Committee.

Workforce Problems -- Overview

Recently, a great deal of attention has been paid to the shortage of primary care physicians, but there has been relatively little attention paid to the equally acute shortage of surgeons. The Association of American Medical Colleges (AAMC) in its November 2008 report, *The Complexities of Physician Supply and Demand: Projections Through 2025,* estimates that with continued population growth and an aging population physician demand will outpace supply for the foreseeable future. They estimate a deficit of 124,000 physicians and the anticipated physician workforce shortage is nearly identical for primary care as it is for surgery, with a projected shortage of 46,000 in primary care and 41,000 in the surgical disciplines.

The Bureau of Health Professions has also cited significant workforce challenges across the surgical specialties. Between 2005 and 2020, the Bureau projects significant decreases in a number of surgical specialties. Over the same time, the Bureau projects that the number of primary care physicians will increase by 19 percent.

The Council on Graduate Medical Education (COGME), in its assessment of physician workforce, also reports that in "rural areas, there is a clear need for specialty care." The report goes on to say that though "primary care would be an essential area of medical service and training, subspecialty and surgical disciplines are also sorely needed in underserved areas."

At present, there are fewer than 3500 practicing board certified neurosurgeons in the United States, serving a population of more than 300 million people. As the population ages and more of our citizens face debilitating and life threatening neurological problems such as stroke, degenerative spine disease, Parkinson's and other movement disorders, and brain tumors, this supply-demand mismatch will become even more acute. The effectiveness of deep brain stimulation for treating movement disorders and obsessive-compulsive disorder makes it likely that there will soon be a minimally invasive, reversible and effective neurosurgical treatment for neurobehavioral disorders such as obesity and addiction. Because of the prevalence of these disorders, many more neurosurgeons will be needed to meet the demand for neurosurgical care. While we anticipate significant workforce shortages for neurosurgery in the future, there is also a current problem in certain subspecialty areas of neurosurgical practice – notably, pediatric and trauma-emergency neurosurgery.

Thus, while the AANS and CNS recognize the importance of ensuring an adequate primary care workforce, Congress' efforts must also strive to maintain access to vital specialty care, such as neurosurgery.

Shortages in Pediatric and Trauma-Emergency Neurosurgery

As noted above, neurosurgeon shortages are particularly acute in pediatric and trauma/emergency neurosurgery. As of March 2007, there were only 174 board certified pediatric neurosurgeons. And according to an analysis that was published in January 2009 in the *Journal of Neurosurgery*, within the next 10 years, 41.7 percent of the current pediatric neurosurgical workforce may be retired. On the supply side, fewer than 10 trainees enter pediatric neurosurgery fellowship training each year and at this rate there will only be an influx of 6 board certified pediatric neurosurgeons entering the workforce each year – far short of the necessary numbers to meet demand. The shortage of pediatric neurosurgeons is extremely problematic when it comes to treating pediatric emergencies. With trauma being the number one killer of children under the age of 14, the limited number of pediatric neurosurgeons available to take trauma call is of great concern. This is further exacerbated given the fact that nearly one-fifth of all neurosurgeons are no longer treating pediatric neurosurgical emergencies.

Concerns related to a shortage of neurosurgeons to provide neurosurgical emergency and trauma care is not restricted to the pediatric population. Closure of trauma centers in Pennsylvania, West Virginia, Missouri, and Florida were due, in part, to shortages of neurosurgeons. Other hospitals have been in jeopardy of losing accreditation because of an insufficient number of neurosurgeons to cover emergency/trauma calls. The National Foundation for Trauma Care reports that after trauma surgeons, neurosurgeons are the specialists with the highest percentage of trauma care. According to this same report, physician shortages caused by a variety of factors, including medical liability expense and decreasing reimbursement, represent one of the major reasons for the closure of trauma centers. With estimates that 10 to 20 percent of the nation's 600 regional trauma centers may be forced to close within 3 years, it appears that neurosurgeon shortages are affecting the availability of trauma care in the United States.

Surveys conducted by the AANS and CNS confirm a lack of neurosurgical emergency call coverage at many hospitals throughout the country. While 93 percent of all neurosurgeons provide some emergency call coverage, only 83 percent report providing such coverage 24 hours per day, 7 days per week, 365 days per year. Furthermore, those neurosurgeons providing emergency care are doing so at more than one hospital at a time, leaving critical coverage gaps and more of nation's citizens at risk of delayed care for neurosurgical emergencies such as head and spinal cord injury, cerebral hemorrhages, and ruptured intracranial aneurysms..

In 2006 the Institute of Medicine released its report series on the *Future of Emergency Care in the United States Health System.* This report found that, among other things, hospital emergency departments and trauma centers across the country are severely overcrowded and neurosurgical specialists are often unavailable to provide emergency and trauma care. To alleviate this situation, and improve the emergency care and trauma workforce, the IOM called for an overhaul of our emergency and trauma care. In this report, the IOM suggested that regionalizing our emergency health care system would allow for a more appropriate distribution of neurosurgeons to help compensate for workforce shortages.

Contributing Factors to the Shortage – Medical Liability, Reimbursement and Lifestyle

While there are many complex factors that lead medical students to select one medical specialty over another, we can clearly point to two principle reasons for shortages in the neurosurgical workforce – medical liability and a lack of reimbursement for pediatric and emergency care.

Medical Liability Reform

Neurosurgeons continue to face increased professional liability insurance costs. According to data recently submitted to the Centers for Medicare and Medicaid Services, the national average medical

liability premium for neurosurgeons is $81,882 (compared to approximately $15,000 for primary care specialties), and in some areas of the country, including New York, these costs approach $300,000 per year. In addition to the high price tag for insurance, given the high risk nature of the specialty, neurosurgeons are sued more often than other medical specialties. Indeed, at any given point in time, there is an active lawsuit pending against one-third of all neurosurgeons – and most of these are without merit. The medical liability crisis is diminishing the workforce available to take care of patients with neurosurgical emergencies. According to an AANS/CNS survey conducted a few years ago:

- **Neurosurgeons are no longer providing emergency and/or trauma care** and over 35 percent have limited the types of emergency and/or trauma cases that they treat, they have limited the hours that they serve on-call to hospital emergency departments, or they have stopped providing emergency and/or trauma call altogether.
- **Neurosurgeons are no Longer providing high-risk medical procedures** and 56 percent have changed the types of cases they treat because of rising medical liability insurance premiums and/or increased risk of suit. Of those limiting services, 71 percent no longer perform aneurysms, 23 percent no longer treat brain tumors, 75 percent no longer operate on children, and 34 percent no longer perform complex spine procedures. These patients are typically sent to academic medical centers for treatment, often requiring patients to travel great distances to receive neurosurgical care.
- **Neurosurgeons are no Longer treating certain patients** and 44 percent are limiting the types of patients that they treat. Medicare, Medicaid and uninsured patients now have greater difficulties in getting access to neurosurgical care.

Clearly these are alarming trends that need to be reversed and medical liability reform legislation would help address aspects of the physician workforce shortage. As President Obama has acknowledged, rising premiums are "forcing physicians to give up performing certain high-risk procedures, leaving patients without access to a full range of medical services" and he is "open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance" so as to "make the practice of medicine rewarding again."

Reimbursement

Over the past several years we have heard that poor reimbursement is contributing to the shortages of primary care physicians and more medical students are choosing higher paid specialties rather than primary care because of the perceived disparities in reimbursement. Well, primary care is not alone in facing these issues – reimbursement for neurosurgeons that treat children and take care of emergency/trauma cases also fails to adequately compensate these specialists, contributing to the manpower shortages in these neurosurgical subspecialties. In addition, steep decreases in reimbursement for the surgical specialties, coupled with lifestyle issues and medical liability concerns, may too be driving medical students away from many surgical disciplines.

Since the inception of the Medicare Physician Fee Schedule in 1992, there has been a considerable reimbursement shift among the medical specialties. This has resulted in significant increases for primary care physicians and significant decreases for all other specialties, particularly the surgical specialties. During the initial 5-year transition to the resource based relative value scale (RBRVS), on which the Medicare Physician Fee Schedule is based, Medicare reimbursement for primary care services increased by 35 percent, while reimbursement for some surgical specialties decreased by nearly 20 percent. Since the initial transition, these reimbursement trends have continued. Reimbursement for one of the most common service provided by primary care physicians – the established patient office visit – has increased by over 90 percent. In contrast, reimbursement for one of neurosurgery's most common spine procedures has decreased by 30 percent. These decreases to

surgical specialties' reimbursement come at the same time practice expenses and professional liability insurance premiums have exploded.

When it comes to reimbursement for pediatric and emergency neurosurgery, the situation is far worse. In the typical pediatric neurosurgical practice, 30 to 60 percent of the payer mix is Medicaid – which in most states pays far less than Medicare -- and another 10 to 15 percent is self-pay. Similarly, many patients with emergency neurosurgical conditions get their care through the hospital emergency department. Because the federal government mandates (through the Emergency Medical Treatment and Labor Act –EMTALA) that all patients with emergency medical conditions must be treated regardless of their ability to pay, those specialties – including neurosurgery – tend to see more patients who either are uninsured or underinsured. Reimbursement for these services is therefore untimely or nonexistent, which services as a major disincentive for neurosurgeons to provide pediatric and emergency/trauma neurosurgical services.

Lifestyle

The aforementioned AAMC report also predicts that physician practice and utilization patterns will be very different in the future. These differences include changes in work schedules -- with older physicians continuing to work more hours and younger physicians working fewer -- and a greater concern for lifestyle issues. Because of the intensity of neurosurgical practice, with its frequent emergencies requiring long hours of neurosurgical care, lifestyle issues also contribute to a shortage of available neurosurgeons. Ultimately, these factors could lead to fewer medical students choosing a neurosurgical career, thus exacerbating a shortage of neurosurgeons that already exists. In some areas of medicine physicians assistants and advanced practice nurses offer excellent care and can address a shortage of physicians (particularly in primary care), but there is no good substitute for a well trained neurosurgeon for patients with head and spine injuries, brain tumors, stroke, hydrocephalus and other neurosurgical emergencies.

Length of Residency Training

After graduating from medical school, a physician must train for a minimum of six years to complete neurosurgery resident training; although it takes many neurosurgeons 7 to 8 years to fully complete their residency and fellowship training. Presently, about 50 percent of neurosurgical training programs are 7 years in duration and about 50 percent of trainees, at the conclusion of resident training elect to obtain further subspecialty fellowship training. There are only 97 neurosurgical training programs in the United States, with the many programs training only one resident per year. Compounding this problem, in 2003, the Accreditation Council for Graduate Medical Education (ACGME) established an 80-hour work week for resident duty hours. Due to the time and intensity required to adequately train a neurosurgeon, restricting weekly work hours will not permit neurosurgery to shorten its length of training if we want to have well trained neurosurgeons.

Making physician workforce predictions is difficult. Past studies examining our nation's workforce needs have largely missed the mark. Therefore, Congress must exercise extreme caution when making significant policy changes that could influence the choices medical students make in selecting their medical specialty. This is especially important in the surgical field where it takes many, many years to adequately train a neurosurgeon. If fewer medical students choose neurosurgery as a profession, and the demand for neurosurgical services increases at its current pace, we simply will not be able to refill the neurosurgical coffers in a timely fashion, further aggravating future neurosurgical workforce shortages.

Conclusion

The convergence of declining reimbursement, rising practice costs, increasing liability premiums, more on-call time, higher caseloads and less time for non work related activities may deter young

physicians from making the extra sacrifices necessary to become a neurosurgeon. This is likely to exacerbate what are already acute problems with access to neurosurgical care. As the ratio of surgical specialists to U.S. population continues to decline, these problems will only worsen. This situation will be compounded by an aging surgical workforce, fewer medical students choosing a surgical career and a growing elderly population that will require more interventional, rather than primary care, services. Congress should therefore consider including the following in health care reform legislation:

- Establish a pediatric subspecialty scholarship and loan repayment program to encourage more physicians to choose pediatric neurosurgery and other pediatric subspecialties in short supply.

- Funding for demonstration programs to develop models for regionalizing emergency/trauma care.

- Medical liability reforms, including:

  - Studying alternatives to civil litigation, including: early disclosure and compensation offers; the administrative determination of compensation model; and health courts;
  - Providing medical liability protections for physicians who follow established evidence based practice guidelines;
  - Protections for physicians volunteering services in a disaster or local or national emergency situation; and
  - Provisions similar to those in place in California or Texas, which includes reasonable limits on noneconomic damages.

- Repealing Medicare's sustainable growth rate formula (SGR) and refraining from adopting payment policies that enhance reimbursement for primary care physicians at the budget neutral expense of specialty physician reimbursement.

- Preserve Medicare funding for graduate medical education, eliminate the cap on Medicare's support and refrain from redistributing any unused residency training slots to primary care only.

Thank you for this opportunity to speak with you today. I would be happy to answer any questions.

Statement
of the
American College of Surgeons

Presented by

George F. Sheldon, MD, FACS

before the
Committee on Small Business
United States House of Representatives

"The Looming Challenge for Small Medical Practices:
The Future Physician Shortage
And
How Health Care Reforms Can Address the Problem"

July 8, 2009

Chairwoman Velazquez, Ranking Member Graves, and Members of Committee, the American College of Surgeons (College) is grateful to you for holding this hearing on the challenges facing our nation's healthcare workforce. I am Dr. George Sheldon, and I am honored to represent the College, which includes more than 74,000 surgeons worldwide. I am currently Professor of Surgery and Social Medicine at the University of North Carolina-Chapel Hill. I also serve as the Director of the American College of Surgeons Health Policy Research Institute and am a member of the Institute of Medicine. I have also previously served as President of the College, Chair of the American Board of Surgery, and President of the American Surgical Association. In 1985, I was also appointed to serve as a charter member of the Council on Graduate Medical Education (COGME).

Surgery in the Context of Reform

Surgeons in the United States are responsible for over 30 million operations annually and are an essential part of modern health care. Last year, the College issued a comprehensive document that outlined principles for healthcare reform. As we are now at a period of intense focus on how this might be best done, we are honored to have the opportunity to offer our input and to contribute to today's discussion of the challenges facing our nation's healthcare workforce.

While we all are anxious to improve our healthcare system, it is important to note the benefits the current healthcare system has given us. I want to bring your attention to an editorial by Nobel laureate Gary Becker titled, "Longer Life was the Greatest Gift" (Business Week, Jan 31, 2000). Becker notes that we have almost doubled the life expectancy of Americans in the last 100 years. This is unprecedented in the history of human experience. While many things contribute to a healthy environment, a healthy population is a stable population. For example, it was a poor health care system that resulted in an unhealthy and unstable population in the former Soviet Union. It has been documented that this instability and the poor health of the Soviet population played a significant role in hastening the Soviet Union's ultimate collapse in 1991 (Notzon, FC, Komarov YM, Ermakov SP:Causes of Declining Life Expectancy in Russia. JAMA 1998: 279-793). In short, as we go through healthcare reform, it is important not to "throw the baby out with the bath water" and create a new system that undermines the great achievements of our health care system that have served to produce a more healthy and stable population. While there is certainly room to improve and areas that we must address, it is important that we build on what has worked and that we base our action on a clear understanding of what the true problems are and not what we may perceive them to be.

