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PRIMARY CARE WORKFORCE ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

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PRIMARY CARE WORKFORCE ISSUES

FRIDAY, MAY 14, 1993

U.S. SENATE,
COMMITTEE ON FINANCE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Thomas A. Daschle, presiding.

Also present: Senators Baucus, Chafee, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H–22, May 11, 1993]

FINANCE SUBCOMMITTEE ON MEDICARE TO HOLD HEARINC ON PRIMARY CARE WORKFORCE ISSUES

WASHINGTON, DC—Senator John D. Rockefeller IV (D–WV), Chairman of the Committee on Finance Subcommittee on Medicare and Long-Term Care, announced today that the subcommittee will hold a hearing on primary care workforce issues in the health care industry.

The hearing is scheduled for *10:00 A.M. on Friday, May 14, 1993,* and will be held in room SD–215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Rockefeller stated: "President Clinton has spoken about the need to repair our economy's infrastructure—our roads and bridges, our telecommunications systems—as part of our economic revitalization. Health care reform also requires repair of its infrastructure, and chief among these is the workforce that provides primary care services. A reformed health care system will increase the demand for primary care physicians and other providers because these people will be a critical force in answering the twin demands of increased access and cost savings without sacrificing quality. Yet we also see fewer students choosing this care path."

"This hearing will examine possible changes in Medicare's graduate medical education policies, including paying only for an appropriate mix of primary care practitioners and specialists with federal Medicare dollars and developing mechanisms for improved Medicare reimbursement for residency training in clinics, HMOs, and other approved outpatient settings. We will also look at the role of the National Health Service Corps in addressing the lack of primary care providers in underserved areas," Senator Rockefeller stated.

OPENING STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. The hearing will come to order. I want to welcome everybody to this hearing of the Subcommittee on Medicare and Long-Term Care. I am substituting this morning for Senator Rockefeller who unexpectedly had to be away. He asked me to express his apologies and his appreciation to all of our witnesses.

This hearing will probe one of the fundamental issues facing our health care system today, the nature and distribution of America's health care work force. Although the United States is the world's

leader in high technology medicine, many Americans lack access to basic primary care and preventative health care services.

One of the major reasons is that our health care work force is inadequate for this task. Evidence suggests that this problem will only get worse over the next several decades if no action is taken soon.

This subcommittee held a hearing last July which outlined the scope of this problem and today we will hear from a number of experts on potential solutions. It has become clear that primary care providers include more than generalist physicians, such as family physicians, general internists and general pediatricians. Nurse practitioners, physicians' assistants and other non-physician practitioners comprise the backbone of our primary care system, and can often provide primary care services for lower costs while maintaining the quality of care our citizens expect and deserve.

As medicine becomes more complex, the role of the primary care provider in coordinating this care becomes crucial. But despite the demand for more physicians trained in primary care, family physicians, general internists and general pediatricians account for fewer than 30 percent of the practicing physicians in the United States today.

Compare this figure to the 80 percent of U.S. physicians who practiced primary care in 1931 and the 50 to 75 percent of physicians in Germany and Canada, Japan, England, and Holland who are in primary care. The problem is even worse in our inner cities and in rural America.

Many counties in the State of West Virginia, for example, have no primary care providers whatsoever, and I can say the same for South Dakota.

We cannot expect these figures to change any time soon. Fewer than one-quarter of the recent medical school graduates have expressed interest in primary care careers. Even if by some action we were to begin this year to convince half of all graduating medical students to choose this kind of career, we would not achieve the more desirable 50/50 generalist to specialist ratio until the year 2040.

It is not surprising that this problem has multiple underlying causes—a reimbursement system that favors specialty services, despite this committee's work in passing the new Medicare physician payment system; increasingly sophisticated medical technology that dominates our health care system; and the fact that students often lack the needed role models to encourage them towards primary care.

In addition, our government spends over $6 billion in support of graduate medical education, most often in ways that only serve to reward teaching hospitals for increasing the number of students being trained for highly specialized care.

Finally, as the cost of education has risen, medical student debt has risen as well, and now averages over $50,000—hardly what would encourage students to choose careers in the lower paying primary care disciplines.

Previous efforts to address this problem by increasing the number of physicians being trained have failed. The number of primary care practitioners has actually decreased. Other programs that sup-

port primary care physicians and non-physician practitioners, such as the National Health Service Corps, have not been able to fulfill their missions because of the substantial budget cuts these programs endured during the 1980's.

We have invited to the hearing a number of experts to discuss with us potential solutions to these problems. John Eisenberg, the new chairman of the Physician Payment Review Commission, is with us today, and I welcome him to the hearing and the Commission.

We will also hear from Dr. Marilyn Gaston, the Assistant Surgeon General and Director of the Federal Bureau of Primary Care, about the role of the National Health Service Corps.

Dr. David Brown, a dean from the University of Minnesota, will tell us what medical schools can do to improve the number of primary care professionals that they graduate.

Dr. Bulger will testify on behalf of the Academic Health Centers and discuss their unique proposal.

Dr. Wanda Huff, representing the International Coalition of Women Physicians, will talk with us about some of the minority issues that are often raised when discussing graduate medical education.

I am happy that Dr. Alan Nelson will talk about the American Society of Internal Medicine's proposal to promote primary care.

The American College of Physicians will be represented by Dr. Jim Nolan. He is a practitioner from Buffalo, NY.

Leah Harrison will tell us about the role of nurse practitioners in delivering primary care services.

We hope all these witnesses will help us craft practical solutions to this problem, to help ensure access to health care for those in need, and to help broaden access to careers in health care. I look forward to all of their testimony. They could not be here at a more appropriate time.

Speaking of good timing, the ranking member of this subcommittee has arrived just in time for whatever opening remarks he might make and I welcome him at this point.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you very much. Thank you for taking on the challenge of being Jay Rockefeller today in light of Sharon's problems and so forth. Let me congratulate him and you. This is the second time, I guess, in less than a year we have taken up this subject; they are both sort of historic because this committee has not done much of this sort of thing, and as you pointed out in your statement, it is very timely.

We all know the vast number of issues that are considered part of health care reform. The list is a very long one. And if you look at the dark circles under the eyes of the health staffers, the 544 members of the task force, and all the rest of the people you know, you should not have any doubt about the enormity of this undertaking.

Some issues are more fundamental than others and cannot be overlooked if you want to do successful reform. The nature of the physician in America and the numbers thereof, the kinds of special-

ties they choose, where they practice, and how they practice, represent to me at least the core and very fundamental issue.

If we do not deal appropriately with the definition of the medical professional or physician, or the problems related to that, we really will not be able to do a good job of health care reform.

It seems simple. But until you begin to look at this as a problem, you do not really realize how complicated it is. I have been here in the Senate since 1978, and the problems of physicians supply have been addressed by various of our predecessors from the 1960's and the 1970's and on into the 1980's. Why are we still grappling with the issue now? I think it is because Federal policy has failed to define the problem and appropriate terms have failed to articulate any kind of a work force policy that is appropriate to our future needs.

Instead of medical education, our health care delivery infrastructure and our reimbursement system all gang up to discourage students who wish to be primary care physicians, or physicians who wish to practice in underserved areas. We could go on and on and characterize our problems.

Mr. Chairman, I think this statement is rather long, and I know you did not come here to listen to me. I would guess probably 90 percent of the folks out there did not either. They really came to hear the witnesses who have come to be with us today.

Just let me close by saying, I believe this to be a critical issue. I know you do. The chairman of the subcommittee does, and everyone who is here today to testify on behalf of the Americans who have committed themselves professionally to this issue agree as well.

I will ask to have my full statement made a part of the record.

Senator DASCHLE. Without objection, Senator Durenberger, that will be done.

[The prepared statement of Senator Durenberger appears in the appendix.]

Senator DASCHLE. With that, let me invite Drs. Eisenberg and Gaston to come to the panel. We are pleased that they could be with us this morning.

Dr. Eisenberg, we are, as I said, very pleased you could be with us. I see you have somebody accompanying you. Perhaps you could identify him and we will take your testimony at this time.

STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, WASHINGTON, DC, ACCOMPANIED BY PAUL GINSBURG, EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Dr. EISENBERG. I would be pleased to. This is Paul Ginsburg, who is the executive director of the Physician Payment Review Commission.

As the Congress knows the issue of the physician work force is one that the Physician Payment Review Commission has been concerned about for some time. Our concerns are guided by two principal issues. One is that first the aggregate physician supply and secondly the imbalance across specialties are contributing to the rising costs of health care and also could serve as barriers to broad-

er health reform, to increasing cost effectiveness and to assuring appropriate levels of care to the public.

So what we have done is to propose a system which responds to those concerns, which would limit growth in the number of residency positions, shift the balance between generalists and subspecialists and facilitate training in ambulatory settings.

Our concern is that if we do not change the way in which graduate medical education is financed and organized, the initiatives that are currently underway to improve the health care system will be undermined and secondly that these kinds of changes need to be taken in the context of health reform. But independent of health care reform as well, we believe that these changes need to be undertaken.

The short-term changes that may occur in the health care system over the next several years are exciting to many of us, but anxiety provoking to those of us who are concerned about the physician work force. Because we are very concerned that as we improve competition and in some ways even as we improve access to the existing health care system, that we not lose sight of the fact that the physician work force is a critical element of the infrastructure of the future of the health care system.

We are concerned that more aggressive purchasing of hospital services might undermine the current graduate medical education system in this country which is dependent upon the financial health of academic medical centers and teaching hospitals; and that aggressive purchasing in a system which otherwise might improve health care in this country could undermine that infrastructure particularly in the area of primary care.

So we believe that it is in the public's interest that we consider reform of the financing of graduate medical education and we have a five-point proposal from the commission.

First, the commission suggests that there be Congressionally set limits on the number of residency positions.

Second, that there be a Federal body which would determine the distribution of those residency programs by specialty.

Third, that decisions about which residencies would be funded, should be made by the accrediting bodies that have the capacity to evaluate the educational quality of those programs.

