Testimony of

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30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?

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My name is Fitzhugh Mullan. I am a professor of Health Policy and a professor of Pediatrics at the George Washington University. The first 23 years of my medical career were spent as a Commissioned Officer in the United States public health service, beginning as a National Health Service Corps physician in a community clinic in northern New Mexico. Subsequently, I served as Director of the National Health Service Corps, Director of the Federal Bureau of Health Professions, and Secretary of Health and Environment for the state of New Mexico. In recent years, I have studied and written about medical education, health professions workforce, and health equity. I am pleased to be here today to talk about the challenges of primary care as set within a changing health care system. I will address health workforce adequacy, the National Health Service Corps, Teaching Health Centers, nurse practitioners, physician assistants, certified nurse midwives, and workforce data and planning.

Getting It Right: Challenges to Building a Strong Health Workforce

We are facing a period of enormous challenge in building our health care system to improve access and quality while managing costs. All evidence points to the demands on the current system rising appreciably based on the aging of our population and the extension of health insurance to 30,000,000 Americans under the Affordable Care Act. What does this mean for our health care workforce and where do we stand now?

The United States has about 280 physicians/100,000 people, which puts us in the middle ranks of developed nations -- somewhat above Canada and the UK and somewhat below Germany and France. Roughly one third of our physicians work in primary care, which makes us disproportionately specialist-heavy as compared to many other developed nations (Figure 1).

Additionally, and importantly, we have approximately 106,000 nurse practitioners, 70,000 physician assistants, and 13,000 certified nurse midwives providing clinical services side-by-side with 835,000 physicians.[1,2,3] This means that for every 4 physicians we have 1 non-physician clinician providing services as well—a rich asset that no other nation enjoys.
A critically important and much debated question today is whether we have an adequate number of clinicians to meet our national needs. There has been a lot of scholarly debate on this issue. In my judgment, we have a reasonable range of clinical providers (physicians and non-physician clinicians) to address our current needs. These needs will increase slowly as our population grows and ages and there will clearly be an appreciable increase in demand for service in 2014 when the insurance provisos of the ACA kick in. All of these challenges will call on us to be resourceful and strategic in the use of our current resources

[1] AHRQ. *Primary Care Workforce Facts and Stats No. 2*. October 2011. Retrieved from http://www.ahrq.gov/research/pcwork2.htm
[2] American Midwifery Certification Board, http://www.midwife.org/Essential-Facts-about-Midwives
[3] Kaiser Family Foundation. *Total professionally active physicians, November 2012*. Retrieved from http://www.statehealthfacts.org/comparemaptable.jsp?ind=934&cat=8

and will require us to consider new and different strategies to address educational and practice needs to build our future clinician workforce. Toward that challenge, we should plan gradual and thoughtful growth in our physician workforce aiming to increase the number of physicians entering practice in high need specialties.

However, well-established evidence points to the fact that pure increases in physician numbers are associated with higher costs and not associated with better distribution of physicians or improved patient outcomes. In fact, our national experience points to certain benefits of a "leaner" physician workforce. Examples of this include the development of the physician assistant and nurse practitioner professions as well as the legislative birth of the National Health Service Corps during earlier periods of physician shortage. Moreover, the experience of organized health systems, ranging from Kaiser Permanente to the Mayo Clinic that employ significantly fewer physicians per population than the national average, suggest that excellent care can be provided by better practice organization and payment incentives.

The Primary Care Challenge –
Medical School Reform Necessary but not Sufficient

The education and maintenance of a strong primary care sector is important to all aspects of excellence in health care—access, quality, and affordability. Robust and consistent data from the US and global studies affirm the association of strong primary cares systems with better outcomes, lower costs, and better patient satisfaction.