While the College appreciates the White House's attention to health care reform, we are concerned about the assumptions embodied in the June 2nd publication of the White House Council of Economic Advisors titled, "The Economic Case for Health Care Reform, in which they endorse the concept that a 30 percent reduction in health care costs can be achieved by addressing the issue of regional variations in spending and

doing so, in part, through the False Claims Act. This position is one that has been articulated by researchers at Dartmouth in the Dartmouth Atlas and in numerous other publications and forums as well. This position, however, is based on limited, focused data that relies only on Medicare and a set of arbitrary boundaries to assess costs and rates of activity. Moreover, it does not include total costs invested in the health care system by all payers, and it essentially attempts to mix apples and oranges when making comparisons between the health care expenditures of rural and urban areas. This Dartmouth position has led to a lively national debate, with contrary data being generated by respected investigators, such as Robert Berenson, M.D. of the Urban Institute, Thomas G. Ricketts, Ph.D. of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, and Richard A. Cooper, M.D. of the Wharton School of Business at the University of Pennsylvania. In short, the Dartmouth results have neither been replicated nor fully validated to the point that they ought to be used to set national public health policy, as was noted in a June 8, 2009 Wall Street Journal editorial. Many have articulated the belief that healthcare costs are extracting valuable funds from American industry and getting the costs under control will benefit our overall economy. While agreeing with that to a point, it is important to note that healthcare itself is an industry, and one in 55 people work in health care. In fact, it is the only part of our economy that has not lost jobs during the current recession.

We also are concerned at the seeming tunnel vision of many proposals that focus only on specialties that fall under the broad rubric of primary care. When considering primary care, it is important to remember that modern health care comprises a spectrum of providers of which physicians only comprise 7 percent of our nation's health care workforce. We support primary care and subscribe to the definition provided by the Institute of Medicine, which in 1992 properly defined primary care as a service and not a specialty. In other words, it is a needed service for all patients but one that can be provided by a spectrum of providers, including non-physician practitioners (Donaldson M, Yordy K, Vanselow N., eds. Defining Primary Care: An Interim Report, National Academy Press, 1994). The primary care physician, the internal medicine specialist, the family practitioner, the pediatrician, and the advanced practice nurse all have a spectrum of overlap in the primary care services they provide. In contrast, surgeons are uniquely qualified to provide necessary and life-saving procedures that no other professional, including other physicians and even other surgeons, can provide. For example, a general surgeon will do a spectrum of procedures but usually is not trained to do neurosurgery or more complex parts of other surgical fields. Even in our larger communities, a urologist and a neurosurgeon cannot cross cover for each other in urgent or elective procedures. In short, the needed services of surgeons, which account for an essential part of our healthcare system, are under great stress because there are more limited numbers of surgeons who are qualified to provide these services to patients.

The Surgical Workforce – A Growing Crisis

Today, we are here to discuss a crisis shortage of essential healthcare providers, including surgeons. My comments will largely focus on the largest surgical specialty, general surgery, but other surgical specialties including urology, orthopaedics, neurosurgery, and cardiothoracic surgery are also facing significant workforce challenges. In 1981, the American Board of Surgery provided certification for 1,047 general surgeons graduating from accredited training programs. In 2008, the American Board of Surgery certified 1,032. Today, there are approximately 4 percent fewer general surgeons than a decade ago, and this has translated to a 20 percent decline in the number of surgeons per population over the past ten years. Since 1981, the number of general surgeons completing residency has been almost constant, hovering around 1,000 graduates each year. In that same period of time, the population of the United States has increased by 25 million people each decade.

Critical access areas in rural America are rapidly losing general surgeons, as illustrated on the provided map. These areas encompass about 59 million people—approximately twenty percent of the American population. Surgical services are essential for small community hospitals in these areas. These hospitals rely on having surgical services for their financial health. Without surgical services, these hospitals often close, and as a result, obstetrical services, primary care services, and other important services often cease to be provided as well. Moreover, the small hospital is often the largest employer in the community, meaning that the closure of a hospital in small community leaves an economic vacuum that is not easily, if ever, filled. In addition, businesses, especially those of a high-tech nature, which might consider locating in smaller communities, rarely if ever choose a community where there are no identified healthcare services in the immediate area. In short, the general surgeon shortage not only has implications for the delivery of health care services but it also has implications for our local hospitals and economies as well. It is for these reasons that the shortage has reached crisis proportion, and, therefore, it would be a serious oversight in public policy not to use the opportunity before us now to address it.

Every specialty of surgery has fewer surgeons entering practice than twenty years ago (Dartmouth Atlas). All surgical specialties have an increasingly older profile with one third of all surgeons over 55 years of age. Some specialties, such as cardiothoracic surgery, are actually closing some of their training programs as the emphasis in American medical schools has shifted increasingly to primary care. These trends are complicated by the fact that the services provided by surgeons cannot be replicated by other health providers. For example, in emergency services it is vital to have a general surgeon to deliver trauma care. To ensure that surgeons are trained to provide this essential, life-saving care, and to ensure that surgeons have the support they need, the American College of Surgeons has established the Trauma Verification Program. This has provided a strong safety net, which was not present even twenty-five years ago. It relies on a spectrum of providers, from ambulance drivers, emergency medical technicians, emergency room physicians, and others. The critical element of the program is the leadership, most often provided by a general surgeon, who brings in a

spectrum of involved specialists in other branches of surgery, such as neurosurgery and orthopaedics, to meet the needs of patients.

Trauma remains the most common cause of death for Americans under the age of forty and the fourth highest overall. Trauma is responsible for the most years of potential productive life lost (YPPL). Studies show that when optimal trauma care is available, 25 percent of trauma-related deaths can be avoided.

Cardiac disease is the most common cause of death overall. Great progress has been made with mortality from heart disease, which is now half of what it was in 1950. The paradox of its remaining the most common killer is that medical and surgical interventions have allowed the patient with acute cardiac disease to be treated effectively and often live fifteen to twenty-five or thirty years of productive life after an acute event. In spite of these added years of life, patients often will still succumb to heart disease, but of a different mechanism. Unfortunately, the ability to continue extending heart disease patients' lives could be complicated by the fact that we are now not only dreadfully short of cardiothoracic surgeons needed, but we also lack the needed numbers of cardiothoracic surgeons in training as well.

The second most common cause of death, cancer, relies heavily on surgery for the diagnosis and therapy. In fact, nearly eighty percent of all cancers that are cured are done so by the intervention of surgery. Cancer care most often requires a team approach in which surgeons, medical oncologists, and a variety of other health providers pool their skills and devise a plan that involves surgery, adjunct therapy, and other interventions. Survival rates for breast cancer, colon cancer, and other cancers are higher in the United States than in any other country in the world (OECD data). These are but a few examples of how surgical and medical specialists have helped create a healthier and stronger America.

Surgery's Unique Challenges

The long-term outlook for surgery brings added stress to the surgical profession which contributes yet another factor for fewer medical students and residents to choose a career in surgery. Unlike many other medical specialties, there are no good substitutes or physician extenders for a well-trained general surgeon or surgical specialist. Moreover, surgical training is vastly different from other physician training programs. Mastery in surgery requires extensive and immersive experiences that extend over a substantial period of time. Whereas non-surgical residencies can be completed in as few as three years, surgical residencies require a minimum of five years and often several more for specialties such as cardiothoracic surgery. Of course, the rigor of a surgical residency is certainly not for everyone: the work hours, sleep cycles, and intensity fit a surgical resident's personality much in the same way dermatology, internal medicine or pediatrics fits another. However, the prospects of declining payment coupled with rising practice costs; increasing liability premiums and the escalating threat of lawsuits; a diminishing workforce leading to more on-call time, higher caseloads, and

less time for patient care; and an uncertain future for the U.S. health care system—all of these factors understandably deter would-be surgeons from making the extra sacrifices necessary to become a surgeon.

The decrease in the numbers of general surgeons most directly impacts the 54 million Americans who are cared for in small and rural hospitals. While some of the rural workforce challenges relate directly to the difficulty in recruiting surgeons to those areas, some are also the result of a lack of workforce reinforcement. For instance, the level of on-call time is greatest in rural areas; in some cases, general surgeons are forced to take call 24 hours a day, 7 days a week. Needless to say, after spending several intensive years in residency, such a requirement may not, understandably, be an attractive one for a surgeon who has likely already sacrificed several years of family time during training. In addition, because of economic and other forces beyond their control, older surgeons in rural areas know that retirement or a less stringent workload may be further off than planned. Surgeons in rural areas also have a lower day-to-day volume of the types of procedures they are expected to perform at any given moment, making them less confident about the quality of care they will be able to provide and adding to liability concerns. For those who stay in rural areas, these issues are of great worry, and many surgeons are choosing to leave rural areas for the relative professional security of a more populated place to practice.

Solutions—Preserving and Improving Access to Surgical Care

The American College of Surgeons has developed several proposed measures and would be open to other solutions that improve patient access to surgical care and ensure the needed surgical workforce in the future. Foremost is the need to support the residency programs that already exist and to promote the development of additional residency programs as well, particularly in rural areas. In addition, it is important to develop appropriate supports and incentives for medical students who are interested in pursuing a surgical career while also eliminating the disincentives that push medical students away from the surgical profession. To this end, the American College of Surgeons would encourage the Congress to strongly consider the following policy options:

- Preserve Medicare funding for graduate medical education (GME) and eliminate the residency funding caps.
- Fully fund residency programs through at least the initial board eligibility.
- Include surgeons under the Title VII health professions programs, including the National Health Service Corps (NHSC) program, making them eligible for scholarships and loan assistance in return for commitment to generalist practice following training.
- Alleviate the burden of medical school debt and promote rural/underserved care through loan forgiveness programs that stipulate work in rural/underserved areas.

- Extend medical school loan deferment to the full length of residency training for surgeons.
- Allow young surgeons who qualify for the Economic Hardship Deferment to utilize this option beyond the current limit of three years into residency.
- Increase the aggregate combined Stafford loan limit for health professions students.

Two pieces of legislation have been introduced that are consistent with our proposed solutions. While our preference would be to lift the present caps in GME funding entirely, the College supports the "Resident Physician Shortage Reduction Act of 2009" (H.R. 2251), which has been introduced by Rep. Joe Crowley (D-NY) and would take an important step of addressing physician workforce shortages by raising the number of Medicare-funded residency slots by 15 percent over current levels. The College also supports the "Access to Frontline Health Care Act of 2009" (H.R. 2891), which has been introduced by Rep. Bruce Braley (D-IA), that would offer loan repayments to relieve some of the staggering debt burden faced by many health professionals, including general surgeons, ophthalmologists, and otolaryngologists, that are in short supply but high demand in underserved areas. This assistance would allow surgeons in these specialties who are motivated to care for underserved communities to enter and complete training that might otherwise be unaffordable to them. The loan repayment would free them to take a career path that may be less lucrative, but more satisfying. Communities identified as "frontline shortage areas" would gain access to needed health care services that could continue after the minimum time commitment has ended.

In addition, the American College of Surgeons also supports legislation that seeks to increase the number of residency training programs. At present, most residency training programs exist in or near major metropolitan cities. While the current programs continue to excel at producing high quality surgeons, they do not adequately distribute surgeons to communities across the nation. A major obstacle often preventing the establishment of new residency training programs are the costs associated with the creation of such programs. The Physician Workforce and Graduate Medical Education Enhancement Act (H.R. 914), which was introduced by Representative Michael Burgess, MD (R-TX) and Representative Gene Green (D-TX), would establish an interest-free loan program where hospitals committed to starting new residency training programs in one or a combination of seven medical specialties, including general surgery, could secure start-up funding to offset the initial costs of starting such programs. By providing a greater number of residency training programs in previously underserved areas, the surgical workforce shortage could be reduced for many states. In addition to the measures previously discussed, the American College of Surgeons believes this legislation would be an appropriate step toward addressing the workforce challenges we are witnessing in rural areas. The American College of Surgeons will continue to support this and other legislation that helps ensure patient access to surgical care.

Surgeons complete their training and enter their profession with full knowledge that certain requirements will be made upon their time and family life, and this includes

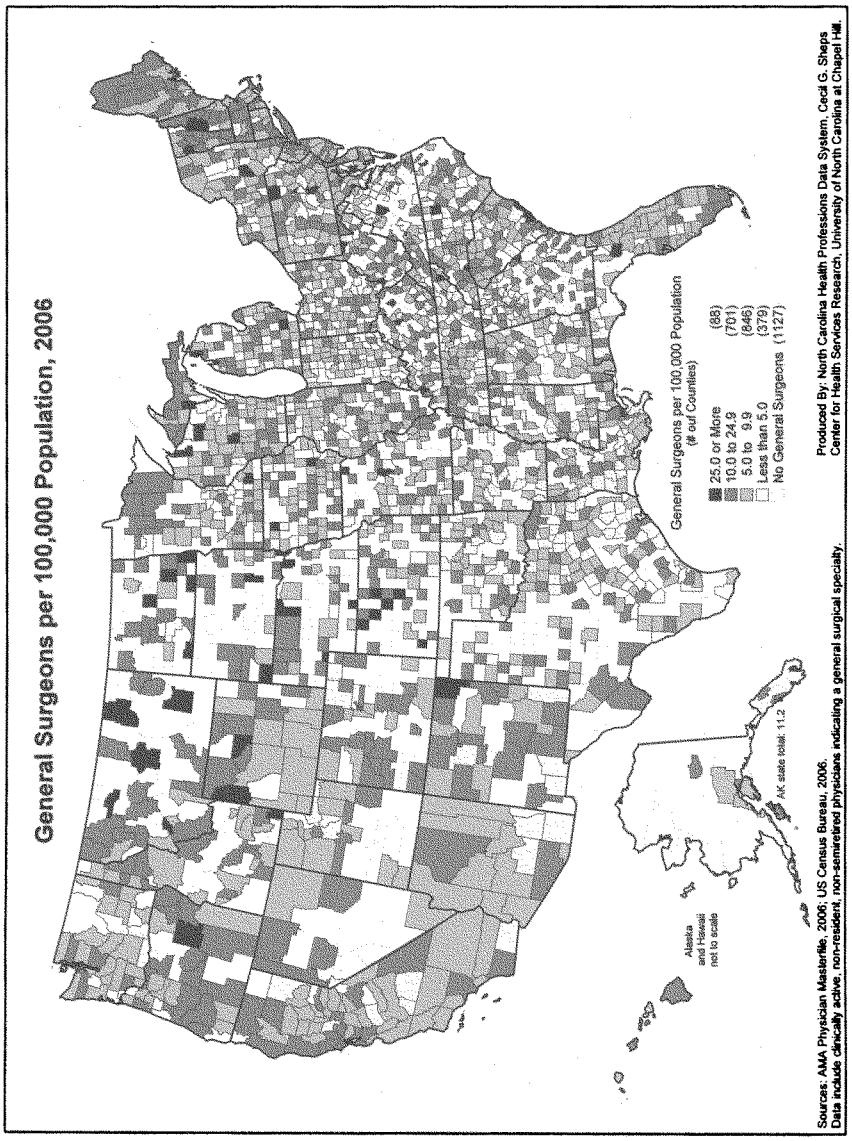
serving on on-call panels for emergency and trauma care situations. Yet, as has been already noted, there are structures and disincentives within our current health care system that complicate this task and complicate surgeons' ability to provide the emergency and on-call services on which all Americans depend. In addition, these on-call responsibilities can be particularly significant in rural and lesser populated areas, further complicating efforts to recruit surgeons to these areas. To support these surgeons' commitment to provide emergency surgical care, particularly in rural areas, and to help avert an emergency surgical workforce crisis, the College encourages consideration of the following measures:

- Include surgeons in bonus payment structures for health professional shortage areas.
- Allow surgeons access to Medicare's disproportionate share program, currently restricted to hospitals, when they operate on patients they see in the emergency department (ED) or as a result of care provided under the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).
- Provide tax relief to surgeons who perform EMTALA-related care. This could be based on overhead costs as related to the Medicare physician fee schedule.
- Adjust Medicare practice expense pools for each specialty to account for uncompensated care related to ED or EMTALA-related care as is done for emergency medicine.
- When hospitals pay stipends to surgeons who take emergency call, Medicare should recognize these costs as is currently done for critical access hospitals.
- Provide liability reform for surgeons who perform EMTALA-related care.
- Expand the Federal Tort Claims Act to include surgeons who provide services to patients who are referred through their primary care physician at a community health center.