Fourth, that there be funding for graduate medical education. Currently we call it direct medical education payments. That those payments should be made from a national pool that would be financed through a mechanism whereby all payers would contribute.

And fifth, we are concerned that in the interim that we be sure that there are not hospitals or health care delivery systems which are currently dependent upon residents for the delivery of care, who then would be unable to provide care to the disadvantaged or those who otherwise might have difficulty gaining access to care. Some transitional relief would be necessary for those components of the health care system.

I want to point out that we are not talking about new money. In fact, we estimate that this proposal would save a substantial amount of money. Some have estimated as much as $400 million.

What we are proposing is a more rational system which in the long run we believe would engender lower costs, more cost effective care and more appropriate care for the American public.

We are proposing that this system be introduced by the Congress either in the context of health care reform or separate from it, but that we consider it as soon as possible. We are concerned that other short-term proposals, for example, like weighting certain kinds of residencies different from others, may help a little but will not help sufficiently.

We are concerned that when you look at the total amount of funds that are available to teaching hospitals that a relatively mild shift in the percentage of funding that comes for primary care residents or others would not have the kind of impact that is needed to have the right kind of physician work force in the future.

So whether or not this is in the context of a broader health care reform package, we believe that the Congress should begin to consider as soon as possible changing the way in which graduate education is financed in our country.

Thank you.

Senator DASCHLE. Thank you very much, Dr. Eisenberg.

[The prepared statement of Dr. Eisenberg appears in the appendix.]

Senator DASCHLE. Dr. Gaston, welcome. We are delighted you are here. I see you, too, have people accompanying you. Perhaps you could introduce them and then we will take your testimony as well.

STATEMENT OF MARILYN H. GASTON, M.D., DIRECTOR, BUREAU OF PRIMARY HEALTH CARE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, AND ASSISTANT SURGEON GENERAL, ROCKVILLE, MD, ACCOMPANIED BY DONALD WEAVER, M.D. AND NORRIS LEWIS, M.D.

Dr. GASTON. Thank you, Mr. Chairman, and good morning. I am Dr. Marilyn Gaston, the Director of the Bureau of Primary Health Care, in the Health Resources and Services Administration of the Public Health Service. With me this morning is Dr. Donald Weaver, Director of the Bureau's National Health Service Corps Division; and Dr. Norris Lewis, Director of the Division of Scholarships and Loan Repayment.

We are here today to describe the essential role of the National Health Service Corps in meeting the needs of medically underserved people in our country. The Bureau develops and administers programs that play a key role in promoting access to primary health care by decreasing the multiple barriers underserved populations face in obtaining essential preventive primary care in our Nation.

We accomplished this three approaches. By establishing systems of primary care, community and migrant health centers, health care for the homeless programs and primary care in public housing. Also by targeting very special and very vulnerable populations—people that are abusing substances, people infected with HIV, mothers and children, the elderly, native Hawaiians and immigrants.

Our third approach is the National Health Service Corps which recruits places and retains primary health care professionals in underserved rural and urban areas in the country. These professionals include family physicians, pediatricians, internists, obstetricians, psychiatrists, also nurse practitioners, certified nurse midwives and physician assistants.

Changes in the financing of health care reform, although necessary, will not guarantee availability and accessibility of health care providers and services. Lack of facilities, rural isolation and overwhelming urban social problems make it unlikely that purchasing power alone will assure adequate providers in the majority of our underserved areas.

There are approximately 43 million underserved people without access to primary care providers. As you know, this leads to poor health outcomes, increased infant mortality, decreased immunization rates, and many health outcomes which could have been prevented or diagnosed early and treated earlier are seen late in advanced and severe stages.

The National Health Service Corps currently has only 1,200 providers in the field serving a total of 1.8 million people, a significantly small number of providers for the millions of people in need. The National Health Service Corps, which celebrated its 20th anniversary last year is an invaluable vehicle for meeting the medical needs of underserved people.

Over 17,000 National Health Service Corps primary care professionals have served in underserved areas over these past 20 years. Areas where people say not is there a doctor in the house, but is there a doctor in the county. And without the Corps for many of these communities there would have been no doctor at all.

The National Health Service Corps assists communities in recruiting providers through its scholarship and loan repayment programs. In return for educational financial assistance, providers agree to serve from 2 to 4 years in needy areas.

If you look at the chart, you can see the line at the top shows that the number of providers increased to a peak of 3,000 in 1986. And then you can see the decrease which coincides with a significant decrease in funding. The funding is portrayed by the bars. The decrease in funding occurred in the 1980's and now you begin to see an increase in our field strength commensurate with our increase in the dollars beginning in the 1990's.

The Corps places health professionals in federally designated health professional shortage areas that are determined to be of greatest need. Factors which are used in determining greatest need are the ratio of health professionals to population, poverty, infant mortality and access to services.

The 1990 revitalized National Health Service Corps legislation broadened the mission to include not only primary care physicians, but also nurse practitioners, nurse midwives and physician assistants.

To enhance recruitment and retention of primary health care professionals to serve needy populations, the Corps has initiated activities to provide its students and residents with mentoring networks and educational and clinical hands-on experiences in underserved areas.

A Junior National Health Service Corps may be developed to expose junior high and senior high students to primary health care, to service in underserved areas, and to appropriate role models and mentors.

This chart shows projections of the NHSC field strength needed to meet the need up to the year 2000. We fully expect the National Health Service Corps to continue to play a major role in providing primary health care to underserved communities.

We think the Corps has had an outstanding track record of serving underserved populations for over 20 years. It has placed health care professionals in some of the neediest world communities and inner urban areas in the Nation where others would not serve.

We have years of experience, and we think we can successfully meet the needs of people who will continue to have barriers to new preventive and primary health care.

Thank you very much.

Senator DASCHLE. Thank you, Dr. Gaston.

[The prepared statement of Dr. Gaston appears in the appendix.]

Senator DASCHLE. You mentioned just now that you have provided the needs of the inner city with the National Health Service Corps. I know you are very familiar with and supportive of the effort to also place National Health Service Corps participants on reservations and in very remote parts of rural America.

I know in South Dakota we would simply not be able to provide health care anywhere near the decrease to which we are doing so today were it not for National Health Service Corps doctors on reservations. It is absolutely critical. It is really the primary source of providers that we have. But were it not for that program, we just would not have enough providers on reservations.

I cannot emphasize enough the degree to which rural areas have also come to rely upon the program and the chart you showed is really illustrative of the direct relationship between the amount of primary care providers and the degree to which graduate medical education in primary care has been supported in the Congress.

As Congress reduced primary care graduate education funds, the number of primary care providers decreased. And with the numbers down, we simply were not meeting health care needs, especially in rural America.

Dr. Eisenberg, obviously the most significant new idea that has come forth with regard to dealing with the issue of the distribution of residencies and a reallocation of resources towards primary care providers has been your proposal to put a cap on the number of residences, and then determine the distribution through a Commission.

I understand a lot of the reasons why you have concluded that that might be the most appropriate approach. Some express concern that such a plan would be unsuccessful or that it is unnecessary.

I would be interested, if you would elaborate on the degree to which less regulatory approaches and congressional prodding in the past have not worked.

Would you just elaborate a little bit about the history of our efforts to reallocate medical education resources and to find ways with which to address this problem in a less regulatory mode?

Dr. EISENBERG. Certainly. Many of the mechanisms that have been used in the past have been to offer either financial penalties or restrictions in the way in which medical education has been supported. I may just run through a couple of them.

For example, there was a decision to fund individuals who are in subspecialty fellowships in internal medicine at a level which would be less than a full fellowship salary in what would be the second and third years after completing their 3-year internship and residency in medicine.

And yet, we have continued to see an increase in the number of positions in those subspecialties, principally because there are exciting technical changes taking place in those specialties and there are financial incentives are available for physicians who enter those fields. There have been incentives, in fact, for the hospitals to fund fellows through the hospital mechanism because it's a relatively inexpensive way of attaining support for their labor.

Our concern is that most of that desire to increase the number of residents has been service driven. And since the dollars have been related to the service provided and have been channeled through hospitals and in almost all incidents solely through hospitals, what we have done has been to encourage a continued focus on hospital-based education, which was exactly the opposite, I think, of what the Congress wanted to do.

Second, the Congress has provided some funds in the past to the programs that Dr. Gaston has referred to. But these have been programs which have provided a mechanism for taking physicians who have either trained in primary care programs and are interested in inner city or rural practice to do so, but have not have as big an impact on the training themselves.

The Bureau of Health Professions has had opportunities through Title VII, funded through the Congress, obviously, to sponsor model programs. But those model programs have not been able to be disseminated because they are financially infeasible given the way in which primary care and ambulatory education are funded today. Those are some examples.

These were attempts to change the current system of financing, by jiggling a little bit of money here and a little bit of money there, we think the intent was correct, but the impact just was not substantial enough.

Senator DASCHLE. As I understand it, the proposal would result in a cut of about 2,500 residency positions initially and 11,000 over a longer period of time. Is there any reason to believe that these cuts could result in less access to care?

Dr. EISENBERG. We share the concern that in the short term there may be problems for hospitals who are dependent upon those residents. So is there a risk in the short term in those hospitals? We think there is. And that is the reason why we have proposed that there be some transitional relief for those hospitals.

In the long term will there be less care? We do not think that there will if there is an adjustment in the way in which the distribution of those physicians to specialties and to geographic areas is remedied.

If we continue to have the same mix of physicians, that is the same distribution by specialty and geography, then I think you are

right, that limiting the number of physicians could be risky. That is the reason why we believe that we have to have a change in the distribution as well as a change in the total number of physicians who are coming through the system.

Senator DASCHLE. Some of our people are concerned that this could result in fewer residents going into urban teaching hospitals. Then what would happen is that to fill that gap these hospitals would rely more on nurse practitioners and other midlevel practitioners.

Rural residents feel that if that were to happen, urban hospitals would lure nurses and physicians' assistants away from rural areas, exacerbating the rural primary care shortage. How much of a concern is that? And have you addressed that prospective problem?

