



Statement for the Record

American College of Physicians

Hearing before the Senate Finance Committee

Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

March 24, 2009

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. Those numbers are compelling, considering the fact that primary care is known to improve health outcomes, increase quality, and reduce healthcare costs.

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.

The Association of American Medical Colleges estimates that there will be a shortage of 124,000 physicians by 2025. 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. 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. Further, greater use of nurse practitioners (NPs) and physician assistants (PAs) are not expected to make enough of an impact on this shortfall. 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.

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. Primary care physicians who are satisfied with their careers are more likely to indicate that they plan on remaining in the field than those who were not (98 percent vs. 65 percent). 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.
- According to the American Medical Association's *Physician Characteristics and Distribution in the U.S.*, 35 percent of physicians nationwide are over the age of 55 and will most likely retire within the next five to 10 years, contributing further to anticipated workforce shortages.

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. 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.
- 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

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.¹ 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.”ⁱⁱ
- 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 reduced 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 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.
- Primary care has the potential to reduce costs while still maintaining quality.
- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke.
- 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.
- The supply of primary care physicians is also associated with an increase in life span. An increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons.
- 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.
- The preventive care that primary care physicians provide can help to reduce hospitalization rates. 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.
- 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. 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.
- 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*. 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.

ACP would be pleased to provide the Senate Finance Committee with the references cited above as well as a summary of the results of dozens of additional studies that

demonstrate the value of primary care in improving quality and lowering the costs of care.

Solutions to Improving the Primary Care Workforce

1. 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.
- 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 lowest average starting salary of any specialty was family medicine (\$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.
- A 2008 analysis found a strong direct correlation between higher overall salary and higher fill rates with U.S. graduates.
- One author suggests that achieving a national goal of 50 percent of clinicians practicing in primary care will require “improving the payment gap between primary care physicians and specialists such that the generalist-to-population ratio increases.”

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties. [ACP analysis based on data from two sources: Medical Group Management Association- 2008 and Merritt Hawkins- 2008 Review of Physician and CRNA Recruiting Incentives- Top

Twenty Searches]. 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.

Other countries have made investments to increase pay to primary care physicians to make them competitive with other specialties, and have found such investments to be effective in attracting more physicians to primary care. The new contract for the English National Health Service helped increase recruitment into primary care and was advantageous to family physicians, whose incomes increased 58 percent between 2002-03 and 2005-06.

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 intends 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 demonstrate 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. 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.

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.
- 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 improve the quality of care while at the same time reducing costs.

ⁱ Wilper, AP, Woolhandler S, Lasser KE, McCormick D, Bor DH et al. A National Study of Chronic Disease Prevalence and Access to Care in Uninsured U.S. Adults, *Ann Intern Med.* 2008;149:170-176.

ⁱⁱ Bodenheimer, T. Chen, E. Bennett, H. Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job? The answer is “no”—not as currently constituted. *Health Affairs*, Volume 28, Number 1, January, 2009