Finally, the most immediate challenge for patient access to surgical care is the precarious payment situation confronting surgeons and surgical practices. Medicare payments to physicians will be cut 21.5 percent on January 1, 2010 if Congress does not act. The American College of Surgeons calls on Congress to take action to stop this cut, to provide an increase in Medicare payments for all physicians in 2010, and to initiate reform for Medicare's physician payment system this year. The College greatly appreciated Congress's passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) last July that reversed the 10.6 percent cut in Medicare physician payments. In addition, MIPPA included the largest Medicare payment increase for physicians since 2005 by replacing a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase this past January. MIPPA also made changes to how physician work was valued under Medicare, increasing payments for some surgical services. In spite of these important measures, Medicare payments for many surgical procedures have been reduced significantly over the past twenty years and, in some cases, they have been cut by more than half from reimbursement levels in the late

1980's. In spite of these payment trends and the workforce challenges just outlined, some, most notably the Medicare Payment Advisory Commission (MedPAC), have proposed financing increased reimbursement for primary care by simply cutting reimbursement for care provided by other physician specialties. Such proposals, while seeking to promote efforts to help Americans better manage their care, would further exacerbate the workforce challenges previously described and ironically establish a reimbursement structure that would ultimately undermine patients' ability to access the life-saving acute care services that only surgeons are qualified to provide. After all, increasing Americans' access to health insurance coverage will have little value if Americans cannot obtain the care they need from the appropriate physician. As a result, it is critical that Congress take steps now to ensure a stable surgical and a stable physician workforce for all Americans for years to come. The College supports efforts to prevent disease and to manage patient care not only because it is in the best interests of the patient and health care system but also because, when these patients need surgery, they are much less likely to encounter complications and much more likely to recover quickly from the operation. However, regardless of how well patients' care is managed, acute situations requiring prompt and definitive access to surgical care will continue to occur.

Thank you for the opportunity to testify regarding these important challenges facing our nation's surgical workforce. The College remains committed to enacting reforms that preserve and further patient access to surgical care and to the range of important services provided by our colleagues in medicine. The College looks forward to working with you and with the Congress to enacting measures to address the surgical workforce crisis. This includes stopping the pending Medicare payment cut and initiating much needed reforms of Medicare's payment system this year. The American College of Surgeons stands ready to work with you to ensure that all Americans will continue have access to the comprehensive health care services that America's surgeons and physicians provide.


General Surgeons per 100,000 Population, 2006
General Surgeons per 100,000 Population
(# out Counties)
25.0 or More (88)
10.0 to 24.9 (701)
5.0 to 9.9 (846)
Less than 5.0 (379)
No General Surgeons (1127)
AK state total: 11.2
Alaska and Hawaii not to scale
Sources: AMA Physician Masterfile, 2006; US Census Bureau, 2006.
Data include clinically active, non-resident, non-semiretired physicians indicating a general surgical specialty.
Produced By: North Carolina Health Professions Data System, Cecil G. Sheps
Center for Health Services Research, University of North Carolina at Chapel Hill.

AMERICAN OSTEOPATHIC ASSOCIATION

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Statement of Carlo DiMarco, DO
President, American Osteopathic Association

Presented to the
Committee on Small Business
U.S. House of Representatives
July 8, 2009

The Looming Challenge for Small Medical Practices:
The Future Physician Shortage and How Health Care Reforms Can Address the Problem

Chairwoman Velazquez, Ranking Member Graves, Representative Dahlkemper and members of the Committee, thank you for the opportunity to testify before you today. As President of the American Osteopathic Association, which represents 67,000 osteopathic physicians across the country, and as Professor and Regional Dean at the Lake Erie College of Osteopathic Medicine or "LECOM" in Erie, Pennsylvania, I have witnessed first hand the challenges of addressing our nation's physician workforce shortage, particularly in the field of primary care.

LECOM's mission is to prepare health care professionals trained in the osteopathic tradition of competent and compassionate, whole-person primary care. The number of LECOM graduates who pursue careers in primary care, at 67 percent, places LECOM at eighth in the nation for training family physicians and other primary care specialists. Consistent with the osteopathic profession's commitment to rural and underserved communities, LECOM and other colleges of osteopathic medicine are located in regions that historically have had limited access to physician services.

Despite the strong commitment of our leadership and students to primary care, the challenges facing this profession are increasingly prohibitive. From graduate medical education to an inequitable and broken physician payment system, disincentives prevail.

Studies indicate that income disparities have a significant negative impact on the choice of primary care over subspecialties in which incomes are nearly three times that of a primary care physician. This trend can only exacerbate the shortage of primary care physicians, which the Health Resources and Services Administration predicts could exceed 40,000 by 2025.

The instability of the physician payment system stemming from the flawed sustainable growth rate formula (SGR) results in the threat of annual cuts triggered by the SGR. This unpredictability forces small primary care practices with limited revenues and narrow margins to make difficult decisions about whether to lay off staff, reduce their Medicare patient population, defer investments or opt for early retirement. We believe that a comprehensive overhaul of the payment system to accurately reflect the cost and value of providing care is essential to maintaining our existing workforce and community-based health care delivery system.

In addition, we urge Congress to enact immediate financial incentives for primary care physicians by providing a bonus of at least 10 percent for primary care services in 2010 with a mandate for annual increases to achieve market competitiveness.

Measures of professional satisfaction among primary care physicians indicate an increasingly dismal practice environment. While physicians in all specialties face unnecessary and costly administrative hassles, the burden on primary care physicians in small practices is particularly excessive, detracting

from the time available for patient care. Primary care physicians' role in coordinating care and making needed referrals to specialists typically involves frequent interaction with managed care organizations and other third-party payers to obtain required approvals, services, and payment, resulting in paperwork and overhead expenses almost twice as great as those of other physicians. A typical primary care physician must coordinate care for Medicare patients with 229 other physicians working in 117 different offices, yet receives no compensation for these care coordination services. As a result, the average primary care physician spends only 55% of his or her workday on face-to-face patient care.

The physician payment system today places more value on the volume of services than on prevention and the coordination of care that can lead to better outcomes. The AOA seeks to reform this model and encourages Congress to support efforts to adopt the patient-centered medical home. This model would provide additional reimbursement and potentially reduce administrative burdens for practices that have the infrastructure and capability to provide patient-centered, physician-guided, coordinated, comprehensive, and longitudinal care.

Practices that organize to deliver patient-centered care through the medical home model should be paid a monthly, risk-adjusted care management fee for each eligible patient, fee-for-service payment for face-to-face encounters with patients and performance-based payments for reporting on quality, patient satisfaction, and efficiency metrics. The total payments for the patient-centered medical home must be high enough to fully cover the costs and result in an overall and substantial gain in net revenue to primary care physicians in such practices. Total compensation for PCMH should support the goals of making primary care more attractive, thereby bolstering the workforce.

Our nation's graduate medical education system also plays a central role in deterring young physicians from entering the field. The average osteopathic medical school graduate has a debt load of $168,031 which, as you can imagine, makes the prospect of opening a small practice extremely daunting. To reach medical students early in the pipeline, Congress should examine options for targeted scholarship, loan deferment and loan forgiveness programs to encourage medical school graduates to invest in new small primary care practices that so many communities are lacking.

Reforms to the GME training system are also an essential component of workforce development. Research has shown that physicians who are trained in community health centers, for example, are twice as likely to work in underserved settings and four times more likely to work in health centers after completing their residency. However, qualitative assessments reveal that the affiliation between health centers and primary care residency programs is hindered by financial and administrative barriers.

Currently, the time residents spend training in non-hospital settings can be counted as long as the hospital pays "all or substantially all" of the training costs at that site and the resident spends his or her time in patient care activities. Measures to provide greater flexibility for residency training programs should include a clarification of the meaning of "all or substantially all" to allow for the counting of patient care activities as long as the hospital continues to incur the costs of the stipends and fringe benefits of the resident during the time the resident spends training in the non-hospital setting.

We urge Congress to enact legislation that will create new training opportunities in non-hospital settings and clarify existing regulations governing non-hospital training. Under existing law, hospitals

often continue to incur the costs of the stipends and fringe benefits of the resident during this time, but are unable to recoup these costs through GME payments. Providing training opportunities in "real world" settings such as ambulatory care centers provides residents with exposure to primary care specialties and increases the likelihood that residents will choose to practice in these settings.

Today, one in five medical students in the United States is enrolled in a college of osteopathic medicine. By 2015, we project there will be over 90,000 practicing osteopathic physicians. We urge Congress to enact comprehensive reforms to GME and physician payment policies to facilitate their entry into the primary care workforce.

Again, thank you for this opportunity to testify.

AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Before the Committee on Small Business U.S. House of Representatives

Regarding "The Looming Challenge for Small Medical Practices: The Future Physician Shortage and How Health Care Reforms Can Address the Problem"

Presented By
Lori Heim, MD, FAAFP
President-elect
American Academy of Family Physicians

July 8, 2009 – 10:00 AM

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Thank you, Chairwoman Velazquez, Ranking Republican Graves, and members of the Small Business Committee. I am Lori Heim, MD, President-elect of the American Academy of Family Physicians which represents 94,600 members across the United States.

It is particularly exciting to be here before you today testifying on physician workforce needs anticipating the passage of health care reform. The AAFP has called for fundamental reform of the US health care system for two decades and is encouraged that Congress and the Administration are actively working toward a solution to this difficult national problem.

We consider an expanded primary care physician workforce essential to the success of the effort to provide affordable access to care for everyone in the United States. The AAFP supports a cohesive, comprehensive strategy to align our health care workforce with patients' needs within a reformed system.

Focus on Primary Care: Key to Reform
Currently, health care in the United States is an enterprise of uncoordinated, fragmented care that emphasizes intervention rather than prevention and comprehensive management of health. By rewarding volume rather than value, the current US health system fails to promote prevention and wellness and does little to encourage coordinated care and the management of chronic disease.

Primary care, the only form of health delivery charged with the comprehensive care of the whole person, is vital to health care reform. Primary care physicians are trained and skilled in comprehensive first contact and continuing care for people with any undiagnosed sign, symptom, or health concern not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Family physicians are uniquely qualified to provide the whole array of primary care including health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care and day care).

More Americans depend on family physicians than on any other medical specialty. Specifically, family physicians are the main source of primary health care for the Medicare population. Sixty percent of people aged 65 and older identify a family doctor as their usual source of health care. Rural and Hispanic seniors are more likely to identify a family physician as their usual source of health care. In addition, nearly one-half of the physicians who staff the nation's Community Health Centers are family physicians. Since 1971, the National Health Service Corps has placed more than 18,000 health care providers in underserved areas – almost half of the doctors were family physicians.

According to Dartmouth's Center for Evaluative Clinical Sciences, states which rely more on primary care have lower Medicare spending, lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor),

lower utilization rates (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians), and better quality of care (fewer ICU deaths and a higher composite quality score per beneficiary). (*The Dartmouth Atlas of Health Care*, 2006.)

We also know that other developed countries with a robust primary care workforce have population health outcomes that are better than those of the United States at lower costs. (*Health Affairs*. 15 March 2005.)

Uninsured Need Primary Care
It is particularly important that the health care system change fundamentally in order meet the needs of the uninsured. The number of uninsured people, approximately 45.7 million according to the US Bureau of the Census of 2007, is both sobering and unacceptable. While ensuring that all people in the US have health care coverage is essential for a healthier and more productive society, it is not sufficient to address issues of access, quality and cost.

Creating a primary care-based health care system is essential to improve access, quality and efficiency. Primary care has been shown to achieve better health outcomes, higher patient satisfaction, and more efficient use of resources. The AAFP believes that now is the time to design a primary care-based health care system to provide high quality, cost effective care for all.

Patient-Centered Medical Home
The American Academy of Family Physicians and others have promoted a new model of practice called the Patient-Centered Medical Home (PCMH) as the foundation for a reformed health care system based on primary care. The PCMH is a health care model that facilitates partnerships between patients, their personal health care team, and when appropriate, a patient's family.

The PCMH provides improved efficiency and health because it serves as a single source of access and care. As a result, duplication of tests and procedures and many emergency department visits and hospitalizations can be avoided. To achieve these efficiencies and quality improvements, AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association, representing approximately 333,000 physicians, developed joint principles on the characteristics of the PCMH.

PCMH Principles
- Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

- Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Primary Care Physician Shortages
Primary care has been described as the base of the health care pyramid. Unfortunately, the US physician workforce is made up of 31 percent primary care and 69 percent subspecialty. With our workforce pyramid upside down, it's little wonder that our health care system is teetering.

If we are to improve how health care is delivered, we must modernize workforce policies and training policies to ensure an adequate number of primary care physicians trained to practice in the comprehensive Patient-Centered Medical Home model of care which provides patients with access to preventive care and better coordination of the care needed to manage their chronic diseases as well as appropriate care for acute illness.

For people with chronic health conditions, the Robert Graham Center for Policy Studies in Family Medicine and Primary Care found that there are reductions in expenditures with no significant differences in self-rated health status when people have a family physician as their usual source of care (*Health Affairs* 28, no. 2 (2009)). For example, if the 21 million people with hypertension had a family physician or general internist as their usual source of care, it could save as much as $14.5 billion per year in health care expenditures. Patients with a primary care physician as their usual source of care have been shown to have lower costs for the same health outcomes.

To realize the benefits of the PCMH, we must have an adequate supply of primary care doctors, particularly family physicians. The AAFP supports the steps necessary to build the primary care workforce to at least 45 percent of all practicing physicians.

Unfortunately, the current supply is far from adequate. An imbalance of primary care and subspecialty physicians results in less effectiveness and less efficiency than could be achievable. Perhaps, more importantly, the trends for the future are not encouraging.

We have seen a troubling decline in the numbers of graduates from US medical schools choosing primary care. The annual National Resident Matching Program, known as the "Match," showed that medical students continue to demonstrate a preference for non-primary care specialties. In the 2009 Match, interest in family medicine among US medical students returned to its 10-year decline after a slight increase in 2008. In addition, US medical students' interest in two other primary care specialties also declined this year, with fewer US seniors choosing primary internal medicine and pediatrics. Even the students entering those specialties may go on to subspecialize rather than practice primary care.

This obviously raises concerns that when health reform legislation goes into effect, the primary care workforce will not be adequate to provide care to those newly insured. At the same time, we will increasingly struggle to meet the needs of an aging population with more prevalence of chronic disease.

Support for family medicine training programs is needed to address insufficient access to primary care services which is caused by both an overall shortage and an uneven distribution of physicians. Family medicine is a critical part of the solution to providing high-quality, affordable and accessible health care to everyone.

The AAFP's 2006 Family Physician Workforce Reform report called for a workforce of 139,531 family physicians, or a ratio of 41.6 family physicians per 100,000 US population by 2020. To meet that demand, our medical education system must produce 4,439 new family physicians annually. However, we produce an average of 3,400 new family doctors annually. In 2008, there were only 3,351 individuals who completed their family medicine training.