Dr. EISENBERG. We have addressed the question of who would be able to provide the services in hospitals and believe that there does need to be an initiative to train nonphysician personnel who can replace the residents. We also believe that there will be opportunities for physicians to provide some of the services that residents have provided in the past.

I think in the short term we will probably not see the kind of shift that you are describing because the hospital-based substitutes for residents are more likely to be more highly technically trained physician substitutes in relatively narrow areas of expertise, not the more broadly trained nurse practitioner or physicians' assistant.

Senator DASCHLE. Why should Congress set the limit by statute? Does that not appear to be a little inflexible? If you mandated limits by statute, would you have to amend that statute with some frequency?

Dr. EISENBERG. We do not think so, because we think that the limit that we have proposed is a rather flexible one. In fact, the Commission looked at what that limit ought to be and considered a limit at the level of a number of U.S. medical graduates and felt, such a limit might be too limiting, as you imply. We felt that a limit that was greater than the number of U.S. medical graduates would give leeway to be more flexible.

We also considered whether or not this decision might be made by a body other than the Congress and felt that it would be best if the decision were made by a group as publicly responsible as the Congress is.

Senator DASCHLE. Thank you, Dr. Eisenberg.

Dr. Gaston, can efforts be made to broaden the definition of shortage areas so that placement of National Health Service Corps doctors and nurses can be made easier?

Dr. GASTON. There is no question that we have looked at the issue of physician to population ratio. The ratio that we have been using for many years of one physician for 3,000 people is really not adequate to provide quality health care as we know it today. And the national standard is one in 1,500. So that there is no question, we would like to use that as the basis for placing providers in areas of need. However, with so few National Health Service Corps providers currently available for placement, changing the ratio would serve no useful purpose.

I think that by looking at the criteria in terms of infant mortality, the difficulty people have in terms of getting to health care—distance, travel and time that it takes—looking at rates of poverty, at this point in time we think we have no problems placing them in rural areas and in urban areas of need.

We have not considered an expansion of any of the criteria.

Senator DASCHLE. How long would it take under the current criteria to put a National Health Service Corps member in each of those underserved areas? How much money would it take?

Dr. GASTON. Well, our projections are based on underserved people. So we are saying that to reach the millions of people that are needy, we could do that by the year 2000, and it would require around 18,000 people in the field to do that. The costs would increase each year and reach $1 billion in the year 2000.

Senator DASCHLE. A doubling of the budget. So that would mean——

Dr. GASTON. In 1995.

Senator DASCHLE. So in dollar terms, what are we talking about?

Dr. GASTON. We are talking $290 million in 1995.

Senator DASCHLE. $290 million and then level off at $290 million for the years subsequent?

Dr. GASTON. There would be a gradual increase to the year 2000 at which time it would be $1 billion.

Senator DASCHLE. $1 billion by the year 2000?

Dr. GASTON. By the year 2000.

Senator DASCHLE. To reach that goal?

Dr. GASTON. To reach that goal. And that is increasing the scholarship line, building the pipe line. And, remember, it takes about 6 to 7 years before they are ready to go into service. So at the same time we need to definitely increase the Federal Loan Repayment Program and the State Loan Repayment Program and the Community Scholarship Program. We need all of these mechanisms to get providers into underserved areas as quickly as possible.

Senator DASCHLE. I am not sure my light was turned on when I began asking questions. So I may have exceeded my time already. So with that, Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, you are very generous. I am planning to stick around for the whole of this, so you can take as much time as you want. But I am not sure about all of my colleagues. I enjoyed your questions.

Senator CHAFEE. Let us make sure that light is turned on for you. [Laughter.]

Senator DURENBERGER. I read something in our local paper this morning here in Washington, DC, about a prominent Democrat who is well known in health policy circles saying that somehow or other government is more efficient than the marketplace. That just always makes me smile, when I see it either from him, or from anybody else.

When I think back on the history of government's effort to pump more physicians into the system, and to pay specialists much more money than we pay primary care physicians, I just have to sit and chuckle about the efficiency of government.

The fact that we are here today talking about the need for, in part at least, primary care physicians, or primary care persons, if

you will, is an indication that the market out there is changing. People who are paying for health care are no longer willing to pay the prices they pay for specialized care; but, they are willing to pay differently and more appropriately for more suitable kinds of care.

And that government has not had anything to do with that is just a natural reaction from Americans saying, we want more value. I think that is one of the reasons we are here; we have been here over the last 10 or 12 months trying to deal with this particular issue.

My first foray into this area occurred in 1983 or 1984, when I proposed taking all the medical education money from Medicare, and putting it in block grants and sending it back with the States. Then the States would do something like Dr. Eisenberg is suggesting.

Well, I found out about the medical education marketplace very quickly because all the private medical schools said no way. We will never get any of this money. That taught me something about who really is making a market in the medical work force today. In large part, it is the medical schools themselves, the specialty organizations, and so forth.

So John, if I might ask you a question premised on your proposals. You talk about a national pool where we might consider, for example, a premium tax across. If we had a universal access system and everybody was paying a premium, we might have a premium tax of some kind. That money would then go into a national pool. At that point, who is it that would make the decisions about how it gets back out into the system again.

Dr. EISENBERG. What we have suggested is that there be two mechanisms. One is that there would be some national body—a board, a commission—who would make decisions based upon the best available information about the distribution of physicians in different specialties and where we need physicians in different specialties, rather than the current system, which is much more service driven, that is, it is driven by the needs of the hospitals to get residents to provide service in the hospitals. So that is step one—which specialties are in need and, therefore, how is the total pie of residents going to be divided up.

The second decision is one that we think must have the kind of flexibility that Senator Daschle was mentioning earlier. That has to do with residency programs and which areas of the country ought to be the places where these individuals would be trained.

We believe that that decision ought to continued to be made outside of government. We believe that these decisions can be made by the groups who are currently making the decision—the accrediting bodies.

Senator DURENBERGER. But suppose we were successful in actually defining what a market in medicine is and people began to practice differently; they began to network. All of this stuff we are hearing from the task force and from other places. You actually have people linking up the doctors, the hospitals, and the communities. And they are starting to change the specialty mix.

So the signals are coming back into the system, just sort of automatically. Why does it take a government agency to make decisions and to allocate slots? Why is it that students, faculty, institutions,

specialty organizations, will not respond to the demands in a functioning marketplace.

Dr. EISENBERG. I think the principal reason is that if we have a system where there is a natural marketplace, but substantial competition among systems of care, that there is not an incentive for any one of those systems to invest in the infrastructure of research, of work force or of the kind of data that the country is going to need to know whether people have access and high quality care.

Those, I suspect, will continue to need to be decisions that are made at a public level.

Senator DURENBERGER. I could see that. If we think about the present market where you have hugely expensive medical colleges—and we are going to hear from all of these people later on—or when I think of my own, I mean, that is a tremendous public investment and so forth.

But then if I think about the Mayo Clinic. I think about 1,000 or so medical people and 1,000 residents as an investment in research and education. I am not advocating that, you know, as the total American model. But I am saying that there are other ways to look at medical education in the larger context than the traditional model of the university-based system.

Dr. EISENBERG. I agree with you completely. Let me respond in two ways. One is to say that if the Mayo Clinic model is generalizable and if we end up with a system that has a large number of Mayo Clinic type models, or maybe even an expansion of the Mayo Clinic—because as you know better than I, they are starting to develop and will continue to develop satellite sites where primary care is delivered—I think that that would be very exciting.

Then there will probably be more of an inducement for those organizations or networks to get more involved in developing the infrastructure. Until we get there, and that, I suspect, will be a long time, even if we pass some kind of major reform soon that encourages that kind of organization and behavior, we need to have a system that keeps the pipeline going and has the right number of physicians in the right kinds of disciplines.

The second issue is that there will continue to be, I suspect, some concern among those organizations about whether or not they can afford to train physicians so well out of their own funds because not all those physicians are going to stay at the organization.

Remember, the Mayo Clinic is paying for these residencies in part out of Federal dollars, not entirely out of Mayo Clinic physician fees or out of hospital fees. So we suspect that even if we do have a system which encourages the organizations or the accountable health plans, whatever we call them, to develop the infrastructure, there will continue to be the need for some public support for the educational infrastructure, a part which will convince these organizations that it is in their interest, just like it is in the public's interest, to train the right kinds of physicians for the right kinds of specialties.

Thank you, Mr. Chairman.

Senator DASCHLE. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman. I apologize, Mr. Chairman, that I was not here for the first part of the presentation.

I am interested in what Dr. Eisenberg says in his summary. He states, "Current and past Federal policies have had limited impact on the problems of excess physician supply, specialty maldistribution and opportunities for ambulatory training."

In other words, what you are saying is that despite the, it seems to me, rather generous loan forgiveness programs that Dr. Gaston has—Dr. Gaston, you indicate in your testimony that you have one program that forgives $35,000 a year.

Now does that have to be a medical school loan to get the forgiveness?

Dr. LEWIS. The National Health Service Corp Loan Repayment Program will repay graduate and undergraduate educational loans incurred by primary care health professionals, including allopathic and osteopathic physicians, dentists, or certified nurse midwives, physician assistants, or nurse practitioners. This program will repay up to $25,00 per year for the first two years of a contract and then up to $35,000 per year if the contract is extended.

Senator CHAFEE. That is a pretty good deal. I would say quite an inducement. In other words, we recognize that medical education is expensive, but what would a young man or woman in training in medical school, would not $35,000 be——

Dr. LEWIS. The average debt of a medical student coming out today is approximately $52,000–53,000. It also depends upon the medical school. If an individual graduated from George Washington University we are talking an average of around $83,000.

Senator CHAFEE. So in other words 3 years of this and you are home free.

Dr. LEWIS. This program has only been going on since 1987. In 1987 we had 17 people participate in the program.

Senator CHAFEE. Seventeen?

Dr. LEWIS. Seventeen. We had a very small pot of money.