The United States has traditionally undervalued primary care in both education and practice, which is a core problem that needs resolution as part of overall health care reform. Our current physician reimbursement system is effectively hard-wired to Medicare payment policies - policies that compensate specialists (on average) twice as much as primary care physicians. The culture of medical education is, likewise, tilted toward specialties, both because of federal funding streams and the predominance of specialists on faculty. Primary care physicians report time after time that, when they were medical students, faculty members told them they were "too smart to go into primary care." Ten of our elite medical schools yet today do not have family practice departments despite the panoply of specialties represented on their campuses.[4]

In addition to the lower pay for primary care work, many medical students and young physicians consider primary care practice hard work and are opting in large numbers for what are euphemistically called "lifestyle specialties." These are medical specialties that have predictable hours, well-bounded knowledge requirements, and good pay.

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[4] Krupa, C. (2012, December 17). Will physician shortage raise family medicine's profile?. *American Medical Association American Medical News*. Retrieved from http://www.ama-assn.org/amednews/2012/12/17/prl11217.htm

The challenges that bedevil primary care—pay equity, medical school culture, and "lifestyle" preferences—represent long-term problems that will not be corrected by a single reform or strategic initiative. Rather, there will need to be a variety of approaches undertaken at a governmental level as well as at institutional and individual levels in an effort to rebalance our provider complement and maintain a strong primary care presence. This cannot be done in medical schools alone. Pro-primary care reforms in medical schools will not be sufficient if the "pay equity gap" in practice is not narrowed. In the United Kingdom, for instance, where specialists and general practitioners have similar career earnings, there are no problems filling the ranks of the nation's general practitioners.
The advent of the Affordable Care Act and the aging of the baby boom generation represent a challenge to the nation – but also an opportunity for medical educators to revisit the mission of their institutions, examining opportunities to promote primary care and the general social mission of medical education. There are a number of established features of medical schools that are associated with recruiting and graduating physicians who are more likely to work in shortage areas, to choose primary care careers, and to address issues of prevention and population health. A commitment by the nations' medical schools and teaching hospitals to promote the social mission of medical education and practice would launch more graduates into careers dedicated to the oncoming problems of access, quality, and affordability.

Teaching Health Centers – Innovation in Graduate Medical Education

The Teaching Health Center Program (THC), initially enacted in the ACA, is a new residency model that will promote better training of more physicians in community based primary care settings. The principal funding source for residency programs has been Medicare Graduate Medical Education (GME) payments, which are paid to hospitals based largely on the number of residents that they train. Not surprisingly, hospitals recruit residents who fulfill the needs of the hospitals. This tilts residency heavily toward medical and surgical specialties and subspecialties. The vast majority of trainees spend little or no time outside of the walls of the hospital. Studies have demonstrated that only 1% of patients are hospitalized in major teaching hospitals in any three month period and yet that is where virtually all teaching and role modeling take place.

THCs are community based. Residents are recruited to community health centers that, in turn, arrange teaching rotations in regional hospitals. The teaching program itself, the clinical training provided, and values imparted are all community oriented. THCs are funded through modest, dedicated ACA support for 5 years. To date 22 THC residency programs training 140 residents are up and running. Another 17 health centers have recently received awards and it is anticipated that THCs will soon be graduating almost 200 community trained primary care physicians annually. However, despite enormous interest and major reform implications, the THC program, as currently legislated, is effectively a demonstration program whose funding ends in 2014. The absence of Medicare or Medicare-like permanent funding jeopardizes this small but enormously important new model of primary care education. This is a critical, near term legislative challenge.

National Health Service Corps – Tried, True, and Essential

The National Health Service Corps, enacted in 1970, has proven to be a powerful instrument for primary care career development and a brilliant example of service learning in the national interest. Using scholarships and loan repayments as incentives, the program has been able to match large numbers of primary care clinicians to shortage-area delivery sites, year after year. Thanks to the leadership of Senator Sanders and the ACA, the NHSC has doubled its annual appropriation from $150,000,000 to $300,000,000 (Figure 2) and, as we speak, deploys almost 10,000 physicians, nurse practitioners, physician assistants, social workers, mental health workers, and others in thousands of sites in every state in the nation.