Solutions to Primary Care Physician Shortage
The reasons for the inadequate supply of primary care are many, and we must effectively address each one. The first and most critical step toward increasing the number of primary care physicians would be to improve payment for primary care. This will both encourage more interest in primary care and allow existing primary care practices to redesign their practices to improve quality and access.

Congress should also enact other means of providing incentives to medical students to select primary care and family medicine as their chosen specialty. For example, scholarships, loan forgiveness or other forms of debt relief, should be available for those who choose primary care. In addition, increased opportunities in programs such as the National Health Service Corps would help.

Additionally, Congress should reauthorize, revitalize and adequately fund health profession training grant programs and reform Graduate Medical Education payments to ensure that we are training the primary care physician workforce we need.

Title VII, Section 747 – Primary Care Health Professions Grants
For 40 years, the training programs authorized by Title VII of the *Public Health Services Act* evolved to meet our nation's health care workforce needs. Title VII, Section 747 of the Public Health Act provides support for health professions training which is critical to increasing the number of highly skilled primary care physicians needed for the success of health reform.

Title VII, Section 747 is the only federal program to support the development, training, education and faculty of family physicians, as well as other primary care physicians, dentists and physician assistants. Although our nation is facing an alarming shortage of primary care physicians, annual appropriations for Section 747 have steadily eroded since 2003.

The Title VII authorization has been allowed to lapse and these programs have been repeatedly targeted for elimination in Presidential budget requests. However, Congress has appropriated funds for these important activities. In fiscal year 2009, Section 747 received an appropriation of $48.43 million. Although the FY09 level was an increase of less than one percent over FY 2008, the *American Recovery and Reinvestment Act of 2009* provided for doubling that amount. The AAFP is grateful that the Congress and the Administration made that investment in primary care medicine training.

We also appreciate the President's FY 2010 budget request which called for an increase of 16.5 percent over FY09 for Title VII, Section 747. We also commend the President for requesting increases in other important Title VII programs to produce physicians from underrepresented minorities, or those whose graduates practice in underserved communities or serve rural and inner-city populations.

In a study published in the *Annals of Family Medicine* last fall, researchers at the AAFP's Robert Graham Center for Policy Studies Family Medicine and Primary Care found that Title VII, Section 747 grants help produce family physicians and other primary care physicians who work in community health centers and the National Health Service Corps, providing much-needed care in medically underserved areas (Annals of Family Medicine 6:397-405 2008).

Increasing the level of federal funding for primary care training would not only reinvigorate medical education, residency programs, and faculty development, but also prepare physicians to support the patient centered medical home model. In addition, Section 747 is crucial to prepare current and future primary care providers for their critical role in responding to demographic changes in the population, increased prevalence of chronic conditions, increased access to care, and a need for effective first-response strategies in instances of acts of terrorism or natural disasters.

National Health Service Corps
AAFP supports the health reform proposal to increase the National Health Service Corps (NHSC) which offers scholarship and loan repayment awards to primary care physicians, nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, certified nurse-midwives, and dental hygienists serving in underserved communities. We also recognize the value of offering NHSC participants the chance to participate in the program part-time.

Research has shown that student debt plays a complex yet important role in shaping career choices for medical students. The NHSC offers financial incentives for the recruitment and retention of family physicians to practice in underserved communities without adequate access to primary care. The AAFP supports the work of the NHSC toward the goal of full funding for the training of the health workforce and zero disparities in health care.

Modernizing Primary Care Graduate Medical Education
AAFP supports the expansion of primary care training positions and reversing the loss of training capacity over the last decade. The growth of subspecialty positions over the last decade cut the number of internal medicine graduates choosing primary care

careers in half. Finally, the modernization requires more training to occur outside of hospitals. The 1965 model of hospital-focused care training is out-dated. That's not where people get care today. We should be training residents in ambulatory primary care settings using the Patient-Centered Medical Home model of care.

We encourage Congress to include provisions necessary to achieve the desired goals which include adequate numbers of primary care physicians to meet the health care needs of all. If health care reform and coverage for all is to be successful, there must be a sufficient number of primary care physicians to care for the population. The Academy wants to help Congress guarantee coverage by ensuring adequate access to care.

To ensure an adequate primary care physician workforce, Congress should provide the necessary emphasis on primary care training which would include carving out and dedicating a funding stream that provides incentives to grow the numbers of practicing primary care physicians. The best way to do this is to modernize primary care graduate medical education by increasing accountability and responsiveness for same through the primary care residency programs.

Funding for physician training, especially primary care, should be derived from all payers, not Medicare and Medicaid alone. A modest contribution by private insurers of approximately $20 per insured per year would be sufficient to modernize and fund primary care GME. By directly funding primary care residency programs and holding them accountable for producing a workforce consistent with the population needs and other goals associated with health care reform, Congress will have taken responsible steps to ensure both care AND coverage.

The AAFP supports the demonstration project that would allow Direct GME funding to be directed to a federally qualified health center (FQHC) and would encourage the expansion of this demonstration to include residency programs and other nonhospital settings that develop and operate a primary care training program.

We also support:

- Redistribution of unused residency slots to primary care with accountability provisions to ensure that these slots do indeed create primary care physicians.
- Language intended to permanently resolve the volunteer preceptor issue and the didactic training issue.
- Preservation of residency slots from closed hospitals.

The AAFP also supports provisions that are directed toward increasing accountability of GME training programs as recommended by the Medicare Payment Advisory Commission. The study to be conducted by the Government Accountability Office on the evaluation of training programs, including whether programs have the appropriate faculty expertise to teach the topics required to achieve such goals is consistent with the goal of increased accountability and we hope will provide an assessment of the degree to which GME dollars are directed to and used by programs that are responsive to community need, especially in terms of meeting the primary care needs of current and future populations

Providing Medical Student Debt Relief
The AAFP has long-supported loan repayment and scholarship programs. Along with the other primary care organizations, we support establishing a loan repayment program, not to exceed $35,000 per year, for individuals agreeing to serve as physicians in general internal medicine, general pediatrics and family medicine in areas that are not Health Professional Shortage Areas, but that have a critical shortage of primary care physicians in such fields and excluding these repayments from an individual's gross income.

We strongly support the restoration of the economic hardship deferment of medical student debt known as the 20/220 pathway. The College Cost Reduction and Access Act (PL 110-84) eliminated the 20/220 debt to income ratio which had allowed medical students to defer payment without accruing interest on subsidized loans if their debt burden was greater than 20 percent of income and their income minus their debt burden is no grater than 220 percent of the Federal Poverty Level. Medical residents, particularly those entering primary care, need this relief in the face of high medical student debt.

Preparing the Personal Physician for Practice (P^4)
AAFP recognizes that changes in preparing the next generation of family physicians will be needed in undergraduate, graduate and continuing medical education. And we are not relying on the federal government alone to provide the additional resources which will be necessary to develop curricula and training programs which are comprehensive and innovative. Let me outline how family medicine is responding to this challenge.

The American Board of Family Medicine and the Association of Family Medicine Residency Directors are leading an initiative to stimulate innovation in family medicine education. The P^4 study (which stands for Preparing the Personal Physician for Practice) is a case study involving 14 residency programs which are experimenting with curriculum innovation. The goal of P^4 is to prepare family medicine resident-physicians for practice in a patient centered medical home. P^4 is studying innovations in the scope and content of residency training as well as the length, location and structure of training. The project also is looking at innovations in measurement of physician competency.

For example, one of the 14 experimenting residencies, Lehigh Valley Family Medicine Residency Program in Allentown, Pennsylvania, will eliminate the Family Medicine Center and move residents and continuity populations into active community practices. The Hendersonville Family Medicine Residency Program in North Carolina will place residents in a network of high-tech rural family medicine practices in place of their Family Medicine Center. Several other residency programs are offering innovative four-year curricula with varying areas of emphasis during the fourth year.

The P^4 study is now underway, but we have found that the regulatory and accreditation environment in both the clinical and the educational enterprises make change difficult.

CONCLUSION
Thank you for the opportunity to provide our thoughts on physician workforce and health reform. We acknowledge that reforming the health care system is a complex endeavor.

But, without meaningful reform, one fifth of our economy is projected to be health care costs within only 10 years. Currently, 47 million Americans are uninsured and scores more underinsured. Half of all bankruptcies in this country are caused by health care related debt and many of those who declare bankruptcy *do* have health insurance. Now is time to reform the system. We urge Congress to invest in the health care system we want, not the one we have.

Testimony of

Bruce A. Kauk, M.D.
Northland Internal Medicine
Gladstone, MO

Before the

House Committee on Small Business

"The Looming Challenge for Small Medical Practices: The Projected Physician Shortage and How Health Care Reforms Can Address the Problem"

July 8, 2009

Madam Chairwoman, Ranking Member Graves, Members of the Committee, I am Bruce Kauk, M.D., of Northland Internal Medicine in Gladstone, Missouri, where I practice with one partner and specialize in internal medicine. I am pleased to testify today on the issue of physician workforce needs as Congress considers health care reform issues.

A) Introduction: 30 year Practice Traditional Internal Medicine

B) Purpose of Testimony:

1) Traditional Primary Care Internist has been a small businessman.
2) Evolution of Internist.
3) Few-No Internists trained.
4) Employees 4-5 each.
5) Pay taxes.
6) Health Insurance.

C) Cause of Shortage:
- Reimbursement.
- Work hours.
- Quality of Life.
  - Alternate occupations available.
  - Comparison Medical peers.
  - Comparison non-medical peers.
  - Hours spent as gatekeeper for Durable Medical Equipment, Home Health, Oxygen, and scooter changes.

D) Repair Shortage

1) Rely on IMG???
2) Non MD providers?
3) Increase Medical students?
4) Equalize Reimbursement?
5) Retention of Existing?
6) Cannot afford computerization.

E) Emphasize Prevention

1) Limit need.
2) Reduce Costs.
3) Encourage Safeway Foods type plan.

Again, thank you for allowing me to testify today. I would be happy to answer any questions.

Statement for the Record

American College of Physicians

Hearing before the House Energy & Commerce Health Subcommittee

"Making Health Care Work for American Families: Improving Access to Care"

March 24, 2009

Thank you, Chairman Pallone and Ranking Member Deal, for allowing me to share the American College of Physicians (ACP's) views on the primary care workforce and how it affects access to care.

I am Jeffrey P. Harris, MD, FACP, the President of the American College of Physicians, a general internist for three decades, who worked as a Clinical Associate Professor of Medicine at the University of Virginia School of Medicine. Until very recently, I practiced in a small, rural town in Virginia with a population of 40,000 people. I am pleased to be able to represent the College today at this hearing.

The American College of Physicians represents 126,000 internal medicine physicians and medical students. ACP is also the nation's largest medical specialty society and its second largest physician membership organization.

We are experiencing a primary care shortage in this country, the likes of which we have not seen. The expected demand for primary care in the United States continues to grow exponentially while the nation's supply of primary care physicians dwindles and interest by U.S. medical graduates in primary care specialties steadily declines. The reasons behind this decline in primary care physician supply are multi-faceted and complex. Key factors include the rapid rise in medical education debt, decreased income potential for primary care physicians, failed payment policies, and increased burdens associated with the practice of primary care.

A strong primary care infrastructure is an essential part of any high-functioning healthcare system. In this country, primary care physicians provide 52 percent of all ambulatory care visits, 80 percent of patient visits for hypertension, and 69 percent of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce.[1,2] Those numbers are compelling, considering the fact that primary care is known to improve health outcomes, increase quality, and reduce healthcare costs.

The hallmarks of primary care medicine include: first contact care, continuity of care, comprehensive care and coordinated care. The two specialties that provide the majority of adult primary care in the U. S. are family medicine and internal medicine. The training and care that family physicians and general internists provide are distinctly

different. Family physicians are trained to diagnose and treat a wide variety of ailments in patients from children to old age. Family physicians receive a broad range of training that includes internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and geriatrics.[3] General internists, on the other hand, provide long-term, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults, and the elderly. Internists receive in-depth training in the diagnosis and treatment of conditions affecting all organ systems. As documented below, the declining supply of general internal medicine physicians is of particular importance to Medicare beneficiaries' access to care. In 2007, internists provided 229,131,238 allowed services to Medicare patients compared to 130,120,289 for family physicians and 17,780,062 for general practitioners." (Source: CMS).

Primary Care Workforce: The Problem

The U.S. is Facing an Escalating Shortage of Primary Care Physicians

There are many regions of the country that are currently experiencing shortages in primary care physicians. The Institute of Medicine (IOM) reports that it would take 16,261 additional primary care physicians to meet the need in currently underserved areas alone.

Demand for primary care physicians outpaces supply faster than any other specialty group. Specifically, the AAMC estimates that primary care accounts for 37 percent of the total projected shortage in 2025 – about 46,000 FTE primary care physicians.[4] These findings are consistent with recently published projections by researchers from the University of Missouri and the Health Resources Services Administration. The study also predicted that population growth and aging will increase family physicians' and general internists' workloads by 29 percent between 2005 and 2025.[5] Further, greater use of nurse practitioners (NPs) and physician assistants (PAs) are not expected to make enough of an impact on this shortfall.[6] Annual numbers of NP graduates fell from 8,200 in 1998 to 6,000 in 2005 and are projected to fall to 4,000 by 2015. In addition, only about 65 percent of NPs currently work in primary care settings. The number of PA graduates have remained stable at about 4,200 per year, but it is important to note that only one-third of PAs practice in primary care settings.[7]

ACP is particularly concerned about the adequacy of the supply of general internists who provide care in outpatient settings.

- General internists are leaving practice sooner than other physician specialties at the same time that fewer medical students and residents are choosing to make the practice of general internal medicine and primary care their central career goal. Approximately 21 percent of physicians who were board certified in the early 1990s have left internal medicine, compared to a 5 percent departure rate for internal medicine subspecialists.[8]

Equally alarming is the fact that the pipeline of incoming primary care physicians is also drying up, as medical students are drawn to more highly compensated specialties.

- In a survey of fourth-year medical students at eleven U.S. medical schools in the spring of 2007, 23.2 percent reported they were most likely to enter careers in internal medicine, including only 2.0 percent who reported that they were likely to enter careers in general internal medicine.[9] If this trend continues, a shortage of primary care physicians will likely develop more rapidly than many now anticipate.

- The number of third-year internal medicine residents choosing to pursue a career in an internal medicine subspecialty or other specialties has risen each year for the past eight years, while the percentage choosing careers in general internal medicine has steadily declined. In 2007, only 23 percent of third-year internal medicine residents intended to pursue careers in general internal medicine, down from 54 percent in 1998.[10]

- For each of the past two years, the number of U.S. medical students choosing internal medicine residencies has decreased by approximately 1 percent from the previous year. According to the 2009 National Resident Matching Program report, 2,632 U.S. seniors at medical schools enrolled in an internal medicine residency program -- down from 2,660 in 2008 and 2,680 in 2007. These numbers are particularly striking when compared with 3,884 U.S. medical school graduates who chose internal medicine residency programs in 1985,"said Steven E. Weinberger, MD, FACP, senior vice president for medical education and publishing, American College of Physicians (ACP), in response to the match results for 2009. "We are witnessing a generational shift from medical careers that specialize in preventive care, diagnostic evaluation, and long-term treatment of complex and chronic diseases, to specialties and subspecialties that provide specific procedures or a very limited focus of care."