Senator CHAFEE. Oh.

Dr. LEWIS. Last year we——

Senator CHAFEE. So the problem is the money rather than the individuals being——

Dr. LEWIS. The problem was the money initially.

Senator CHAFEE. Well, okay.

Now, back to Dr. Eisenberg. So what you are saying is that those types of inducements and what the Federal Government has done in connection with scholarships and the National Health Service and debt forgiveness do not really affect the supply very much. Am I correct in saying that?

Dr. EISENBERG. That is right. It is not the concepts that we criticize. It is more the funding levels for those programs that have existed; and second, we think that those programs that have existed are on target, but not enough.

Senator CHAFEE. What do you mean not enough? Not enough money or not enough of such programs? I mean, how many different programs do you want?

Dr. EISENBERG. Not enough different ways—let me back up a step, if I may. Our sense is that there are a number of reasons why we have a maldistribution of physicians today. Three of the major ones are that the potential physicians do not have the kinds of inducements or encouragement to enter the fields that are relatively

undersupplied because of their indebtedness and other issues that arise in their early careers and in their repayment of their loans.

Second, we are concerned that——

Senator CHAFEE. Getting back to Dr. Lewis. The forgiveness would only go to those who serve in the underserved areas, would it not?

Dr. EISENBERG. Right.

Senator CHAFEE. And presumably they are primary——

Dr. LEWIS. They are primary care providers. We only fund primary care providers.

Dr. EISENBERG. That will help for the person who has graduated from a program that trains him or her appropriately to provide the kinds of services that are needed in that area.

We are concerned that, in addition to the absence of these inducements, we do not have enough appropriate training programs. And third, the issue of retention is a very serious one. Once these individuals have paid back their loans, will they stay in primary care and will they stay in the underserved area?

We are concerned that the kinds of payment levels that we have today, and the relative payments levels across different disciplines and in different areas of the country have not encouraged physicians to be trained in areas of primary care, to enter areas of need, and to stay in those areas of need. So that is what I meant by it has not been enough.

Senator CHAFEE. Does the whole thing get down to money? That you can make more money as a specialist than you can as a primary care provider?

Dr. EISENBERG. It is a major part. They say that chlorophyll is not the only green catalyst. I am sure that that is right. But I think that we need more than just money. We need to have a system that puts people in a place where they are able to respond to the financial incentives that we put forth for them.

Senator CHAFEE. To be a primary care physician, do you have to take training of a specialized nature? I am sort of a novice in this. In other words, if you come out of medical school where you may have specialized in your internship, you may have specialized in being a pediatric orthopedist, are you pretty well trained to be a primary care physician at the same time?

Dr. LEWIS. It takes 3 years, plus graduating from a medical school to become a basic primary care physician, either internal medicine, general pediatrics or family practice. We even like the family practice physicians to do an extra year so they can get the obstetrics training that they need so that they can provide a full range of service, so that we can place them in rural communities where they can practice as independent providers and provide a full scope of service.

So just being a physician, it does take training in post-medical school to become a primary care provider.

Senator CHAFEE. So if you have gone into surgery of some type you cannot fill a primary care slot without added training?

Dr. LEWIS. Not in our program you cannot. We will not take an individual who has been trained in surgery and place them into a slot for a family practitioner.

Senator CHAFEE. Thank you, Mr. Chairman. Just one final question.

So, therefore, you have to make a decision in medical school at some point that you are going to be a primary care physician. How long into medical school?

Dr. LEWIS. I guess you could say you have to make that when you fill out those pieces of paper, that is the intern match program. But I would think that most people probably have made up their mind by the time they enter their junior year and——

Senator CHAFEE. By the time they do what?

Dr. LEWIS. Enter their junior year, third year of medical school. But the match program actually takes place during the last year of medical school.

Senator CHAFEE. Thank you.

Senator DASCHLE. Thank you, Senator Chafee.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

I suspect that there is not much disagreement about the defining of the problem as a maldistribution specialist versus primary care physicians or the maldistribution of, say, primary care physicians, physicians for that matter around the country between urban and rural, et cetera.

The question is: What is the solution? I take it, Dr. Eisenberg, that essentially you have concluded based upon your analysis of the problem and your analysis of various alternatives to solve the problem, including examining other country's solutions—Canada, Europe, for example, that your recommendation is that Congress should somehow set a limit on the number of specialist residencies and create a board to make residency allocations and so on and so forth, even though it is fraught with certain problems—objectivity, for example, politics and whatnot—that it is still the best solution available. Is that essentially your view?

Dr. EISENBERG. You mean the highest quality education?

Senator BAUCUS. And solves the problem. That is, it solves the distribution problem between specialists and primary care. What I am really getting at is, I have some of the questions that Senator Durenberger has. I think all Americans do. My gosh, what do you mean, the government making these fairly precise, specific decisions. I mean, is that really the American way?

Is that not going to be fraught with red tape and bureaucracy and so forth? But, frankly, I think that your recommendation is probably on the right track. Because as I understand it, Canada has, for example—which I think you would regard as a better allocation between specialists, and primary care physicians—they do it essentially by having the Providences, say to each hospital how much money the Providences are going to give to hospitals and they make these decisions.

And as I understand it, that is the case in Europe as well. That is, Germany, for example, the government basically decides or some quasi government body basically decides, you know, what the ratio is. Is that correct? Is that what those countries do?

Dr. EISENBERG. Our observation of other countries is that Western European countries, like Canada, do have some public input into the distribution of physicians. The answer is yes, they do.

They do it in different ways, some much more regulatory than what we have proposed, but they all have some control.

Senator BAUCUS. And it is your view that the health care reform proposal that the administration seems to be gravitating toward is not a sufficient solution to this problem?

Dr. EISENBERG. Well, I have no particular information on exactly what is going to come out from the President's proposal.

Senator BAUCUS. Well, I am talking about managed competition with global budgeting and so forth, which will tend to put pressure on—provide financial incentives in a way that will tend to get at this problem.

Dr. EISENBERG. We think that the kinds of incentives that are being talked about will help to encourage physicians to want to go into primary care fields and will decrease the inducements for the maldistribution that we have had. But the proposal for the delivery system and the financing system will not solve the problem of how we educate physicians to get into those careers.

So we do believe that we are going to need a separate approach attached to a broader approach that will deal with the graduate medical education problem.

Senator BAUCUS. How does your recommendation help solve the problem of the shortage of physicians in rural areas?

Dr. EISENBERG. We think that it addresses it quite directly in the sense that at present there are relatively fewer physicians trained in the primary care specialties than we believe that the nation needs. And in many ways, the needs of rural America are going to be for access to physicians who can provide a broad array of services.

So that by training more primary care physicians we think that the proposal.

Second, and very importantly, the current mechanism of financing graduate medical education is quite limiting in terms of where the residents can train. Mostly the residents have to train in hospitals or in programs that are operated by the hospitals.

What we have proposed is making it more flexible so that the training could occur in community-based settings, including rural practices and rural sites. We believe that by getting the residents into those community-based sites during their training that they will be more likely to see the potential and the excitement of that kind of a practice.

We suspect it will help in both of those ways.

Senator BAUCUS. Is there some way for the administration in its health care reform to give some financial incentives in two different areas. One would be incentives for more providers in rural areas and inner city areas. But the other side of that perhaps same coin is financial incentives or to help the teaching hospitals who feel they are going to be harmed with fewer specialists that they are training.

Is that part of the solution here, too, within the context of the administration's health care reform as well as we can understand it?

Dr. EISENBERG. Again, I have no information about particular initiatives for academic medical centers. But I think there is great concern that the kind of inducements to purchase low-cost care

that might exist would miss the kinds of programs which are currently cross-subsidized in academic medical centers. That would include education, clinical research and biomedical research.

And so the Commission is concerned, as I know many members of Congress are, that the functions of the academic medical center might be jeopardized by a system that does not take into account the special needs for financing of those functions, particularly if we cannot cross subsidize them out of higher fees in the future.

Senator BAUCUS. So you think the answer is yes?

Dr. EISENBERG. The answer is definitely yes.

Senator BAUCUS. Thank you.

Senator DASCHLE. Just to follow up on that, Dr. Eisenberg. It seems to me that before we would adopt caps one would want to look at four things. First of all, increasing the incentives to serve in underserved areas, second, to fully fund, as Dr. Gaston suggests, the National Health Service Corps, and do through the Corps what we can't do just through incentives; third, to get around this real problem we have with students who are pressured to choose specialties other than primary care in about the second or third year in medical school solutions to the third problem include not requiring students to apologize for wanting to be a primary care physician, forcing schools to change their curricula, putting more prestige and status in primary care than in specialties, and as several Senators have suggested, creating this demand by changing the insurance system.

We do not insure primary care very much today. If we were to insure primary care, it seems to me there would just be this plethora of new opportunities for primary care that, as Senator Durenberger has indicated, would create a market approach to this problem as well.

Why would we not want to try those four things prior to the time we would go to the sort of mandatory approach that you suggest?

Dr. EISENBERG. I think we would want to do all four. But I also am concerned about the fact that that deals with what happens before residency and it deals with what happens after residency. It does not address the problem that many students who come to medical school today thinking that they want to go into primary care or go back to a rural area have their mind changed not only during their student years but during their residency years.

And many students are influenced by the residents with whom they work. So our conviction is that we have to look at the whole continuum of education. And if we leave out those years of residency in the process of reform, then much of what we do before and after residency will be negated.

Senator DASCHLE. When I referred to curricula, I guess I was referring to the entire spectrum of curricula experience. That certainly would include residency as well.

Dr. EISENBERG. Absolutely. Well, we would agree with that. Our concern is that the curriculum within the residencies in primary care programs, which have been improved through the funding from HRSA and the Public Health Service in general, have made a mark and we need to make more changes.

But there have been so many inducements for hospitals to focus on hospital-based education without regard to the need for primary

care physicians. Something has to be done to offset that disincentive for the hospitals to encourage primary care training, and for the institutions to encourage primary care training.

