

Congressional Health Care Reform Education Project
October 21, 2008
Health Care Delivery: Access and Quality

Senate Summary

Fitzhugh Mullen of The George Washington University School of Public Health and Health Services discussed some of characteristics and advantages of primary care.

He presented the definition of primary care worked out by an Institute of Medicine committee: “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” The definition includes physician assistants and nurse practitioners, he noted.

The primary care physician workforce is made up of family physicians, general internists and general pediatricians, Dr. Mullen said. Discussing a map of health care spending by market area, he noted that per capita Medicare spending can be 60 percent higher in one region compared to another. High-spending regions have more inpatient-based and specialist-oriented medical practice than do lower-spending regions. But spending more per patient doesn’t mean that patient outcomes are any better. Neither quality nor access to care is better in higher-spending regions, he said. And patient satisfaction is higher in regions with good primary care, he added.

Dr. Mullen offered an international comparison of primary care emphasis vs. costs. Generally, those countries spending the most per capita for health care place less emphasis on primary care. The opposite is also true -- those countries spending less tend to place more emphasis on primary care.

With the aging of the baby boomers, the workload will increase for primary care providers. But the number of providers is not keeping pace, he said. The ratio of medical specialists per 100,000 population is growing faster than the ratio for primary care providers. One reason: the percentage of U.S. medical students entering primary care residencies has shrunk each year since 1999. Their vacant residency places are being filled in large measure by graduates of non-U.S. medical schools.

A boost for primary care came on October 8, when President Bush signed the Health Care Safety Net Act of 2008. This reauthorizes appropriations for 2008 – 2012 for community health centers and the National Health Service Corps. To reach the desired goal of 69 million patients served, health centers will need at least an additional 51,000 primary care providers, Dr. Mullen said.

To increase the number of primary care providers, encouragement can be offered to children as young as elementary school age, during the undergraduate years, during medical school, in graduate medical education, and once physicians begin practicing.

Key policy action areas to consider are: 1) reinventing and recapitalizing Title VII, 2) further boosting the National Health Service Corps, 3) tying Medicare GME funds to primary care training, and 4) changing Medicare reimbursement to provide a fee boost to primary care providers.

Eugene Rich of Creighton University School of Medicine reviewed several federal policy options for promoting primary care. The options involve changing physician payment, changing GME funding, and boosting funding for primary care training.

Dr. Rich said the physician payment structure in the U.S. has historically favored specialty care. There is no explicit reward currently for primary care functions such as being available to patients at all hours, coordinating care with other providers or spending extra time with patients. Fees to primary care practitioners could simply be increased outright, he said, or fee-for-service spending for primary care could be allowed to grow faster than for fee-for-service specialty care. An expert panel could be convened to identify physician services that have become overvalued.

Another way to boost payment for primary care functions would be to reward practices that meet the criteria for “patient-centered medical homes.” (Some of the characteristics: a personal physician in a physician-directed medical practice, whole-person orientation, coordination of care, emphasis on quality and safety, enhanced access to care, payment reform.) Rewarding medical homes, however, would involve some policy debates, such as exactly which criteria a medical practice or other setting would have to meet in order to qualify.

Turning to Medicare GME funding, Dr. Rich noted that attempts to boost primary care through GME funding changes failed in the early 1990s. Medical residency positions reserved for primary care consistently go unfilled, and the number has been reduced over the past decade. Nonetheless, GME funding reform of a different type could put more future primary care physicians in the pipeline, he said. Some examples: GME grants through the Health Resources and Services Administration (HRSA), GME block grants to states.

Primary care training could also be boosted by increasing funding for HRSA Title VII. This funding has plummeted 10-fold over the past 30 years, Dr. Rich said.

The final speaker of the session was **Mark Miller**, executive director of the Medical Payment Advisory Commission (MedPAC). Like the previous speakers, Dr. Miller cited research suggesting that increasing the use of primary care services relative to specialty care can improve the quality, efficiency and coordination of health care delivery.

He agreed that primary care services are undervalued. The current health care system rewards volume of services delivered, he said, not primary care features such as coordination of care. He said this could be remedied by directly linking payment to quality and efficiency.

MedPAC has begun researching whether Medicare payments should be increased for certain services provided by primary care practitioners, Dr. Miller said. Primary care providers could receive a 5 to 10 percent boost in fees. Since such a proposal would be budget neutral, specialists would get a fee cut.

MedPAC also has approved a plan to initiate a medical home pilot project of sufficient size to produce statistically reliable results. Medical homes in the pilot would be settings focusing on patients with multiple chronic conditions. Medicare could also encourage joint accountability and efficiency between a hospital and its affiliated physicians by reducing payments to hospitals with high admission rates for certain medical situations, and by bundling payment for an episode of care

(combining hospital and physician payments). The episode of care would be defined to include the 15 to 30 days after discharge, as a way of reducing readmissions.

Q&A Session

During the question and answer session, a question was raised about Title VII of the Public Health Services Act. Dr. Mullen said this law was designed to solve a physician shortage in the 1960s and 70s. Support was especially aimed at increasing the number of health professionals in underserved areas, and boosting the number of minorities in health professions. Some \$3 billion was given to medical schools, which did increase the number of graduates. Since the 1970s, however, money for Title VII programs has been gradually reduced and it is now a “vestigial” program, Dr. Mullen said.

Another questioner asked whether more professions should be eligible for the National Health Service Corps. Dr. Mullen said that there is a need for other professions in the areas served by the Corps. But adding more would mean less funding for physicians, around whom the service should be based, he said.

Asked about reform ideas for GME funding, Dr. Miller said the \$8 to \$9 billion now going into GME funding could be linked to increased use of health information technology and coordination of care. Dr. Mullen said the present GME-funded residency system is designed on the basis of what hospitals need – not necessarily on the basis of what patients need.

A question was raised about the role of nurse practitioners. Panelists noted that nurse practitioners are less expensive to educate and are less likely than physicians to use expensive technology. It was also noted that a new designation – doctor of nursing practice (DNP) – will eventually overtake the nurse practitioner field. Panelists wondered whether doctors of nursing practice would meet patient needs as well as nurse practitioners do today.

In answer to a later question, Dr. Graham said that supporting primary care residency programs does more to increase the number of primary care physicians than money for new medical schools. He noted that many physicians wind up practicing within a few hundred miles of where they did their residencies.

Asked whether Kaiser Permanente represents a model of a medical home, Dr. Rich thought not. Despite their advantages, pre-paid group practices achieve one-time cost savings. They don’t “bend the curve” of ever increasing health care spending, he said. Dr. Miller later said that the term “medical home” should be focused on the care of patients with multiple chronic conditions.

If specialists’ fees are cut in order to pay primary care providers more, wouldn’t specialists simply increase their volume to make up the difference? Possibly, Dr. Miller said, but there would be some net savings nonetheless.

Answering a related question about primary care physicians would also trying to generate more services if they received bundled payments with hospitals, Dr. Rich said there is no evidence that primary care visits are a driver of health care costs.