- The 2009 match numbers include students who will ultimately specialize in general internal medicine and provide primary care, as well as those who will enter a subspecialty of internal medicine, such as cardiology or oncology. Currently, approximately 20 to 25 percent of internal medicine residents eventually choose to specialize in general internal medicine, compared with 54 percent in 1998. "This transition is happening at a time when America's aging population is increasing, and the demand for general internists and other primary care physicians will continue to grow at a much faster rate than the primary care physician supply," noted Dr. Weinberger.

Without more Primary Care Physicians, Expanded Health Insurance Coverage Will Not Ensure Access to Care

ACP strongly supports the need to provide all Americans with access to affordable health insurance coverage. We are committed to working with Congress and President Obama

to enact bipartisan legislation this year to achieve this goal, and would be please to share with the subcommittee ACP's specific recommendations on coverage.

We also know that health reforms to expand coverage will *fail* to improve outcomes and lower costs unless programs are created to reverse a growing shortage of primary care physicians:

- Persons who do not have access to health insurance coverage are less likely to have a physician as a regular source of care.[11] They are also less likely to comply with recommended treatments, to take their medications, and receive recommended preventive services. Accordingly, as more persons obtain health insurance coverage as a result of health care reform, they will appropriately seek to form a relationship with an internist, family physician, or pediatrician to serve as their regular source of care.

- Increases in the numbers of patients with chronic illnesses will accelerate the demand for primary care. According to *Health Affairs*, "In 2005, 133 million Americans were living with at least one chronic condition. In 2020, this number is expected to grow to 157 million ... Currently, most chronic illnesses care takes place in primary care physician practices ... Compared with specialist-only care, primary care offers high quality care at lower cost for patients with chronic conditions." The authors support the development of multidisciplinary teams in primary care and public health and recommend that the U.S. adopt the goal of "half of U.S. clinicians practice in primary care."[12]

- Most established primary care physicians are currently working at full capacity and will be unable to absorb the increased number of patient visits that will accompany coverage expansions. A rapid expansion of primary care capacity will accordingly be needed.

Patients will experience <u>reduced</u> access to care if health care reform does not expand the primary care physician workforce capacity at the same time as coverage is expanded:

- For the newly insured, there will be long wait times to get an appointment with a primary care physician, if they are able to find one at all.

- In a growing number of communities, it may become impossible for people who do not currently have a relationship with a primary care physician to find an internist, family physician or pediatrician who is taking new patients. Not because established primary care physicians do not want to accept the newly-insured into their practices, but because they have no time left in an already over-scheduled day to take on any additional patients.

- Patients of established primary care physicians who already are working at full capacity, but who still try to accept more of the newly insured into their practices,

will experience a reduction in the qualitative time their doctor is able to spend with them. Wait times for appointments will increase. Despite insurance coverage, without changes in the way care is provided, physicians may have to further decrease the time they currently spend with patients in order to try to accommodate increased demand for services – which could have a negative impact on quality, access, and timeliness. Primary care physician "burn out" is likely to increase because of physician dissatisfaction with not being able to spend enough time with their patients or being able to see them in a timely manner. Such burn outs will likely lead more primary care physicians to consider getting out of practice, which will then put further stress on remaining primary care physicians in their community.

- Massachusetts' experience is a case in point of what can happen if coverage is expanded without expanding the primary care workforce. When health insurance coverage was recently expanded to nearly 95 percent of the state's residents, some low income residents reported difficulty finding a physician or getting an appointment.[13] In fact, the wait to see primary care physicians in Massachusetts has reportedly grown to as long as 100 days.[14]

- The higher price tag associated with coverage expansions that do not concurrently address the need to rapidly expand primary care physician workforce will be borne by taxpayers and employers in the form of higher taxes and by increases in premiums and cost-sharing for persons who have health insurance coverage.

Primary Care is the Best Medicine for Better Care and Lower Cost

A fundamental goal of delivery system reform should be to recognize and support the value of primary care in improving outcomes; reducing preventable over-utilization of emergency rooms, hospitals and testing facilities; and achieving overall costs savings.

More than 100 studies, referenced in ACP's recent paper, *How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?*, demonstrate that primary care is consistently associated with better outcomes and lower costs of care. Highlights of that paper include:

- When compared with other developed countries, the United States ranked lowest in its primary care functions and lowest in health care outcomes, yet highest in health care spending.[15] [16] [17]

- Primary care has the potential to reduce costs while still maintaining quality.[18] [19] [20] [21] [22]

- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke.[23] [24]

- Individuals living in states with a higher ratio of primary care physicians to population are more likely to report good health than those living in states with a lower such ratio.[25]

- The supply of primary care physicians is also associated with an increase in life span.[26 27] An increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons.[28]

- Primary care physicians have also been shown to provide better preventive care compared to specialists, reflecting their ability to better manage the whole health of patients.[29 30 31]

- The preventive care that primary care physicians provide can help to reduce hospitalization rates.[32 33 34 35 36] During the year 2000, an estimated 5 million admissions to U.S. hospitals involved hospitalizations that may have been preventable with high quality primary and preventive care treatment; the resulting cost was more than $26.5 billion. Assuming an average cost of $5,300 per hospital admission, a 5 percent decrease in the rate of potentially avoidable hospitalizations alone could reduce inpatient costs by more than $1.3 billion.[37]

- Hospital admission rates for five of 16 ambulatory care-sensitive conditions "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease," increased between 1994 and 2003, suggesting worsening in ambulatory care access or quality for those conditions.[38 39] Studies of certain ambulatory care-sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.[40]

- One study found that an increase of 1 primary care physician per 10,000 population in a state was associated with a rise in that state's quality rank *and a reduction in overall spending by $684 per Medicare beneficiary.*[41] By comparison, an increase of 1 specialist per 10,000 people was estimated to result in a drop in overall quality rank of nearly 9 places and increase overall spending by $526 per Medicare beneficiary.

Solutions to Improving the Primary Care Workforce

1. ***ESTABLISH A NATIONAL HEALTH CARE WORKFORCE POLICY:*** The federal government should develop a national health care workforce policy that includes sufficient support to educate and train a supply of health professionals that meets the nation's health care needs and specifically to ensure an adequate supply and spectrum of primary care physicians trained to manage care for the whole patient. General internists, who provide long-term, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults, and the elderly, should be a crucial component of a high functioning primary care system.

Rationale:
In the U.S., the numbers and types of health care professionals being trained are largely determined by the availability of training programs, the number of applicants, and inpatient service needs of academic medical centers. But, institutional service needs are a poor indicator of national health workforce requirements, particularly as patient care has continued to shift from inpatient to outpatient settings. The nation needs sound research methodologies embedded in its workforce policy to determine the nation's current and future needs for appropriate numbers of physicians by specialty and geographic areas. The Council on Graduate Medical Education has made numerous calls on the federal government to establish of a national health care workforce policy, most recently in September 2007. In its December 2008 report, the Institute of Medicine did so as well, recommending that the Department of Health and Human Services, along with other public and private partners, "develop a comprehensive national strategy to assess and address current and projected gaps in the number, professional mix, geographical distribution, and diversity" of the health care workforce.

In June 2006, the AAMC recommended a 30 percent increase in U.S. medical school enrollment and an expansion of Graduate Medical Education (GME) positions to accommodate this growth.[42] The current Medicare GME-funding limits on residency training positions are impeding the establishment of new residency programs and additional training positions in existing programs. While medical schools have done their part to expand class sizes, this effort will not increase the total number of physicians in the country unless GME capacity is increased as well. ACP has considered the option of increasing the number of overall GME positions to increase the supply of physicians, but concluded that increasing the overall pool of physicians would not assure that adequate numbers enter and remain in practice in primary care. Instead, ACP recommends a more targeted approach, recognizing the nation's increasing demographic demands for health care and the dwindling supply of primary care physicians. ACP recommends strategically increasing the number of Medicare-funded GME positions in adult primary care specialties. For internal medicine, the College recommends that the positions be increased in IM- primary care positions rather than IM categorical positions.

With an estimated shortage of 44,000 – 46,000 primary care physicians anticipated by 2025, the federal government must act now to eliminate such a deficit. Since it takes 7 years to educate and train a primary care physician, this expansion of GME positions must start now to avert the predicted shortfall.

2. ***INVEST IN THE PRIMARY CARE PIPELINE***

Incentives for Medical Students: The federal government should create incentives for medical students to pursue careers in primary care and practice in areas of the nation with greatest need by developing or expanding programs that eliminate student debt for physicians choosing primary care linked to a reasonable service obligation in the field and creating incentives for these physicians to remain in underserved areas after completing their service obligation. This should include:

a. New loan repayment and medical school scholarship programs in exchange for primary care service in critical shortage health facilities and geographic areas.

b. Increase funding for scholarships and loan repayment programs under Title VII.

c. Increase funding for National Health Service Corps (NHSC) scholarships and loan repayment programs.

Rationale:
New loan repayment and scholarship programs: There are many health care facilities across the country facing shortages of primary care physicians. A Critical Shortage Health Facility is defined as a public or private nonprofit health facility that does not serve a health professional shortage area (HPSA), but has a critical shortage of primary care physicians. ACP proposes the establishment of scholarships (not to exceed $30,000 per year to a maximum of four years) in family practice, internal medicine and pediatrics through the Department of Health & Humans Services (HHS) that require graduates to practice in critical shortage health facilities for a minimum of two years and up to four years for each year that such scholarship is awarded.

The College also calls for the establishment of a loan repayment program to primary care physicians in the fields of family practice, internal medicine and pediatrics who agree to practice in an area of the country that is not a health professional shortage area (as designated under section 332), but has a critical shortage of primary care physicians (as determined by the Secretary) in such fields. A maximum of $35,000 per year in loan repayment (principal and interest) should be provided for each year of such service obligation.

These programs would require service in specific health facilities that are experiencing critical shortages of primary care physicians, or in a physician office or other facility in a geographic area of the country that is experiencing a critical primary care shortage. They offer an alternative option to service in HPSAs through National Health Service Corps (NHSC) and would offer a broader impact on increasing the primary care workforces as they would be limited to primary care physicians and would allow them to meet their service obligation in more areas of the country and in more facilities that are experiencing a critical primary care shortage. Since the NHSC requires that physicians practice in designated HPSAs, it excludes many areas of the country and facilities that are experiencing critical shortages.

Increase funding for Title VII: The Primary Care Loan (PCL) program awards funds to accredited schools for medical students who agree to enter and complete residency training in primary care within four years after graduation and practice in primary care for the life of the loan. Such loans can serve as a great incentive for medical students considering careers in primary care.

The Faculty Loan Repayment Program is designed to assist degree-trained health professionals from disadvantaged backgrounds in pursuing academic careers. Individuals selected agree to serve on the faculty of an accredited health professions college or university for a minimum of two years for payment of up to $20,000 of their educational loans. In FY 2004, this program received 148 applications, but only 43 were funded.

The Scholarships for Disadvantaged Students Programs provides scholarships to full-time, financially needy students from disadvantaged backgrounds, enrolled in health professions and nursing programs. In FY2008, the Scholarships for Disadvantaged Students program distributed $42.3 million in scholarship funds to 224 colleges and universities, ranging from $1,548 to $1,781,268; the average award was $189,121. Such scholarships help greatly in diversifying the health care workforce.

Increase funding for the National Health Service Corps: The NHSC scholarship and loan repayment programs provide payment toward tuition/fees or student loans in exchange for service in an underserved area. The programs are available for primary medical, oral, dental, and mental and behavioral professionals. Participation in the NHSC for 4 years or more greatly increases the likelihood that a physician will continue to work in an underserved area after leaving the program. Over the years, the number of clinicians in those programs has grown from 180 to over 4,000. In 2000, the NHSC conducted a large study of NHSC clinicians who had completed their service obligation up to 15 years before and found that 52 percent of those clinicians continued to serve the underserved in their practice.[43] The programs under NHSC have proven to make an impact in meeting the health care needs of the underserved, and with more appropriations, they can do more.

The NHSC estimates that nearly 50 million Americans currently live in health professions shortage areas (HPSAs) - underserved communities which lack adequate access to primary care services - and that 27,000 primary care professionals are needed to adequately serve the people living in HPSAs. Currently, over 4,000 NHSC clinicians are caring for nearly 4 million people.[44] The outstanding need remains unmet.

Limited funding has reduced new NHSC awards from 1,570 in FY 2003 to an estimated 947 in FY 2008, a nearly 40 percent decrease. The NHSC scholarship program already receives seven to fifteen applicants for every award available. The National Advisory Council on the National Health Service Corps has recommended that Congress double the appropriations for the NHSC to more than double its field strength to 10,000 primary care clinicians in underserved areas.[45]

Deferment of Medical School Loans: Congress should enact legislation to allow deferment of educational loans throughout the duration of training in primary care residency programs.

Rationale:
During residency training, physicians receive a stipend in acknowledgment of the patient care services they provide. However, medical residents receive far less income and

typically work many more hours per week (up to 80 hours) than their counterparts with postgraduate degrees in other professions. Loan repayment in residency makes it even more difficult for physicians-in-training to start or support a family and leaves little discretionary income for products that will advance physicians' professional development (conferences, journal subscriptions, etc.). By deferring payment of interest and principal on medical student loans until after completion of postgraduate training, residents will have increased funds necessary for professional development and more of an opportunity for a reasonable lifestyle. This will reduce financial pressure for residents to moonlight to supplement their income. It will also better enable young physicians who want to enter primary care careers to do so with less pressure to enter a more lucrative specialty in order to pay off their student debts.

3. *REFORM PAYMENTS TO SUPPORT PRIMARY CARE*

Make Payment to Primary Care Physicians Competitive with Other Specialty and Career Choices: Congress should enact Medicare payment reform so that the career choices of medical students and young physicians are largely unaffected by considerations of differences in earnings expectations. This will require immediate increases in Medicare fee-for-service payments to primary care physicians, starting in the current calendar year, followed by continued annual increases in payments for primary care physicians.

Rationale:
Medical students and young physicians should make career decisions based on their interests and skills, instead of being influenced to a great extent by differences in earnings expectations associated with each specialty. Yet there is extensive evidence that choice of specialty is greatly influenced by the under-valuation of primary care by Medicare and other payers compared to other specialties.

- A 2007 survey of the perception of fourth-year medical students pertaining to internal medicine, compared to other specialties they had chosen or considered, is telling. Respondents perceived internal medicine as having lower income potential while requiring more paperwork and a greater breadth of knowledge.[46]
- A recent study compared residency position fill-rates with average starting salaries by specialty and found that U.S. medical students tend to choose more highly compensated specialties. For example, the average starting salary for family medicine was $130,000 while the highest average starting salaries were in radiology and orthopedic surgery. In 2007, only 42.1 percent of first-year family medicine residency positions were filled by U.S. medical school graduates compared to 88.7 percent in radiology and 93.8 percent in orthopedic surgery.[47]
- A 2008 analysis found a strong direct correlation between higher overall salary and higher fill rates with U.S. graduates. [48]

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties.[49] This

compensation gap is contributing to a growing shortage of primary care physicians, and particularly primary care physicians in smaller practices.

To eliminate differential income as a critical factor in medical student/resident choice of specialty, the average net income for primary care physicians would need to be raised to be competitive with the average net income for all other specialties.

- The level of payment for services provided principally by primary care physicians must be increased to be competitive with other specialty and practice choices, taking into account any additional years of training associated with specialty training programs.

- A target goal for raising primary care reimbursement to make it competitive with other specialty and practice options should be established by the federal government based on, in part, an analysis of the current marketplace and the price sensitivity of physicians with respect to projected income and choice of specialty.

For instance, Medicare and all other payers would need to increase their payments to primary care physicians by 7.5-8 percent per year over a five-year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80 percent of those for all other specialties, all other factors being equal. Achieving 100 percent parity would require annual increases of 12-13 percent over five years.