Senator DASCHLE. Thank you.

Thank you, Dr. Gaston.

Senator Durenberger, did you have additional questions?

Senator DURENBERGER. Maybe one or an observation. We passed over one of the serious political problems we have here, and that is the existing subsidies to a lot of hospitals in this country, and in particular, hospital-based care. We debate graduate medical education and indirect medical education up here all the time. Then we debate foreign medical graduates in or out, and they always stay in.

I just sort of, by way of a warning for those of you who have to help us, think about this. The critical nature will be the transition from this, you know, East Coast predominance of medical schools—very few of whom turn out primary care physicians these days. That is just an added burden. I mean, in making that tradition without killing anybody that ought to stay alive is going to be very, very difficult.

This city in which we are sitting right now is number one in America in primary care physicians per capita. It is number one in the amount of Medicaid spending per capita. It is number 50 in adequate prenatal care. It is number 50 in access to primary care. All the health measures, it is number 50. But regarding the spending and the primary care doctors, it is number one.

That sort of inconsistency I know has a lot of other factors, other than the adequacy of professionals. But I doubt if we double the number of primary care physicians in the District of Columbia that we would get them up even above the median in terms of access.

It is like there are other access problems than just putting a doctor in town in a lot of our communities.

Dr. Gaston, would you care to reply to that?

Dr. GASTON. There is no question. I alluded to that earlier, that there are many barriers to getting appropriate preventive primary health care. The financial one being only one of them, a very important one. Certainly the geographic ones we know. The language and the cultural barriers. Those can loom very significant in many of our communities.

And again, the barriers that very vulnerable populations—our homeless populations—face barriers that if they do not have a provider that is available, that is not only culturally and linguistically sensitive, but also understands everything that that homeless person needs to improve their health, then you are right—just having a provider there is not going to solve the problems.

These are major issues and in the Bureau we try to address all of those barriers. And certainly one way to address it is to put providers there that understand the needs of the communities they are serving.

Senator DURENBERGER. Thank you.

Dr. GASTON. If I might, Mr. Chairman, I would like to clarify some information provided earlier on the loan repayment program—that is that we only have 17 people in the loan repayment program. That was at the beginning. We started with 17. This year

we will have 500. We are up to almost 1,000 in the field at the current time.

We received over 1,000 applications for this program last year. And let me just also mention that for the scholarship program we are very encouraged that this year we have received over 4,000 students that want to come into the Corps. So, again, there is a great need. There is a response out there that if the dollars were there we could do it.

Thank you.

Senator DASCHLE. Senator Chafee, did you have additional questions?

Senator CHAFEE. No additional questions.

Senator DASCHLE. Senator Baucus?

Senator BAUCUS. No questions, Mr. Chairman.

Senator DASCHLE. We thank you very much for your contribution. We appreciate your being here this morning.

At this time I'd like to invite Dr. David Brown, Dr. Roger Bulger and Dr. Wanda Huff to come to the table. We are very pleased you could be here with us as well. We are anxious to hear your testimony.

Senator Durenberger, since Dr. Brown is from Minnesota I do not know if there is any particular introduction you wish to make.

Senator DURENBERGER. There is a long one, but he would not expect me to make it. I am very, very grateful you invited Dean David Brown to be here today. He has been at Minnesota since 1984, not only at the University of Minnesota but the University of Minnesota, Deluth, with a program that Ron Franks runs up there.

And as you know very well from South Dakota, we really have made a commitment to primary care in our State institutions at no small cost to the institution.

Also, he is serving in a medical market in which you are all aware of, in which all this hospital competition is driving them crazy. Because trying to do research and education and compete with big powerful hospitals and so forth in your community is not easy.

So I am particularly glad that David was invited here.

Senator DASCHLE. With that, Dr. Brown, we are pleased you could be with us. We would invite you to proceed.

STATEMENT OF DAVID M. BROWN, M.D., DEAN, UNIVERSITY OF MINNESOTA MEDICAL SCHOOL, MINNEAPOLIS, MN, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY RICHARD M. KNAPP, PH.D., SENIOR VICE PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. BROWN. Thank you, Mr. Chairman. Mr. Chairman and members of the Subcommittee, I am David Brown, dean of the University of Minnesota Medical School. Accompanying me this morning is Dr. Richard Knapp, senior vice president of the Association of American Medical Colleges.

My statement will not address the impact of the administration's Medicare payment proposals on teaching hospitals because testimony on these issues was presented to the Senate Finance Com-

mittee on April 1, 1993. However, my colleague, Dr. Knapp, can answer questions the committee may have on Medicare issues.

I am pleased to appear before you to discuss initiatives to increase the supply of primary care physicians. My written statement comments on the Physicians' Payment Review Commission (PPRC) recommendations on graduate medical education commonly referred to as GME. However, given the time constraints my oral comments will focus on goals adopted, and initiatives undertaken both by the Association of American Medical Colleges and the University of Minnesota Medical School to increase the supply of generalist physicians.

The AAMC is committed to increasing the number of generalist physicians and has adopted a policy statement that calls for an overall national goal that a majority of graduating medical students be committed to generalist careers—defined as family medicine, general internal medicine, and general pediatrics—and that appropriate efforts be made by all medical schools so that this goal can be reached within the shortest possible time period. The policy document identifies and recommends strategies for the Association, schools of medicine, graduate medical education programs and the practice environment to facilitate reaching that goal. Our experiences in Minnesota have taught us that changes are required throughout the medical education continuum and that the process that is necessary to achieve change is both lengthy and difficult. The AAMC statement also calls for private sector organizations and governmental bodies joining together in a partnership to eliminate the many barriers that exist to meet the need for more generalist physicians.

A number of medical schools currently are successful in training generalist physicians. Among them is the University of Minnesota which has defied conventional wisdom that a so-called research intensive medical school cannot provide an environment to foster primary care training. According to the AAMC's "Institutional Goals Ranking Report," the University of Minnesota Medical School ranked 16 of 120 schools in producing primary care physicians and ranked 23 in the amount of money awarded for Federal research grants and contracts. Our most recent achievements in producing primary care physicians for rural Minnesotans are presented in the table accompanying my written statement. The same report ranked East Carolina University School of Medicine first in producing primary care physicians. East Carolina was founded to produce generalist physicians for rural eastern North Carolina and has remained dedicated to that mission. That school has done everything conceivable to produce as many primary care physicians as possible. However, they are graduating still only a little more than 50 percent generalist physicians.

Successful medical schools and primary physician work force development is founded in an individual institution's commitment to generalist training. The University of Minnesota has maintained a long-term commitment to placing family practitioners throughout the State. As a result, more than 35 percent of Minnesota's family practitioners work in non-urban settings compared to a national average of almost 27 percent. The 2-year School of Medicine in Duluth was established in 1969 to address the continuing need to

train physicians for family practice, particularly in rural areas. Today it draws nearly 70 percent of its students from communities of 20,000 or fewer. Since 1972, 75 percent of the 700 students who have completed their basic science training in Duluth have entered primary care after graduation, while 60 percent of them practice in non-urban settings.

The AAMC policy statement, noting most students make their choice of specialty before the end of the third year of medical school advocates the early introduction of positive patient-related experiences for students, particularly in ambulatory settings.

Funded by the legislature in 1971, the Rural Physicians Associates Program provides an annual opportunity for third year medical students to spend an academic year in rural settings under the supervision of local physicians who share the cost of the program. Since the beginning of the program, 582 students have participated in the experience—66 percent of those have chosen to be family practitioners in non-urban settings. In 1990, the State Legislature provided more funding to expand the program to accommodate additional students. In spite of these accomplishments, however, Minnesota has not yet met its needed objectives. State health reform legislation passed last year directed the university campuses in Duluth and Minneapolis to increase the supply of primary care physicians for rural Minnesotans and to encourage graduates to establish practices in areas of rural Minnesota that are medically underserved. The medical school has responded to this challenge by developing several initiatives, including curricular reform at the medical student and primary care residency levels. It is important to note that the State Legislature has provided additional financial support for these incentives. The initiatives underway are described in detail in my written statement to illustrate the complex environment and the level of effort required to bring about substantial change. We are doing all that a school might do to help achieve State and national goals. Yet we know that it will also take substantial change in the environments external to our school to create the success that society wants and expects.

Thank you, Mr. Chairman. I am pleased to answer any questions the committee may have.

Senator DASCHLE. Thank you very much, Dr. Brown.

[The prepared statement of Dr. Brown appears in the appendix.]

Senator DASCHLE. Dr. Bulger?

STATEMENT OF ROGER J. BULGER, M.D., PRESIDENT, ASSOCIATION OF ACADEMIC HEALTH CENTERS, WASHINGTON, DC

Dr. BULGER. Thank you, Mr. Chairman. I come from the Association of Academic Health Centers. That is important, I guess, in terms of what I wanted to say today in that we represent not just the osteopathic and allopathic medical schools, but those campuses that have more than medicine but include nursing, and allied health, and pharmacy, and public health, and dentistry, and are generally attached to universities.

So if there is any perspective or bias that my presentation will bring to this issue, it is a multi-professional bias and it is one that attempts to ask the question, what can universities and academic

health centers take in broadly as I have mentioned. What can they contribute to the issues here?

We have a task force on human resources for health that includes 22 of the members. That's about a fifth of our membership and they have worked for 2 years on the issue of access, preparing themselves and asking from the public's perspective what is the key problem and what can we suggest as some possible solutions here.

That is this wonderful purple report that is up there. I know, and a more recent document which attempts, and please excuse the chutzpah that we have here. We are not proposing to you that we know how to write legislation but what we thought would be good exercise for us would be to see if we could write these things down as kind of a reality test to see if this idea really had any benefit to it and if we could lend some practicality to our comments. That is also in your hands there.

Basically, this arises from the fact that really giving financial access to everybody in the country is not going to provide true access to medical care and to health care generally. That has been expressed many times today. Then the question is, where is the shortfall going to be. And the answer is, in general, in primary care.