In return for educational debt relief, National Health Service Corps health care workers are "doctors" to resource poor communities all over the country. The 40,000 clinicians who have served in the NHSC over 40 years is a tribute to good legislation and good will.[5] With the advent of the ACA, the program will need to expand its clinical participants and communities served.

Nurse Practitioners, Physicians Assistants, and Certified Nurse Midwives

Nurse practitioners (NPs), physicians assistants (PAs), and certified nurse midwives (CNMs) are key providers of health care in general and primary care in particular throughout the country. Currently, as noted above, there are estimated to be 190,000 of them working clinically throughout the country. It is estimated that 52% of NPs and 43% of PAs work in primary care[6]. CNMs are important providers of women's health in general. Scope of practice laws and prescriptive authority have expanded over time in most states with the result that NPs and PAs can provide, augment, and supplement services that were previously limited to physicians. This availability, as well as the spectrum of clinical capabilities within these groups of clinicians, makes them extremely important resources in service delivery in all settings. Moreover, the length and expense of their training is less than that of physicians and they are able to choose and modify their career courses in a far more nimble fashion than physicians. Their presence, skills, and numbers are an important contribution to primary care today and the ability to expand their educational programs quickly will make them crucial players over the next decade as the demand for services increases. As documented above, the majority of PAs and a growing number of NPs are working in specialty settings. I believe this to be an important asset for the health system and not, as some believe, an abdication of their "primary care role." If we are to develop a balanced workforce where specialty services are used appropriately, NPs and PAs are

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[5] National Health Service Corps. Retrieved from http://nhsc.hrsa.gov/corpsexperience/aboutus/index.html

[6] AHRQ. *Primary Care Workforce Facts and Stats No. 2.* October 2011. Retrieved from http://www.ahrq.gov/research/pcwork2.htm

positioned to support specialists and perform clinical tasks in a way that attenuates the need to train larger numbers of specialty physicians. This will be an important contribution to recalibrating the specialist/generalist mix of the workforce of the future.

The Workforce Will Not Manage Itself

Generalist and specialist physicians as well as NPs, PAs, and CNMs require lengthy basic education, including graduate level practice-focused training. Key clinicians such as these cannot be produced quickly, and their education and training require educational "infrastructure" (schools, specialized classrooms and labs, faculty, and clinical training sites) and substantial educational financing (for schools, faculty, and students). Public policies relating to practice are also important and, often, intricate. New practice models (Primary Care Medical Homes and Accountable Care Organizations), reimbursement policies, scope of practice laws, and loan repayment options – to name a few – have an impact on career choices and service patterns of physicians and other clinicians.

While many career decisions will be made by individuals and will call on them to use their own financial resources, public policy at the federal and state level will contribute greatly to individual choices about where and how to practice. The pressures of the system in the near future will reinforce the importance of the public role in health workforce policy. However, the history of public planning in the area of health workforce is spotty at best. No senior agency of government is charged with policy planning in this area. Data on health professions workforce is limited and dispersed among federal agencies (HRSA's National Center for Health Workforce Analysis, the Bureau of Labor Statistics, the Veterans' Administration), private associations (AMA, AAMC, AACON), and state boards of nursing and medicine.

As a first step to providing better federal leadership in health workforce planning, the ACA enacted a National Health Care Workforce Commission charged with the responsibility of drafting and promulgating periodic reports on the workforce as a whole and specific workforce issues in particular. It was to bring focus to the many issues of health workforce analysis and planning. The state of that endeavor is that Commissioners were appointed but no funds have been appropriated to allow the commission to meet or function. The continued absence, then, of any focal effort in workforce planning at the national level will only become more problematic as the challenges of access, quality, and cost continue to increase as the demographics of the country evolve and the programs of the ACA come into play.