Such market competitiveness targets could also be adjusted to take into account expansion of existing programs and development of new ones to reduce or eliminate student debt for physicians selecting primary care careers, so that the combined differential between debt and expected earnings is comparable to other specialty choices.

The Medicare Payment Advisory Commission (MedPAC) recommends that Medicare pay a bonus for primary care services furnished by physicians whose practices focus on primary care. While MedPAC would defer to Congress to determine the precise bonus payment amount, it identifies the 10 percent bonus currently paid for services furnished in health professional shortage areas and the 5 percent bonus that was previously provided for services in areas with a low physician-to-population ratio as a starting point for discussion. MedPAC initially made this recommendation in June 2008—when it devoted an entire chapter in its Report to Congress to "Promoting the Use of Primary Care"—and reiterated it in its March 2009 Report to Congress "to emphasize its importance." The MedPAC rationale for the bonus payment is that primary care services are undervalued and that physicians focused on furnishing primary care services cannot increase the frequency with which they furnish these services—as can be more readily done for tests and procedures—to increase their revenue.

ACP appreciates the MedPAC attention to the payment disparity problem. The MedPAC recommendation that the bonus payment not increase the overall amount that Medicare spends on physician services, however, deviates from the College's position that the

funding should not be restricted to budget neutral adjustments in the Medicare physician fee schedule and instead should take into consideration the impact of primary care in reducing overall Medicare costs, including costs under Part A associated with reductions in preventable hospital, emergency room and intensive care unit visits associated with primary care.

A better way to fund primary care would be to re-define budget-neutrality rules to consider the impact of paying more for primary care on total aggregate Medicare spending, Parts A, B, C and D combined. A portion of anticipated savings in other parts of Medicare (such as from fewer preventable hospital or emergency room admissions associated with care coordination by primary care physicians) could then be applied to fund increased payments for primary care.

It also is not clear whether MedPAC intents for the adjustment to be a one-time adjustment or one that is sustained and continued over several years until the market compensation gap between primary care and other specialties is closed. The College believes that a one-time adjustment, even if it is as high as 10 percent, will be insufficient to make primary care competitive with other specialties. In addition, the amount of the adjustment should not be left up to Congress to decide each year, but should instead be scheduled in advance so that annual compensation increases in increments until parity reached with other specialties. Such predictability is needed to influence the career decisions of medical students and associates who are contemplating the current and future potential of primary care compensation, as well as to established primary care physicians who may be contemplating a career change or early retirement.

Support New Primary Care Delivery Models/Patient Centered Medical Home:
Public and private payers should invest in other new practice models that support the ability of primary care physicians to deliver comprehensive, preventive, and coordinated care to patients. ACP strongly supports the patient centered primary care model of health care delivery and recommends that the current Medicare demonstration be expanded to a pilot project.

Rationale:
The Patient-Centered Medical Home is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH practice is responsible for providing for all of a patient's health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues.

The PCMH enjoys the support of a wide range of health care stakeholders, including physician organizations, consumer organizations, employers, health plans, and quality-focused organizations. Policymakers view it as a promising reform model, with Congress authorizing the Medicare Medical Home demonstration project through a 2006 law and supplementing it with dedicated funding and increased ability for expansion through a 2008 law. MedPAC recommends a Medicare medical home pilot project to supplement

the demonstration currently being developed that focuses on practices that use advanced HIT. Other bills have been or are likely to be introduced that would direct additional Medicare medical home test projects.

Numerous states are incorporating PCMH tests into reform of their Medicaid and SCHIP programs. There are a myriad of private payer PCMH tests, many involving multiple health plans, underway or being developed across the country.

Practices must demonstrate that they have the structure and capability to provide patient-centered care to be recognized as a PCMH. The most recently used PCMH recognition module classifies a qualifying practice as one of three medical home levels, each indicating a progressive level of capability. While practices must demonstration capability beyond what is typical, they have some ability to reach the requisite PCMH recognition score in different ways. ACP is aware that government programs exist that address focused areas that are relevant to the PCMH. The current scope of work governing the Medicare Quality Improvement Organization (QIO) program involves 14 organizations focusing on improving transitions in care, e.g. inpatient to ambulatory setting, in certain geographic areas.[50] The Department of Health and Human Services maintains a program that facilitates the ability of physicians to provide language translation services to patients. The federal government should provide sufficient funding for programs to help smaller physician practices qualify as PCMHs.

In addition, the current Medicare Medical Home Demonstration, which is limited to eight states, should be expanded to a national pilot. CMS should also set a timeline for expeditiously transitioning to a new payment model for all practices nationwide that have voluntarily sought and received recognition as Patient-Centered Medical Homes following completion of the Medicare demonstration/pilot. The budget should also provide states with dedicated federal funding to implement PCMH demos for Medicaid, SCHIP, and all-payer programs.

The Commonwealth Fund's Commission on a High Performing Health Care System recently issued a report that advocates that the federal government "Strengthen and reinforce patient-centered primary care through enhanced payment of primary care services and changing the way we pay for primary care to encourage the adoption of the medical home model to ensure better access, coordination, chronic care management, and disease prevention." The report estimates that widespread implementation of the medical home model would reduce national health care expenditures by $175 billion over ten years.[51]

Eliminate Payment Cuts under the Sustainable Growth Rate (SGR): Congress should eliminate payment cuts, as a result of the flawed SGR, and account for the true costs associated with providing updates. Updates should reflect increases in the costs of medical practice by increasing Medicare baseline spending assumptions.

Rationale:
Over the past several years, one of the College's main priorities has been urging Congress to reform Medicare's flawed physician payment formula known as the Sustainable Growth Rate, or SGR. This formula has led to scheduled annual cuts in physician payments for the past seven consecutive years. On January 1, 2010 physicians face a 21 percent Medicare payment decrease unless Congress intervenes to avert this cut. This uncertainty in Medicare reimbursement rates makes it nearly impossible for physicians to plan their budgets for their practices. Although Congress has acted to avert scheduled Medicare payment cuts in the last several years, it has not acted to permanently fix the flawed payment formula. Unless Congress acts to provide the funding necessary to fix this flawed Medicare payment formula, physicians will face continued uncertainty over Medicare reimbursement rates in the future.

The College appreciates that the President's budget recognizes a shortfall in the current Medicare payment formula and intends to dedicate funding to account for "additional expected Medicare payments to physicians over the next 10 years." Accounting for funds needed to reform the flawed sustainable growth rate (SGR) payment formula could remove the greatest single barrier to reaching a consensus on a long-term solution to the SGR payment cuts.

Summary and Conclusions

ACP applauds Congress and the Administration for their resolve in addressing major health care reform this year. The College firmly believes that sustaining and improving the primary care workforce is essential to providing patients with access to high-quality care at reduced costs. Congress should take the necessary steps to ensure an adequate primary care workforce by:

- Recognizing that primary care is positively and consistently associated with improved outcomes, reduced mortality, lower utilization of healthcare resources, and lower overall costs of care.
- Developing a national workforce policy to help ensure adequate numbers, availability and distribution of primary care physicians
- Investing in the pipeline of incoming primary care physicians by creating new loan repayment and medical school scholarship programs, increasing funding for Title VII programs, increasing funding for the National Health Service Corps, and allowing deferment of educational loans throughout training in primary care residency programs
- Increasing Medicare payments to primary care physicians to make them competitive with other specialties and career choices
- Modifying Medicare budget neutrality rules to allocate a portion of anticipated savings associated with primary care, such as from reduced preventable hospital and emergency room admissions, to fund increases in payments for primary care services
- Funding programs to support and expand the Patient-Centered Medical Home

- Eliminating payment cuts from the SGR and accounting for the true costs associated with providing updates that reflect increases in the costs of medical practice by increasing Medicare baseline spending assumptions

The College appreciates the opportunity to share its views on the primary care workforce. We look forward to working with this committee on reforms that will expand health insurance coverage to all Americans, improve the quality of care, reduce costs, and ensure that all patients have access to a primary care physician.

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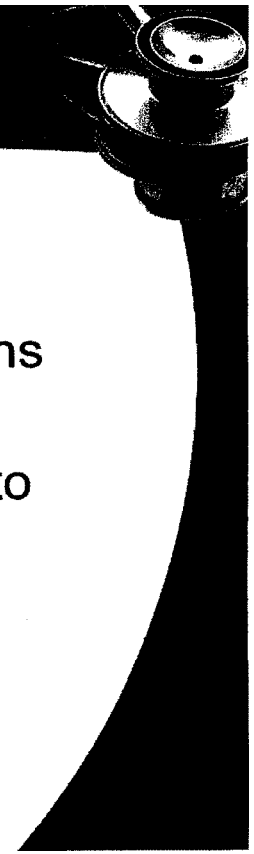
Physician Supply and Economic Impact

A project of the METROPOLITAN MEDICAL SOCIETY *of* GREATER KANSAS CITY

Why the Research?



- Identify the aging of physician population
- Quantify the commitment of physicians to clinical research
- Define the importance of physicians to a vibrant community

Scope of Work

- Multi Part Study
  - Physician Attrition
  - Economic Footprint
- Research conducted June through September 2008

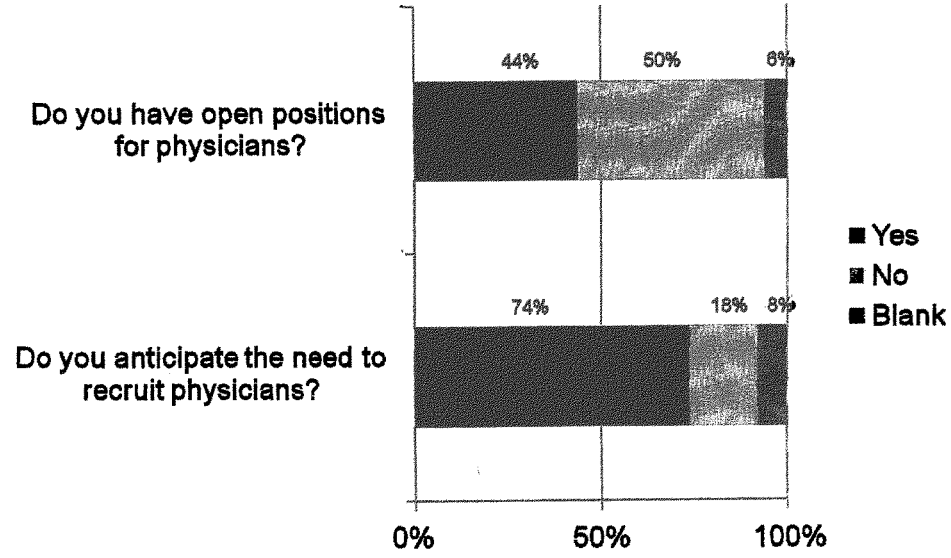
Survey Respondents

Profile Summary

- Male (72%)
- Age 46-55 (38%)
- Private Practice (63%)
- Primary Care (36%)
- Lived in KC over 25 years (48%)

Metropolitan Medical Society of Greater Kansas City

Need to Recruit



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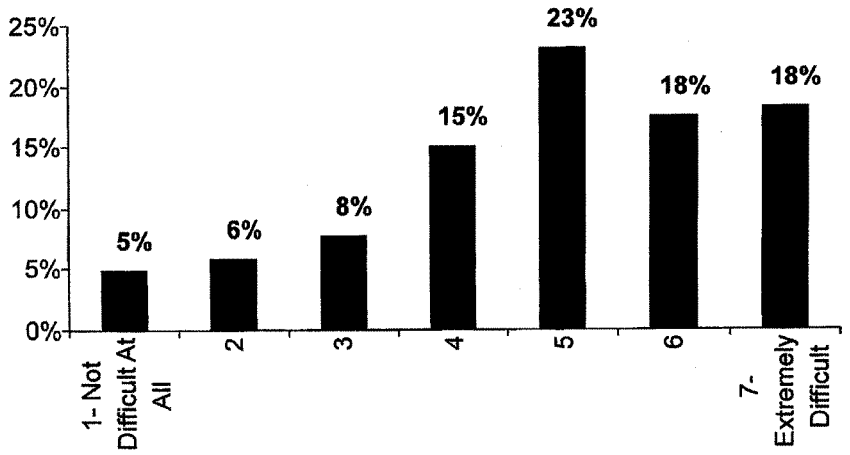
Recruiting Difficulty

How difficult is it to recruit physicians to KC?



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Recruiting Challenges

- Low reimbursement
- High med mal costs
- "Many physicians…are not aware of the potential for growth and the family friendly atmosphere of KC"
- "No water or mountains"

Reasons for Concern

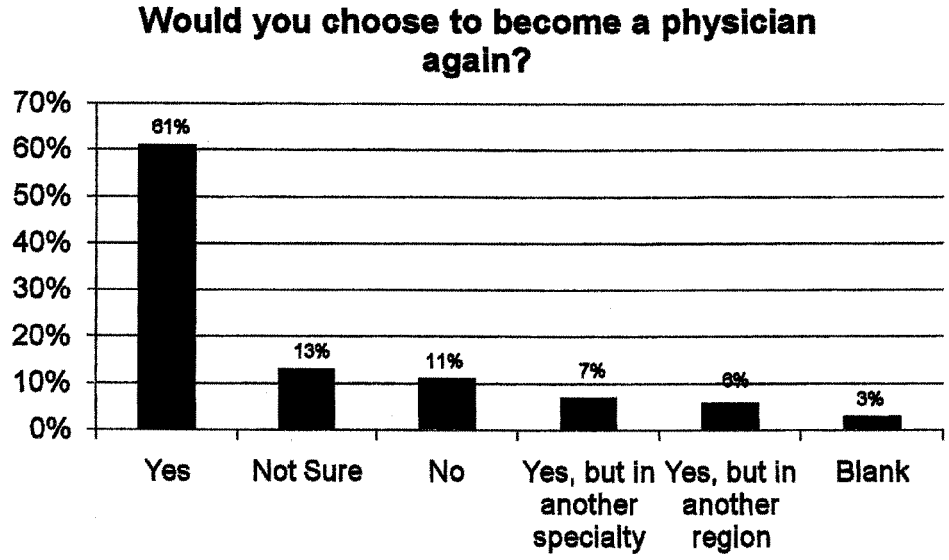
- Aging physician population
- Openings
  - 44% have openings now
  - 74% project openings in next 5 years
- Smaller physician workforce
  - 68% plan to reduce services within 2 years
  - 20% will retire in 5 years; 40% in 10 years
- Patient access
- Perception of difficulty attracting physicians

Metropolitan Medical Society of Greater Kansas City

Reasons for Optimism

- Many believe recruitment is easy
  - Strong training programs
  - Good place to live
- Expanding and growing practices
- Strong and vested interest in clinical trials

Physician Satisfaction



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Clinical Research

- 26% of Kansas City physicians are involved in clinical research

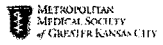
Economic Footprint

- Office Economics
  - Employment and wages
  - Taxes
  - Operating expenses
  - Capital
- Uncompensated Care
- Community Impact
  - Donations
  - Community service

Metropolitan Medical Society of Greater Kansas City

Typical Practice

- Nationally, typical physician employs
  - 3.82 full time employees and
  - 0.51 part time employees
- **Typical KC practice is larger**
  - 4 physicians
  - 15 full time staff
  - 2 part time staff



Office Economics

- Capital investment per physician $43,242
- Operating expenses per physician $240,558
- Taxes paid per physician $45,763