And it is in geographically underserved areas, a finite number that can be defined. Maybe you need more definition. But they are both in the inner city and rural areas. Well, what is the answer? A lot of the answer seems to be focusing on doctors and it should. And all the things that we have heard are very positive. But really the answer is a multi-professional answer.

So if one then says, okay, it is multi-professional then we get to Senator Durenberger's comment about Washington and how come. And so our committee decided it was not just multi-professional, but it was systematic. It was organization and that something had to be done with that as well.

And whatever you want to call our thrust in which we are going, we call them organized delivery systems. We concluded that really what ought to happen in the geographically underserved areas is that we ought to ensure that there is and organize the infrastructure, we start building the infrastructure for organized delivery systems in those areas.

When you think about that, then you immediately start to say well, how do we do it. And certainly a reform program that we may be hearing from may do that in the marketplace. There is no real evidence that it will. There may be some evidence that it will not. And it seems to us that we ought to start with another initiative, at least testing it to see if 5 years from now we know something.

Therefore, we propose that, let's look at what is already out there—the community health centers, the rural health centers—whatever is in an area, including from our perspective the academic health centers and the National Health Service Corps and try to integrate all of those activities, provide a program that would help to build the infrastructure in a given area, linking community centers through telecommunication with community hospitals and the Academic Health Center, providing easy access to specialists, providing access to educational facilities and educational personnel,

and providing sites that would be appealing for students as they went through their training and students from all the relevant professions.

It is that recommendation that is really in here. We know that the next thing somebody will say is, how much is it going to cost, and we know there is not enough money to do that for everybody right now obviously. It seemed to us that there ought to be enough money to put 5 or 10 sites out there, to test them, to see if people in a given geographic area and institutions in a given geographic area could respond to an RFP that would ask for people who could come together in a consortium to build an organized delivery system or work towards that, that would, in fact, be able to deliver the primary care that now the citizens would have the ticket to gain them access to.

It is that that is described here and it is that that we propose to you. I might say that we do have the support for this from each of the other major health professions and associations and from the National Health Association of Community Centers and Rural Health Association.

Thank you.

Senator DASCHLE. Thank you, Dr. Bulger.

[The prepared statement of Dr. Bulger appears in the appendix.]

Senator DASCHLE. Dr. Huff?

STATEMENT OF WANDA HUFF, M.D., MEMBER, INTERNATIONAL COALITION OF WOMEN PHYSICIANS, LOS ANGELES, CA

Dr. HUFF. Good morning. I am Dr. Wanda Huff, chief of medicine at North General Hospital in New York City. I am representing the International Coalition of Women Physicians in place of Dr. Jessie Sherrod, who could not be here because of an emergency.

On behalf of the coalition, I am pleased and honored to have this opportunity to discuss issues of minority physicians related to anticipated changes in health manpower needs, and enhancement of primary health care services.

Our membership aligns itself in purpose with the 16,000 African-American physicians of the National Medical Association and the 516 members of the National Black Caucus of State Legislators.

Although a need for more primary care practitioners exists, what is true for the majority is not true for African-American and other under represented minority physicians. In fact, African-American physicians have been forward thinking in their predominant choice of primary care specialties and their commitment to serving high-risk, poor and underserved populations.

As David Satcher, President of Meharry Medical College stated, "Blacks have no obligation to service the poor, but they identify with this group and share a unique history. It is experience, not pressure, that gives them the orientation to serve the underserved."

Several studies have documented this commitment to primary care and service to minority and indigent populations. Keith, et al. in 1985, reviewed the experience of the 1975 graduates and found that for minority graduates 55 percent versus 41 percent of non-minority graduates chose the primary care specialties of family

practice, internal medicine, pediatrics and OB/GYN. Additionally, minority physicians were more likely to practice in manpower shortage areas and care for Medicaid recipients. The comparison was 31 percent to 14 percent.

In 1985 also a New York State survey revealed that almost 45 percent of minority graduates planned to serve in socio-economically deprived areas versus 15.6 percent of all students surveyed.

Finally, the Council of Graduate Medical Education (COGME), noted in its third report that African-Americans had been shown to be more likely to follow through with initial plans to practice primary care medicine than other racial ethnic groups.

Despite this record of provider career choice, health statistics have worsened for the African-American community. In 1985 60,000 excess deaths were documented; by 1992 the number rose to 75,000. The U.S. census data for 1980 and 1990 reveal a much lower ratio of physician to population numbers for African-Americans than majorities; 51 per 100,000 population for African-American physicians to African-American population in 1980 compared to 198 majority physicians per 100,000. In 1990 the number had increased only to 71 African-American physicians per 100,000 population compared to 251 majority physicians to 100,000 population.

It is clear more African-American physicians are needed. We are concerned that the vehicles to increase minority physician numbers will place an unfair burden on students to choose only primary care careers. While we recognize the value of primary care and preventive service, we also recognize the need to continue efforts to improve representation of African-Americans in all the specialties and on medical school faculties.

In 1981 less than 2 percent of medical school faculty were African-American, by 1990 the census data revealed the increase was only to 2.5 percent; 14 percent of these clinical faculty reside in three predominantly African-American schools. While this underscores the special value of these schools, it also documents the need to protect opportunities for minority physicians to choose careers in all spheres of medicine.

Restrictions that decrease minority representation in faculty and specialty positions would have negative repercussions down to the student level. Physicians must become specialists before they can choose to seek specialty faculty positions and appointments. Minority faculty members are critically important in mentor and support roles for minority medical students.

It is only the last decade that a substantial number of African-Americans have begun to have representation in specialty areas, academic medicine, research and health policy. The negative affect of the under representation among faculty on recruitment, enrollment and graduation of minority students has been reported by COGME.

The health care needs of the minority community cannot be met in the near future by minority physicians alone. Culturally sensitive practitioners are needed. Minority faculty are needed to serve as role models for all students. Financial incentives to increase primary care physician numbers must not become road blocks to alternative career choices for minority physicians.

The practice of exclusion of African-American primary care providers by some organized physician groups is a topic that requires further review as well. This I raise as an issue today.

After self-directing themselves to these primary care specialties, African-American physicians find they are not desired or admitted because of the high cost of care associated with their high-risk clients who also require additional resources for health education.

In conclusion, first, special circumstances exist for minority providers that require consideration in any health reform model. Minority physicians are currently providing primary care services at a greater level than the majority physician population. Systems to increase primary care participation should not be permitted to undermine the small gang in minority physician representation in the subspecialty and faculty positions.

Second, minority physician participation in reform efforts is critical if redress is to be achieved for the current representation.

Third, the International Coalition for Women Physicians supports flexible loan repayment schedules to facilitate minority student training in all specialties, subspecialties, research and health policy positions.

Fourth, we endorse the 3,000 by 2,000 project of the AAMC.

And finally, practicing physicians must have equal access for the vehicles of health care delivery, under managed care. Monitoring of this process is necessary to document outcomes.

I thank you for this opportunity to present these issues before this committee.

Senator DASCHLE. Thank you very much, Dr. Huff, for an excellent statement.

[The prepared statement of Dr. Sherrod appear in the appendix.]

Senator DASCHLE. Dr. Brown, you talk about the goal of increasing the number of residents for primary care practice to 50 percent or even beyond and you go on to express concern about limits. How do you do that? How do you increase the number of primary care residents to that level and not be concerned about other effects, like the current over-population of physicians, the numbers of providers that are out there?

How do you address that if there are no limits? And how do you ensure that we maintain a high degree of quality with those residents who are coming in if it is percentages we are looking at?

Dr. BROWN. I believe that some of the changes that are happening currently in Minnesota, which differ from the national trend, that is to say medical students are choosing primary care carriers because of the positive environment. That is to say the University of Minnesota has a positive environment encouraging people to go into primary care disciplines. These choices are being made absent restrictions placed upon other alternatives. Medical students are more likely to be pleased with their carriers than if the choices are made only because of limitations that are placed upon them. I think medical students career objectives should be made for positive reasons rather than for negative reasons. Fortunately, that happens to be the experience of the most recent graduating class in Minnesota.

There is very little evidence at this particular juncture, that I am aware of, of concern about too many people in any particular dis-

cipline, which is rather interesting. I suspect that the reason for that is that the marketplace tends to adjust, if you will, the distribution of people within any particular specialty.

I do not believe that the absence of a restriction is likely to yield too many people in any particular discipline for very long because they will find themselves with not much to do.

Now that sounds very laze faire. It is not really such. It happens to be the way the results are coming out in Minnesota. There needs to be a high degree of visibility and advocacy for primary care in the community and that is certainly the case in the highly competitive medical marketplace in Minnesota.

There needs to be more positive incentive for primary care physicians on the reimbursement side of the coin so that they can not only pay off the debts that they accumulated during medical school, but more importantly that they can, in fact, feel that they are being rewarded for the efforts that they put forward.

I think I would tend to be more of an advocate for encouragement rather than choice by discouragement.

Senator DASCHLE. I guess I would, too. Just to clarify. It is your view that we really do not have an overabundance of certain kinds of providers in the country today?

Dr. BROWN. I think there is an inadequate number of primary care physicians.

Senator DASCHLE. That is not what I am asking. Is there an overabundance of providers in certain specialties in certain geographic areas?

Dr. BROWN. I cannot speak for the rest of the nation. There is little evidence of an overabundance of any particular specialty in Minnesota.

Senator DASCHLE. I will not pursue that. But I would be curious as to your view as to the affect of an overabundance in a certain area were there to be one—I am not suggesting that there is.

If there is an overabundance, does that tend to increase costs or reduce costs?

Dr. BROWN. The data would suggest that if there were an overabundance in a highly technically oriented area that that would tend to increase the costs of health care.

Senator DASCHLE. Thank you, Dr. Brown.

Dr. Bulger, I am impressed with the tremendous amount of effort that has gone into the study. You spent 2 years and a good deal of thought, which is reflected in the way in which you lay out the problem and your proposals.