Conclusion

This is an exciting time. We are at the brink of expanding the benefits of health insurance to most of those currently uninsured in our population. This is a moral triumph but also a technical challenge. Meeting this need will require educational and clinical resourcefulness

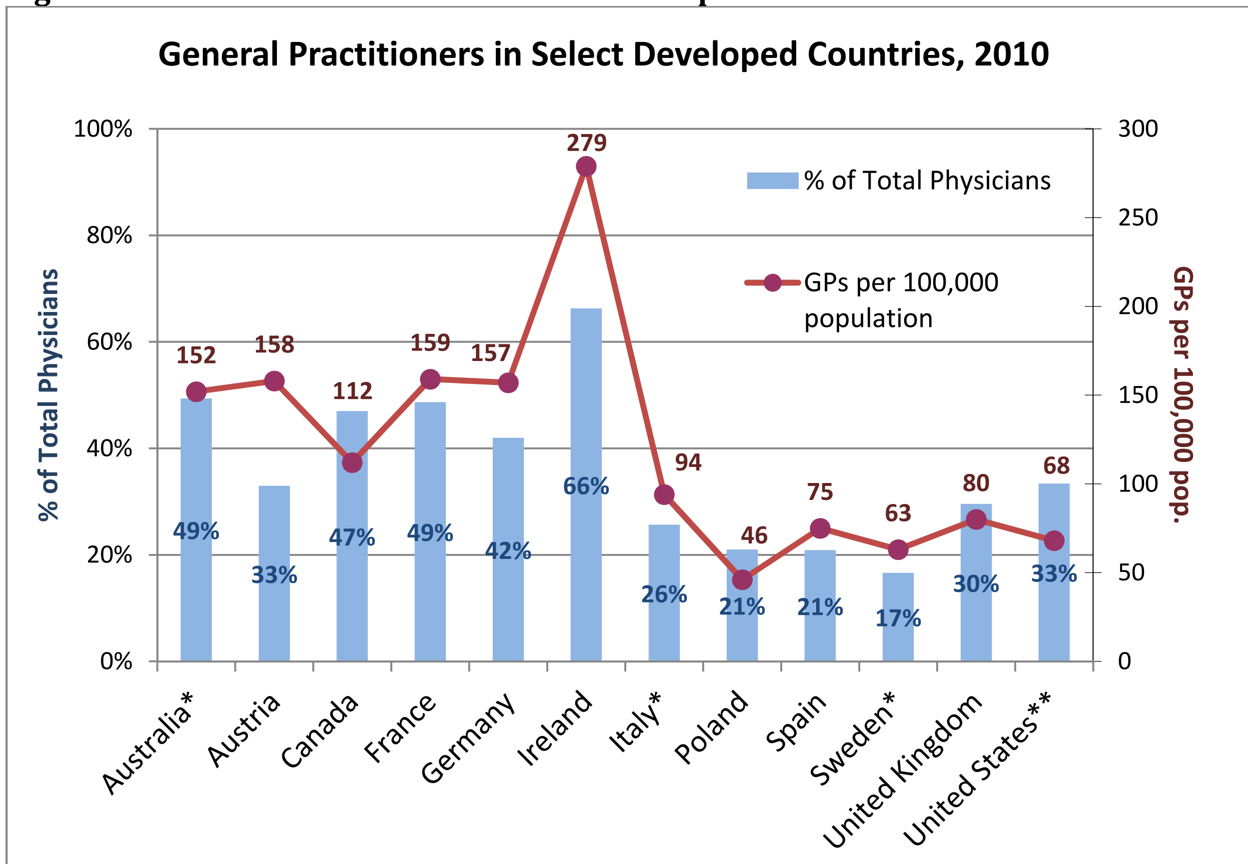
and both public and private investment. There are a number of areas in which federal legislative action will be needed including the conversion of the THCs to a permanent program, extending and expanding the NHSC, operationalizing the National Healthcare Workforce Commission, funding HRSA's National Center for Health Workforce Analysis so that it becomes the robust center that is required for incisive public policy making. A serious examination of Medicare GME is overdue in regard to what can be done to make the program more accountable and responsive to national physician workforce needs.