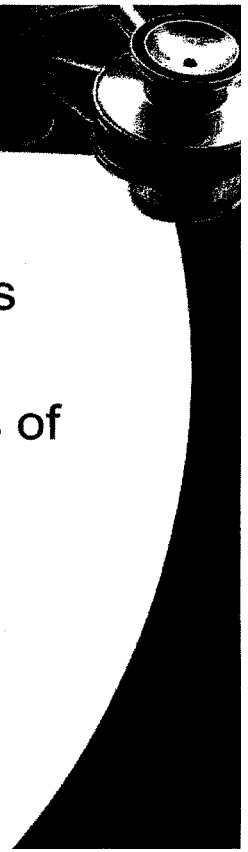
Total Economic Impact

- $2.7 billion in payroll annually
- $191 million in capital investment
- $1.0 billion in operating expenses
- $202 million in taxes annually

Percent of Economy

- Medical practices account for 6.6% of total local wages in KC Metro Area

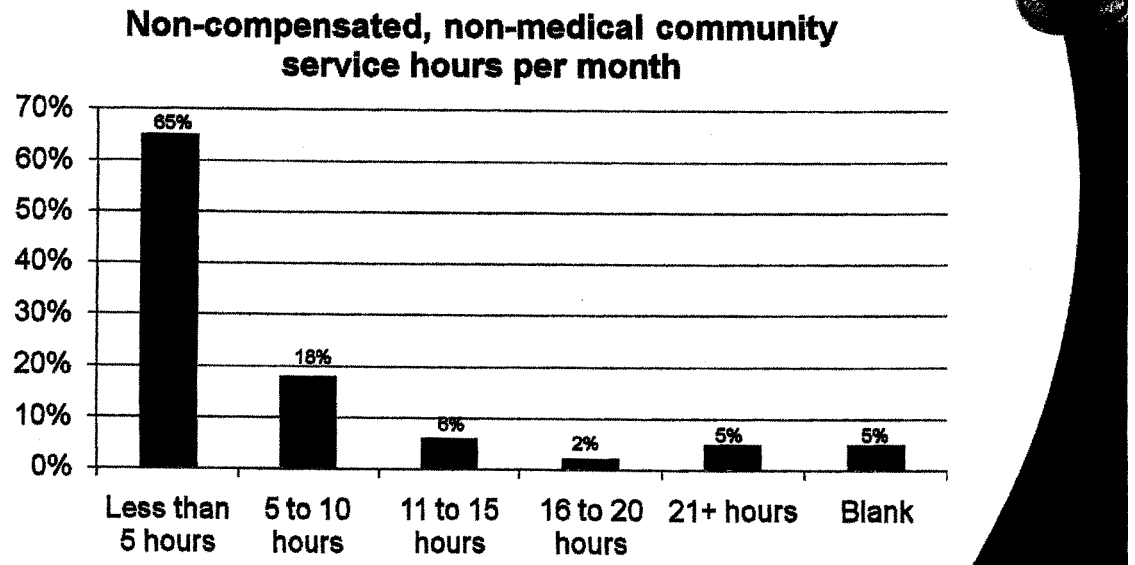
Uncompensated Care



Typical Kansas City Physician

- Sees 127 Medicaid Patients for a loss of $363,683 annually
- Sees 78 uninsured patients for a loss of $155,183 annually

Non-Medical Community Service



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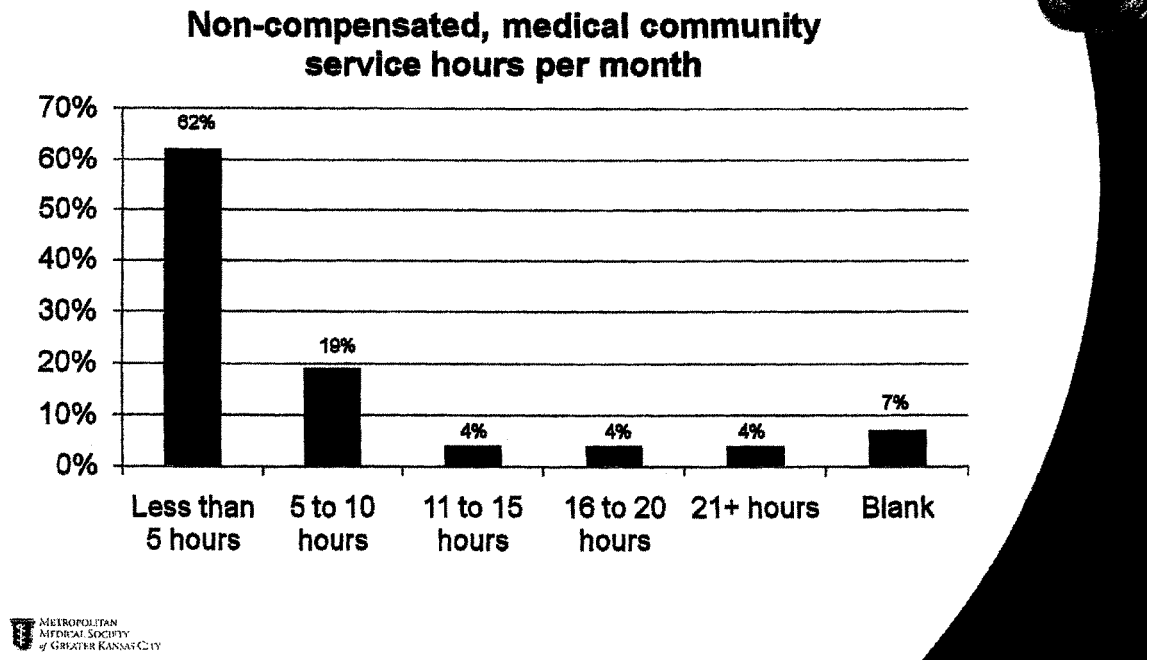
Medical Community Service



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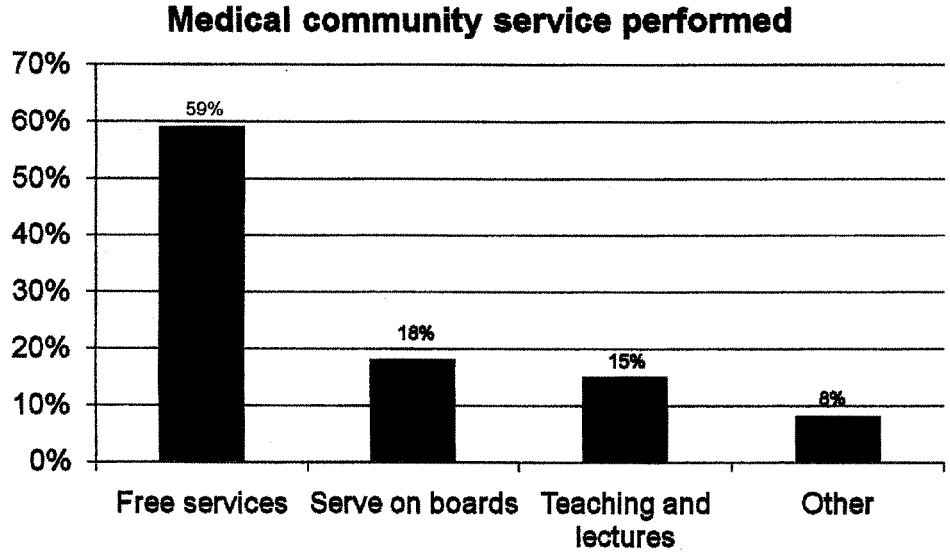
Medical Community Service



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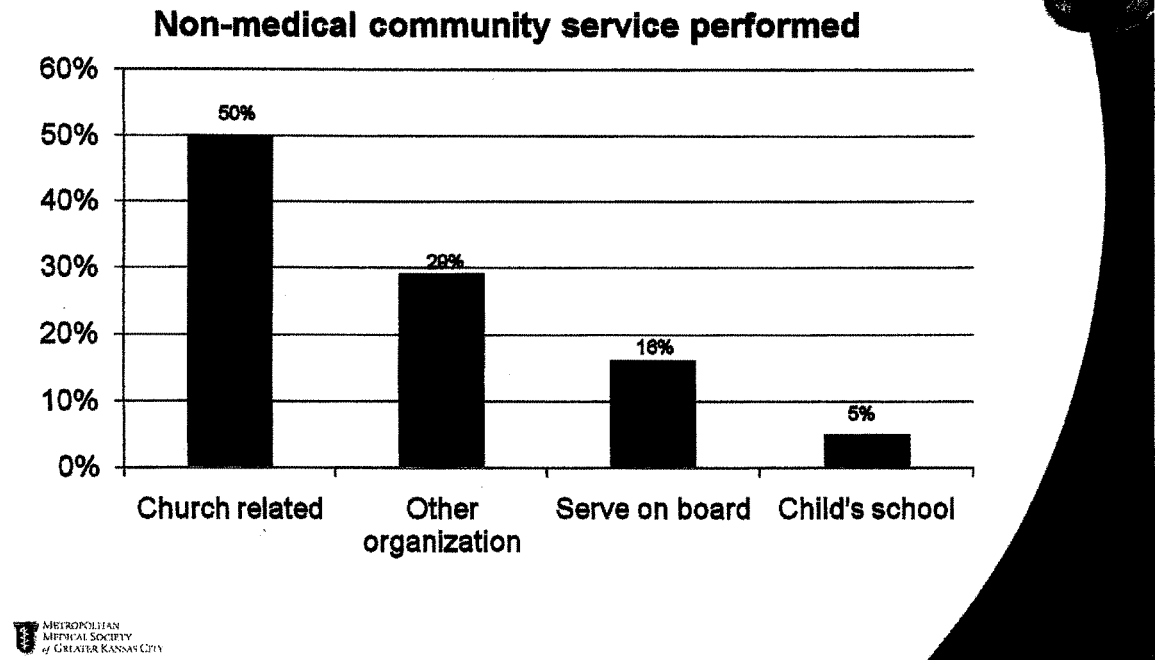
Non-Medical Community Service



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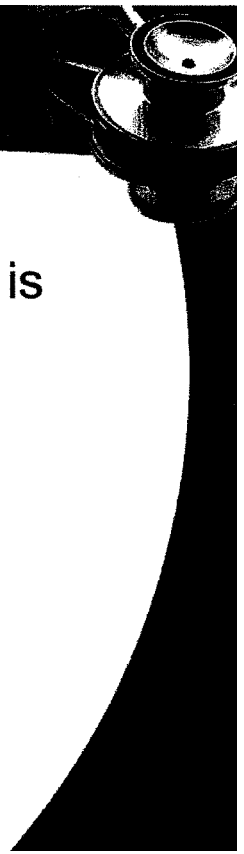
Community Benefit

- $5.5 million in non-educational donations annually
- $13.8 million in educational donations annually
- More than 500,000 hours of volunteer work at an estimated value of more than $124 million annually

KCMEDNET
METROPOLITAN
MEDICAL SOCIETY
of GREATER KANSAS CITY

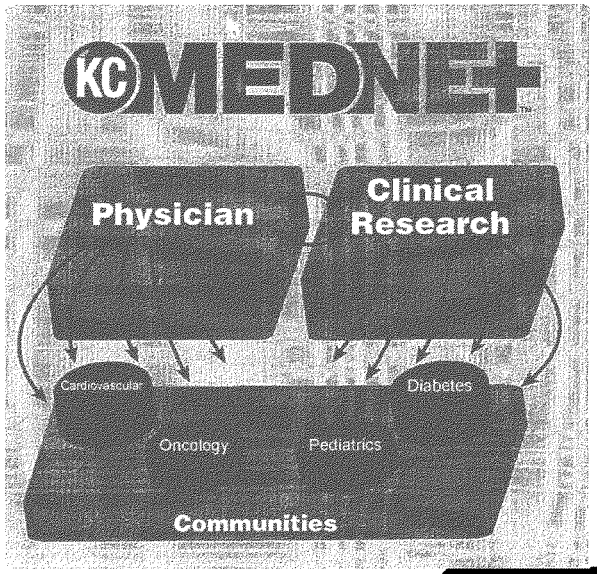
Our Vision



- As the first civic initiative of its kind in the country, the vision of KCMedNet is to improve the overall quality of healthcare in Kansas City through successful physician recruitment and an enhanced focus on the region's clinical trial and contract research assets and opportunities.

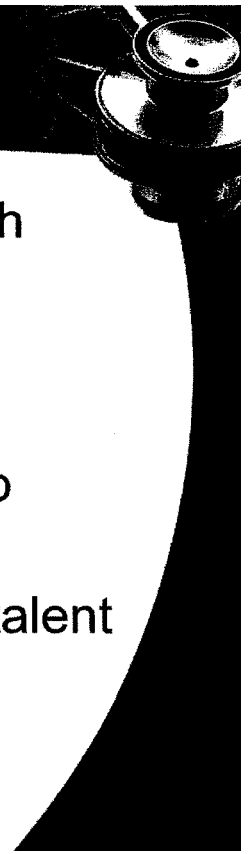
Why?

- Bridge Science
- Bridge State Lines
- Bridge Hospitals



Metropolitan Medical Society of Greater Kansas City

What This Will Do



- Highlight our region's clinical research capability
- Focus on clinical research to drive healthcare innovation
- Encourage physicians and patients to participate in clinical research
- Recruit and retain leading physician talent

Metropolitan Medical Society of Greater Kansas City

For more information contact:

METROPOLITAN
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of GREATER KANSAS CITY

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NATIONAL RURAL HEALTH ASSOCIATION

July 8, 2009

Submitted Testimony

United States House of Representatives Small Business Committee

The Looming Challenge for Small Medical Providers: The Projected Physician Shortage and How Health Care Reforms Can Address the Problem.

Dear Chairman Velázquez, Ranking Member Graves, and members of the Committee:

The National Rural Health Association (NRHA) is pleased to have the opportunity to submit testimony to the Small Business Committee regarding the physician shortage problem in rural and underserved areas.

The NRHA is a non-partisan and non-profit member driven organization with over 18,000 members nation-wide, which includes a broad spectrum of the rural physician workforce. Our diverse membership represents a collection of individuals and organizations with a common dedication to addressing the health care needs of rural and underserved beneficiaries.

The shortage of primary health care in rural America represents one of the most intractable health policy problems of the past century. This problem will only worsen. In just 20 years, 20 percent of the U.S. population will be 65 or older, a percentage larger than at any other time in our Nation's history. Just as this aging population places the highest demand on our health care system, we have some experts who predict a national shortage of physicians alone will be close to 200,000. If that becomes a reality, 84 million patients could be potentially left without a doctor's care.

At the same time, we are losing some of our doctors through attrition. One-third of physicians are 55 years old and older and are likely to retire as this baby boom generation moves into its time of greatest medical need. Additionally, for the last quarter of a century, medical schools have not increased enrollment to keep up with the populations needs. And finally, we are also losing many physicians, quite simply, through frustration. Low Medicare and Medicaid reimbursement rates, coupled with complex regulations and paperwork, leave physicians aggravated, disillusioned and disappointed with the practice of medicine.

The following are key components to recognizing the rural physician workforce shortage:

- **An Increase in the Cap for Rural Residency Programs.** A redistribution of residency slots (the plan proposed by the Senate Finance Committee) will do little if anything to increase the supply of physicians for rural and underserved communities unless it is combined with a method to increase the number of students choosing to enter those residency programs.

Unused residency slots should not go to specialty programs, because the "demand" for these specialties is primarily driven by a lack of primary care physicians, a decrease in primary physician to specialist ratio, and increased specialist capacity.