As I understand it, your major recommendation, as you have discussed, is the demonstration project. What I am wondering is however comprehensive that demonstration project is, and are there more immediate solutions that we could adopt. Is there not something based upon experience and current knowledge that we could begin addressing prior to the time we wait for the results of yet another project of this kind?

Dr. BULGER. Sure. And I think that we should begin doing all of those things that we can do. And I would think that if—what we have done here is to try to focus on what would you really like to have happen.

One of the things we would like not to have happen, it seems to me all of us, is to get to the year 2000 and find we have provided everybody with financial access and find that we have a much better relationship between primary and specialist doctors.

Also find that the 80 percent of us who get our care now pretty well actually have taken up all those primary care doctors and that the people who do not get very good primary care still do not have primary care.

So if there was a program where we could begin to say that we are going to do an organized delivery system and start putting in those elements and some money that would focus the attention of the players that are out there now, they ought to start intersecting, and the academic health centers ought to change these. Our battleships ought to change course, as they are trying to do.

Then I think, you know, we are moving in that direction and it will have a ripple affect to those people who do not get those particular grants. I think also that it may be that whatever comes out—I have this personal feeling that there are so many things that may change, that when we start messing around with manpower and asking, you know, we maybe ought to see what comes out of the economic changes.

As I go around the country, the changes now are quite dramatic. They are going on anyway and they will have a positive affect. But I am not sure they will despite anyone to the contrary, that is going to really deal with the inner city or the rural areas adequately.

I believe that if we had 5 or 10 good—the committee believes, I will sign this—that if we could get 5 or 10 good demonstrations out there, that States might begin to copy it and perhaps the Secretary could be asked to report to the Congress and make the commitment that now that everybody in this country would have access to an organized delivery system, maybe by the year 2003.

And then on the basis of 5 or 10 and whatever else happens, one could then look at what is now not done by 1998 and say, okay, here is how we are going to get the rest of the way, which is after all one reason we are doing this, is the access thing.

I know the cost overwhelms everything. And yet what we want to do is focus on that group that needs to be served.

Senator DASCHLE. Thank you, Dr. Bulger.

Senator Durenberger?

Senator DURENBERGER. Thank you.

On the last point, about watching the market work, I find that interesting. Last Saturday, I was having a recreational experience with a couple of oncologists. I hate playing golf. It was in Minneapolis. And they are both really brilliant young men in their mid-1940's whom practice as part of a large multi-specialty or medium-sized specialty group.

But they make less money per year than I do, they work 80 hours a week doing it, and they love it. They love it.

I was recalling that recently one of these small towns in southern Minnesota, which probably draws some of its hospital services from Tom's home State, paid about the same amount of money to get an internists to come out to that small town.

So, you know, things change. Whether either of those is appropriate, that is just sort of the reality and that is just sort of the commitments that people take when they have choices.

I was curious about two things. One is, do any of you have information you can give us on medical school tuition by school. Do we have some idea of what is charged from one school to the other? Does tuition represent and is it portrayed in a way that tuition can represent the actual cost of education? Does anybody have that?

If somebody asked me today what does it cost to educate a, you know, fill in the blank, specialty. I suppose there is a national average. But does it vary a lot from one school to the other?

Dr. BROWN. I suspect, Senator, you would have to agree on the elements that contribute to the costs of medical education and what percentage of that total cost is represented by the tuition. I suspect education costs differ from one institution to another.

Senator DURENBERGER. You cannot compare tuition. But do any of these Associations here have this kind of comparable information?

Dr. BROWN. In the case of Minnesota, the tuition represents 42 percent of the costs of education. A high percentage of the cost of education is actually borne by patient-care derived revenues.

Senator DURENBERGER. But is it a reality that from one institution to the other, depending on what you are doing, what community you are in, and what kind of competition you have, and things like that, that the amount that tuition bears to the total is going to vary fairly substantially and maybe even the cost of educating people will vary.

Dr. HUFF. I do not have numbers in front of me for tuition variation from school to school. But it can be quite significant from a State school, certainly, to some of the private more expensive or exclusive private universities where tuition is $20,000.

The average indebtedness for medical students of $50,000 would actually be quite low for eastern universities where students are graduating with debts of greater than $100,000. And they are not the exceptions in their class.

Senator DURENBERGER. But would it be your observation that a graduate of the highest priced medical school in America in a certain specialty would be better at their profession than the graduate of the lowest cost public institution?

Dr. HUFF. All of the universities are accredited by the same body. So they all have a single standard to meet. And I am sure that each and every one feels they have their own nitch. But I do not think we can evaluate medical students based on the schools or their value to society based on the school they come from.

Senator DURENBERGER. Thank you.

Dr. Bulger?

Mr. KNAPP. The average tuition in private schools is $19,790. The average in public schools is $6,875. And there is a pretty good range in and among the two categories. On average, with regard to the medical school budget, the revenue of tuition constitutes between 4 and 6 percent. But again, you are aware, as well as I am, that in that budget the large professional fee income dollars in some schools, where those dollars run through the budget and in other schools where they are off to the side, in a private practice

arrangement. The same is true when you make a comparison with a school with a lot of NIH money, those dollars are on the budget, so the percentage varies all over the lot. I think we know a lot about the revenue, but we do not know too much about the cost.

Senator DURENBERGER. Dr. Bulger?

Dr. BULGER. Well, there was a time when cost studies were done and a very detailed one was done about 25 years ago, and it may well be that we are moving—I think we are moving towards the need for that again, which in effect went in and studied how faculty allocated their time spent—what was the cost of instruction, what is the cost of research, what is the cost of service—and then parsing these things out.

I think that what you are getting at, I mean, you could have said, well, here is what it costs to train an osteopathic physician and the graduates of those schools by every test. Are they as good or better on the State examines, qualifying examines, as the allopathic medical schools, sometimes with the tuition or cost that is a lot higher?

I think these are both very good places and both doing the right things. Where I think we are is, that over the years these schools, these medical schools, university-based, have been invested in as a matter of public policy, put NIH money there, and as a matter of public policy we pay specialties. And as a matter of public policy, we build new teaching hospitals.

We wanted what we have and we have put a lot of the money there. And as the people managing that, what we have done is accept the money and we have been allowed to use it creatively, instructively, not illegally. Okay. How do we get these different things done that everybody wants us to do and that we can do? We are creating jobs. We are enormous economic engines.

If you go to State Legislatures and say, do not give us all that money—but if you do not we are going to lose 1,000 jobs. They will say, hey, wait a minute, we do not want that to happen and they really do not.

Because we can show that if we bring in an NIH dollar in, we are going to generate $7 for the local economy. So it is a very complex thing.

And we are really cross subsidizing a vast thing. So when we talk about medical education, that is the reason I object personally to those people when they put up a slide that says here is what the Federal Government has put into education—$8.9 billion NIH dollars. Well, that is, you know, first of all only $4 billion goes to the medical schools, but that all ought to go to research and it does have an impact on the education.

So you work these things out. I think the true cost of education and of instruction does vary from place to place. It depends a little bit on the variety of experiences they want their students to have. And this would go across the board and into dental schools and others. So it is a very delicate balance, I think.

Senator DASCHLE. Thank you all very much. We appreciate very much your testimony and the contribution you made this morning.

Our final panel is comprised of Leah Harrison, Dr. Alan Nelson and Dr. James Nolan. If they will come to the table at this time, we will take their testimony.

We welcome you and we are delighted you are here. Ms. Harrison, let's begin with you.

STATEMENT OF LEAH HARRISON, R.N., M.S.N., C.P.N.P., ASSISTANT DIRECTOR, CHILD PROTECTION CENTER, MONTEFIORE MEDICAL CENTER, NEW YORK, NY, ON BEHALF OF THE NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS

Ms. HARRISON. I am pleased to be here today. I represent the National Association of Pediatric Nurse Associates and Practitioners and 4,000 members who specialize as pediatric family or school nurse practitioners. On behalf of the members, I would like to express our deep appreciation for the support the Senate Finance Committee has given over the years.

Pediatric nurse practitioners are primary care providers. We have been providing the care for the past 25 years. It has been safe. It has been effective, and high quality to our Nation's children.

If the health care system is going to be reformed and focused on primary health care, two major efforts are needed. The first is, we need financial incentives to educate nurses to become pediatric nurse practitioners. It takes increased funding to direct nurses as staff nurses who are making a higher salary.

Presently in New York a staff nurse to go in to graduate school and come out as a pediatric nurse practitioner actually takes a pay cut in her practice or their practice.

We need to restructure the graduate medical education program, targeting payments to nurse education programs and increase funding for the National Health Service. The demand now exceeds the funding that is available.

The second major policy is, we need to make it more attractive for nurses, one, to want to stay in nursing and two become advanced nurse practitioners. We need leadership from the Federal Government relating to reimbursement policies and we need the barriers of our practice to be removed so we might practice throughout the country without the problems of access to care for many children.

Much of the focus has been on changing the ratio of physician specialists and physician primary care providers. It has been suggested today, a national goal, that we should strive to have 50 percent of our physicians practicing in primary care. The percentage is often justified by the fact that this is the case in most other developed nations.

However, I would like to point out that nurse practitioners and physician assistant professions do not exist in the other countries; and as a result other countries rely on physicians for provision of primary care.

We believe that there may not be a great need for more primary care physicians if nurse practitioners and other primary care providers are integrated into that mix and into the work force projection.

We serve the rural. We serve the underserved. We do it because we like to do it. In my practice, I provide care for over 700 abused children annually. I work in an academic setting. I have to plead

with the medical residents and fellows to rotate through my program because they are not interested in spending their time working with that population.

We like providing the care for well babies, providing their immunization, sitting and talking to the mothers about how to prevent problems of safety and other issues relating to children. We would like to be able to continue it.

Our education and training is less costly than a physician's. To become a nurse practitioner you first need to be a registered professional nurse. There are about 44 education programs in the country where you then can go on to receive your Masters of Science Degree in nursing and be able to take your certifying board and practice.