I hope that these remarks have helped to point out the opportunities and challenges that face us. I very much appreciate the chance to testify today, and would be happy to be of assistance to you and the Committee in any way I can in the future.

Thank you.

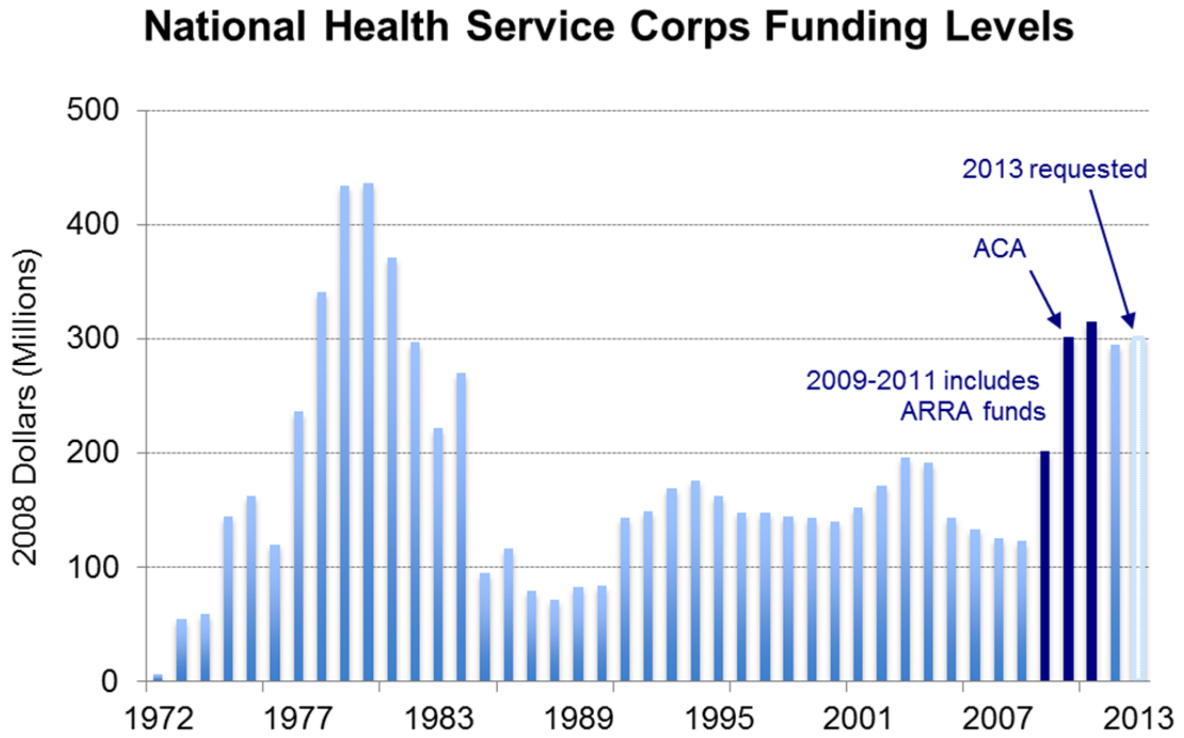
The author wants to thank Hannah Wohltjen, MA, for her assistance in the preparation of this testimony.

Figure 1. General Practitioners in Select Developed Countries



Source: OECD Stat Extracts; * most recent data available is 2009; ** US primary care figures include general practitioners, family physicians, general internists, general pediatricians, and geriatricians (source: AHRQ)

Figure 2. National Health Service Corps Funding Levels



Source: Data provided by the Health Resources and Services Administration