An incentive program must be created to fill vacancies in rural programs, and assist in the expansion of rural programs. (If there is no incentive, the increase in cap will only serve to enrich the specialty programs that will likely receive the slots if primary care is unable to fill in the match in the next three years.)

To account for these disparities, the NRHA recommends the following legislative solutions:

A. Physician Residency Programs should be allowed to be established or expanded if the following requirements are met:

A program is a **rurally located** (RUCA 4 or greater zip code) residency training program of at least 6 total months over the course of 3 or more years of training (e.g. a traditional "1-2" RTT with 24 months of rurally-located training; an integrated RTT by the NRHA definition with at least a total of 6 months of rurally-located training, or a rurally-focused program with a "rural training track" and at least 6 months of training in a rural place)

Or

A program is **located in a HPSA** (urban or rural underserved)

Or

A program with **greater than 50% of that program's graduates** in the past three years employed in an initial place of practice located in a rural RUCA zip code or HPSA

The following will apply:

30% increase in the GME cap of existing programs, and removal of any cap on new programs meeting criteria #1 or #2 or #3.

Annual tax credit (or loan forgiveness) for trainees in these programs for each year of training.

Direct supplemental subsidy to these programs for teaching faculty costs and faculty development paid directly to the rural or underserved program in addition to any GME funds currently being given through the rural or underserved hospital, clinic, or associated sponsoring urban institution.

Grant Program. It is cumbersome and costly for a small rural facility to take part in a rural training program. A facility must develop a training/teaching program and get it accredited. Accreditation (ACGME accreditation) can take years and can be costly. A grant program for these small facilities would greatly expand rural training programs and get physicians in areas where there is great need.

Other GME Cap removal proposals. NRHA supports the lift of residency caps on primary care. We do have concerns that a redistribution of unused slots could have the unintended consequence of actually harming rural programs. (That is, a rural primary care slot that was unfilled due to the extreme

shortages in primary care could be taken away in a redistribution - - thereby creating even more hardship in rural areas.)

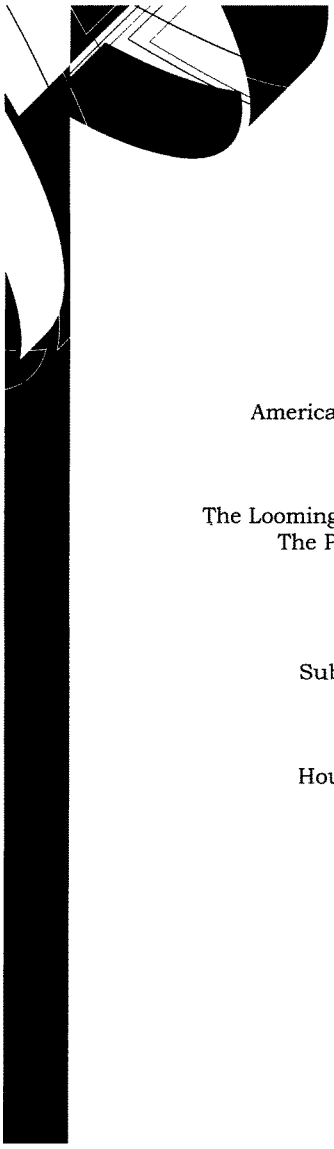
Thank you for the opportunity to submit testimony to this important hearing. The NRHA looks forward to working with the Committee to ensure beneficiaries in rural and underserved areas receive the medical care they deserve.

Sincerely,

Beth Landon

Beth Landon, President

National Rural Health Association



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Testimony of

American Academy of Physician Assistants

On

The Looming Challenge for Small Medical Providers: The Projected Physician Shortage and How Health Care Reforms Can Address the Problem

Submitted for the Hearing Record

of the

House Small Business Committee

July 8, 2009

Summary of the American Academy of Physician Assistants' Testimony

Physician assistants (PAs) are one of three health care professions providing primary medical care in the United States today, and are an integral part of health care reform.

- In 2008, over 257 million patient visits were made to physician assistants, and approximately 332 million prescriptions were written by PAs.
- PAs practice in virtually every area of medicine. Between 35%- 40% of all PAs practice in primary care. PA education is based on the primary care model of care, providing greater flexibility for PA practice upon graduation.
- By design, PAs always work with physicians. However, PAs make autonomous medical decisions. The physician is always available for consult, but the physician may not be onsite, in the same county, or in the case of the state department, in the same country or hemisphere. Reimbursement for medical care provided by PAs in separate than reimbursement provided to physicians.
- PAs serve as medical directors in rural health clinics, community health centers, and other federally qualified health centers. In rural and other medically underserved communities, a physician assistant may be the only health care professional available.
- PAs provide first contact, continuous, and comprehensive care for patients throughout the US. PAs currently manage care for patients in primary care, chronic care, and other areas of medicine.
- Studies show that in a primary care setting, PAs can execute at least 80 percent of the responsibilities of a physician with no diminution of quality and equivalent patient care satisfaction.
- By virtue of PA education in primary care and the ability of PAs to work in all medical and surgical specialties, PAs expand access to care in medically underserved rural and urban communities.
- By design, the physician assistant profession extends the reach of medicine and the promise of health to the most remote and in-need communities of our nation.

In addition to the need to produce more primary care physicians, it is critical that Congress support expansion of PA programs as they develop strategies for addressing health care workforce challenges.

- Funds should be made available to PA educational programs to increase the PA workforce, which in turn, will extend physicians' ability to provide.
- The Title VII, Public Health Service Act's, Health Professions Program is successful in training health care professionals for practice in medically underserved communities. Funding for PA educational programs is woefully underfunded and must be increased.
- The single largest barrier to PA educational programs educating more PAs is a lack of clinical training sites. Attention must be directed to investing in the number of these sites, including loan repayment for preceptors in primary care medical practices and/or the increased use of VA facilities as clinical training sites for PA educational programs.
- Funds must be made available to increase the number of faculty at PA educational programs. Eligible PA students are being turned away because of the lack of faculty and clinical sites.
- Faculty loan repayment, including funding to attract faculty from diverse backgrounds, is also critical for PA educational programs.
- Federally supported student loans and increased opportunities through the National Health Service Corps are key to attracting PA students and clinicians to primary care.
- Graduate medical education funding should be used to support the educational preparation of physician assistants in hospitals and outpatient, community-based settings.

Physician assistants are key to health care reform. However, to be fully utilized, current barriers to care that exist in federal law must be addressed.

- The Medicare statute must be amended to allow PAs to order home health, hospice, and skilled nursing facility care, as well as to provide hospice care for Medicare beneficiaries. (A 2009 report by the Lewin Group estimates an overall cost savings through implementation of the four PA Medicare provisions.)
- Medicaid should be updated to require states to reimburse all covered services provided by PAs under the fee-for-service plan. Additionally, Medicaid should recognize PAs as primary care case managers through managed care plans.
- The Federal Employee Compensation Act needs to be updated to allow PAs to diagnose and treat federal employees who are injured on the job.
- Physician assistants must be fully integrated into new models of care, including the primary care medical home and chronic care coordination.

In brief, AAPA recommends the following changes to the House Health Care Reform Discussion Draft –

- Explicitly recognize physician assistants as primary health care providers throughout the bill.
- Incorporate the Senate HELP Committee language on reauthorization of the Public Health Service Act's Title VII Program, including a 15% carve for PA educational programs in Title VII training on primary care medicine, an updated definition of PA educational programs; and faculty loan repayment for PA education programs.
- Revise Medicare to allow PAs to order home health, hospice and skilled nursing facility care, as well as to provide hospice care for Medicare beneficiaries. (A 2009 report by the Lewin Group estimates an overall cost savings through implementation of the four PA Medicare provisions.)

On behalf of the nearly 75,000 clinically practicing physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA), thank you for the opportunity to submit written testimony for the hearing record of the House Committees on Education and Labor, Energy and Commerce, and Ways and Means.

AAPA Principles for Health Care Reform

AAPA has a longstanding history of support for universal health care coverage. Among the Academy's key principles for health care reform --

- The AAPA believes the primary goal of a comprehensive health care system reform is to ensure access to quality, affordable, and cost efficient health care for all residents of the United States.
- The AAPA supports a health care system that will provide basic services to all residents.
- The AAPA supports health care that is delivered by qualified providers in physician-directed teams.
- The AAPA supports reform that confronts the limits of care and resources.
- The AAPA believes that fair and comprehensive reform of the medical liability insurance system is needed.
- The AAPA endorses system reform that enhances the relationship between the patient and the clinician.

Physician Assistants

Physician assistants are licensed health professionals, or in the case of those employed by the federal government, credentialed health professionals, who —

- practice medicine as a team with their supervising physicians
- exercise autonomy in medical decision making
- provide a comprehensive range of diagnostic and therapeutic services, including performing physical exams, taking patient histories, ordering and interpreting
  Laboratory tests, diagnosing and treating illnesses, assisting in surgery, writing prescriptions, and providing patient education and counseling
- may also work in educational, research, and administrative settings.

PAs always work with physicians. However, this does not mean that the physician is necessarily on site, nor does it suggest that PAs do not make autonomous medical decisions. PAs employed by the State Department, for example, may work with a physician who is a continent away and available for consultation by telecommunication.

PAs are located in almost all health care settings and in every medical and surgical specialty. Nineteen percent of all PAs practice in non-metropolitan areas where they may be the only full-time providers of care (state laws stipulate the conditions for remote supervision by a physician). Approximately 41 percent of PAs work in urban and inner city areas. Approximately 44 percent of PAs are in primary care. Nearly one-quarter of clinically practicing PAs practice in surgical specialties. Roughly 80 percent of PAs practice in outpatient settings.

PAs are covered providers within Medicare, Medicaid, Tri-Care, and most private insurance plans. Additionally, PAs are employed by the federal government to provide medical care, including the Department of Defense, the Department of Veterans Affairs, the Public and Indian Health Services, the State Department, and the Peace Corps.

AAPA estimates that in 2008, over 257 million patient visits were made to PAs and approximately 332 million medications were written by PAs.

Overview of Physician Assistant Education

Physician assistant programs provide students with a primary care education that prepares them to practice medicine with physician supervision. PA programs are located at schools of medicine or health sciences, universities, teaching hospitals, and the Armed Services. All PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant, an organization composed of representatives from national physician groups and PAs.

The average PA program is 26 months and is characterized by a rigorous, competency-based curriculum with both didactic and clinical components. The first phase of the program consists of intensive classroom and laboratory study, providing students with an in-depth understanding of the medical sciences. More than 400 hours in classroom and laboratory instruction are devoted to the basic sciences, with over 70 hours in pharmacology, more than 149 hours in behavioral sciences, and more than 535 hours of clinical medicine.

The second year of PA education consists of clinical rotations. On average, students devote more than 2,000 hours or 50-55 weeks to clinical education, divided between primary care medicine and various specialties, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, surgery and surgical specialties, internal medicine subspecialties, emergency medicine, and psychiatry. During clinical rotations, PA students work directly under the supervision of physician preceptors, participating in the full range of

patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education, and counseling.

After graduation from an accredited PA program, the physician assistant must pass a national certifying examination jointly developed by the National Board of Medical Examiners and the independent National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 continuing medical education credits over a two-year cycle and reregister every two years. Also to maintain certification, PAs must take a recertification exam every six years.

The majority of PA educational programs offer master's degrees, and the overwhelming majority of recent graduates hold a master's degree.

Title VII Support of PA Education Programs

The title VII support for PA educational programs is the only federal funding available, on a competitive application basis, to PA programs. Unfortunately, the level of support has eroded from the highest level of $7.5 million in FY 2005 to $2.6 million in FY 2007.

Targeted federal support for PA educational programs is authorized through section 747 of the Public Health Service Act. The funds are used to encourage PA students, upon graduation, to practice in underserved communities. These goals are accomplished by funding PA education programs that have a demonstrated track record of: placing PA students in health professional shortage areas; exposing PA students to medically underserved communities during the clinical rotation portion of their training; and recruiting and retaining students who are indigenous to communities with unmet health care needs.

The Title VII program works.

- A review of PA graduates from 1990 – 2006 demonstrates that PAs who have graduated from PA educational programs supported by Title VII are 59% more likely to be from underrepresented minority populations and 46% more likely to work in a rural health clinic than graduates of programs that were not supported by Title VII.
- A study by the UCSF Center for California Health Workforce Studies found a strong association between physician assistants exposed to Title VII during their PA educational preparation and those who ever reported working in a federally qualified health center or other community health center.

The PA programs' success in recruiting underrepresented minority and disadvantaged students is linked to their ability to creatively use Title VII funds

to enhance existing educational programs. Without Title VII funding, many special PA training initiatives would be eliminated. Institutional budgets and student tuition fees are not sufficient to meet the special, unmet needs of medically underserved areas or disadvantaged students. The need is very real, and Title VII is critical in leveraging innovations in PA training.

Need for Increased Targeted Support for PA Education

Federal support must be directed to PA educational programs to stimulate growth in the PA profession to meet the needs of universal health care coverage. Targeted funding should be directed to –

- The use of Title VII funds for recruitment and loan repayment for faculty in PA educational programs.
- Incentives to increase clinical training sites for PA education.
- Federally backed loans and loan repayment programs for PA students.

Eliminating Barriers to Care in Federal Law

Eliminating current barriers to medical care provided by PAs that exist in the Medicare, Medicaid, and the Federal Employees Compensation Act (FECA) laws would do much to expand access to needed medical care, particularly for patients living in rural and other medically underserved areas.

- AAPA believes that the intent of the 1997 Balanced Budget Act was to cover all physician services provided by PAs at a uniform rate. However, PAs are still not allowed to order home health, hospice, skilled nursing facility care, or provide the hospice benefit for Medicare beneficiaries. At best, this creates a misuse of the patient's physician's, and PA's time to find a physician signature for an order or form. At worst, it causes delayed access to care and inappropriate more costly utilization of care, such as longer stays in hospitals. For patients at end-of-life, it creates an unconscionable disruption of care. (A 2009 report by the Lewin Group estimates an overall cost savings through implementation of the four PA Medicare provisions.)
- Although most States recognize services provided by PAs in their Medicaid Programs, it is not required by law. Consequently, some State Medicaid Directors pick and choose which services provided by PAs they will cover. Others impose coverage limitations not required by State law, such as direct supervision by a physician.
- Although nearly all State workers' compensation programs recognize the ability of PAs to diagnose and treat State employees who are injured on the job, the federal program does not. As a result, federal workers who are injured on the job may be rerouted to emergency rooms for workers'

compensation-related care, rather than to go to a practice where the PA is the only available health care professional.

The Medicare, Medicaid, and FECA statutes create federal barriers to care that do not exist in State law. The barriers need to be eliminated to promote increases access to the quality, affordable medical care provided by PAs.

Integrate PAs into New Models of Care

AAPA is concerned that health care reform could create new, unintended barriers to care provided by PAs unless special attention is devoted to ensuring that PAs are fully integrated into the medical home and chronic care coordination models of care.

PAs always work with physicians, but in many rural and other underserved areas, the PA is the face of health care. The PA is the medical professional who develops the care plan and coordinates the care. PAs also own and/or provide care in rural health clinics and others settings that may serve as the patient's primary medical home. It is critical that the medical home and chronic care management models of care recognize the ability of PAs to develop and manage medical care plans, without unnecessary limitations. And, it is important that PA-run clinics and practices be eligible for reimbursement from the new models of care.

Medicare Physician Payment Reform

It is critically important that health care reform legislation contains a long term solution to Medicare's physician payment system. The current system is simply not sustainable, nor is it fair to the health care professionals who provide medical care for Medicare beneficiaries.

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