



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”

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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 to 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 greater 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 (P⁴)

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 P⁴ 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 P⁴ is to prepare family medicine resident-physicians for practice in a patient centered medical home. P⁴ 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 P⁴ 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.