We need to increase our Federal financial support and incentives through that training program. I was able in the early 1980's through a training program to actually go on to get my graduate degree and my nurse practitioner. I was one of the lucky ones. Because soon after, the monies started to become very limited and access to providing care in the urban settings was greatly decreased.

The reimbursement policy and the need for consistent policy is a must and it must start from the Federal Government. The Federal Government's lead always encourages the States to follow in their foot steps. We need nurse practitioners to practice in the least restrictive manner in all settings. We provide care in mobile settings, in vans, in rural settings, in urban settings, in the communities, and school-based clinics. We are there providing the care to many, many children—infants, children and adolescents.

We need to be able to expand our settings and location not only to the rural and the disadvantaged, but to all persons who would like to have health care by advanced nurse practitioners.

Under the Medicare program, reimbursement levels for nurse practitioners vary and are dependent on the site and the geographic location. Programs now receive reimbursement for nurse practitioners if they work in the rural areas, not in the urban areas.

We believe legislation by Grassley and Conrad, S. 833 and S. 834, should be enacted into law, that public policy should promote the widest utilization of nurse practitioners. We need least restrictive practice policies and to be able to provide incentives for States to change their nurse practice act in order for nurse practitioners to practice.

Often reimbursement is gotten through what is called indirect. Who receives the payment really is not the one who has provided the care because the care is being provided by nurse practitioners. We need to have the reimbursement be directly reimbursed to the nurse practitioner.

Well, the cost is very important and the cost effectiveness of how much you pay for a service. Our education, our outcome, and our access to care in our past practice has shown that many children benefit by nurse practitioners. It decreases the amount of money that is spent for acute emergency room and improves the continuity of care.

For 25 years pediatric nurse practitioners have helped to make a difference in children's health care. Nurse practitioners have pro-

vided the access to care. We need access to improve our care by educational programs, financial incentives, and a playing field that will allow nurse practitioners to practice without the obstacles that we have been practicing in.

I thank you and appreciate the support from your committee.

Senator DASCHLE. Thank you very much, Ms. Harrison.

[The prepared statement of Ms. Harrison appears in the appendix.]

Senator DASCHLE. Dr. Nelson?

STATEMENT OF ALAN R. NELSON, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, DC

Dr. NELSON. Thank you. I am Alan Nelson, executive vice president of the American Society of Internal Medicine and I commend the Subcommittee for its support for primary care.

In March of this year ASIM released this white paper titled "Rebuilding Primary Care: A Blueprint for the Future," which lays out why primary care is in trouble and what must be done about it.

Rebuilding primary care will not be easy. But ASIM in confident that this country can achieve adequate numbers of good primary care physicians if we alleviate some of the problems that are turning physicians away from primary care.

We advocate policies, then, (1) to improve the economic, regulatory and training environment for primary care, rather than just focusing exclusively or primarily on educational reforms; and (2) emphasize approaches that will make doctors want to go into primary care rather than measures that would force them to do so.

ASIM supports changing the weight assigned to residents for purposes of determining GME funding, so that primary care training programs receive a substantially larger share of funding, part of which would be provided to residents in the form of increased stipends. We also support a requirement that all payers contribute to a pool to finance graduate medical education, with the funds from that pool also distributed according to a weighting formula that benefits primary care.

But we question whether a more restrictive policy on funding graduate medical education will work by itself. The critical question is whether the goal of increasing the number of primary care physicians should best be accomplished by creating incentives for primary care or by making primary care the only training that is available for many physicians.

Our concern is that by directly limiting the total number of slots in other specialties that will be funded by Medicare and other payers, physicians will go into primary care not because they want to practice in that field but because they are coerced into doing so. And if the choice is between going into primary care or not practicing medicine at all, many may end up selecting primary care but some will do so unenthusiastically and some may resent the decision or may not be best suited by skill or temperament for primary care.

ASIM is also not confident that a commission is capable of accurately predicting the precise number of physicians needed in each specialty and anticipating future needs of the health care system.

If the inherent difficulties in accurately forecasting physician work force requirements for each specialty causes residency programs to be eliminated in fields that are later determined to require the production of more physicians, it will take years to rebuild those programs and correct the damage that was done.

ASIM also favors creating loan forgiveness programs for physicians who enter and remain in primary care and funding of programs to expose residents and medical students to primary care and ambulatory settings. Area Health Education Centers have already shown to be a proven model for exposing medical students to ambulatory primary care practices and have been effective in attracting more students into primary care.

ASIM is developing mentorship programs that will match up students in their third year with practicing physicians in their offices so that they can see what internal medicine is like in the real world and not just have their exposure to crisis medicine in the hospital setting.

And we should also expand the National Health Service Corps and expand research into primary care.

These reforms will help create stronger incentives for physicians to go into primary care practices, but such measures by themselves will not succeed in producing the right number or the right kinds of physicians needed to meet the primary care needs of the American people without also attacking the disincentives that exist in the practice environment.

One place to start is for Congress to adopt a consistent, ongoing policy of exempting primary care from further cuts in the Medicare budget and providing preferential fee schedule updates for primary care in the future.

The just released recommendations from the Secretary of HHS illustrate why it is absolutely essential that Congress act now to provide a fair update next year for primary care services and to amend Public Law 101–239 to preclude primary care services from falling even further behind the updates for surgical procedures.

Although the administration has proposed the update for all services except primary care be reduced by 2 percent, surgical procedures will still receive a substantially higher update than primary care. And this absolutely sends the wrong signal to people who are selecting their career choices.

In conclusion, ASIM believes that a better future for general internal medicine and other primary care physicians may be at hand, if we have the wisdom to craft policies that make primary care the field of choice for America's physicians.

We believe the approach and recommendations detailed in "Rebuilding Primary Care: A Blueprint for the Future" provide a framework for developing effective policies to reverse the economic, regulatory and training disincentives for primary care.

The goal should be to increase the numbers of primary care physicians by making primary care more attractive rather than trying to coerce physicians into going into primary care.

Thank you.

Senator DASCHLE. Thank you very much, Dr. Nelson.

[The prepared statement of Dr. Nelson appears in the appendix.]

Senator DASCHLE. I have to apologize. I must leave. But I leave you in Senator Durenberger's very able hands, and welcome you, Dr. Nolan.

STATEMENT OF JAMES P. NOLAN, M.D., MEMBER, BOARD OF REGENTS, AMERICAN COLLEGE OF PHYSICIANS, BUFFALO, NY, ACCOMPANIED BY JACK A. GINSBURG, SENIOR ASSOCIATE FOR POLICY ANALYSIS, AMERICAN COLLEGE OF PHYSICIANS

Dr. NOLAN. Thank you for the opportunity, Mr. Chairman, to present our views concerning primary health care. I am Jim Nolan and I am here today on behalf of the American College of Physicians as chair of the ACP Task Force on Physician Supply and as a member of the Board of Regents.

For many years, the College and others have been sounding the alarm about the declining share of young physicians interested in careers in primary care medicine. More recently, we have voiced our concern about the increasing number of physicians who have become so disillusioned and dissatisfied with the burdens of private practice that they have either joined larger organizations, retired early or otherwise left the field.

Now we are on the eve of enacting major national health system reforms and there is a looming crisis concerning the availability of primary care physicians that has been detailed by other speakers today.

The general internist will play a particularly important role as primary care giver and as a consultant to patients with difficult undifferentiated problems. General internists will be needed to diagnose and treat a wide range of health problems and to evaluate and manage the biomedical and social aspects of illness in the hospital and office.

General internists will be needed more than ever as diagnosticians who can distinguish between routine ailments and symptoms of more serious disease. The ACP on behalf of internists is seeking to develop solutions to help meet the Nation's future needs for primary care physicians.

We have identified a number of Federal policy changes that we believe are necessary to increase the number of generalists in our work force.

First, the college does support the formation of a national work force commission that would assess the need for health care personnel and set targets regarding the supply and specialty distribution of physicians as well as the numbers of other health care professionals.

Our task force will be meeting again within the next 2 weeks to address the possible functions, composition and structure of such a commission and we would be pleased to share our recommendations with the subcommittee.

In internal medicine there are too many subspecialists and not enough primary care generalists. The number of subspecialists should be related to tertiary care needs and academic needs. Accreditation agencies should rigorously evaluate the quality of training programs and anti-trust restrictions should be eased to allow

these nongovernmental agencies to reduce subspecialty training slots based on quality in accord with national work force goals.

Second, in the financing of graduate medical education, we believe that Medicare funding for direct and indirect costs has tremendous financial implications for the types of programs that are offered, the kinds of physicians that are trained, and the location of training sites.

However, we urge you to be very cautious about reductions in Medicare allowances for indirect costs. These payments now help pay for the added costs of teaching hospitals, as well as the costs of hospital services to patients without health insurance, and should not be reduced until alternative funding sources are found.

Third, any proposal for a national health care program must include a financing mechanism to assure that all payers pay their fair share of GME and that costs are not shifted among payers. One proposal worthy of further consideration is to assess all payers a certain percentage of their health care expenditures to be designated to a special fund for distribution among graduate medical education programs.

Fourth, in the area of reimbursement the ever-growing income disparity between primary care physicians and other specialists must be substantially narrowed if current trends in specialty selection are to be reversed.

Substantial revision of the Medicare fee schedule would signal that Congress and the administration are committed to improvements in primary care. Congress should enact an accelerated schedule for the adoption of resource-based practice costs.

The 1997 start date contained in the President's budget proposal is unacceptable.

Several across-the-board proposals have been advanced to achieve Federal deficit reduction and short-term cost controls. We are greatly concerned that fee freezes, both systemwide or limited to Medicare have the potential to drive primary care physicians out of practice.

Across-the-board approaches, while seemingly equitable, in fact, have disproportionately negative impacts on primary care physicians as they lock in current inequities between primary care and procedures.

We also believe that without substantial improvements for evaluation and management services the current RBRVS cannot be applied to other payment systems. Especially at the Medicare conversion factor, the use of RBRVS based fee schedule would be nothing less than devastating to primary care physicians.

Lastly, in the area of regulatory and administrative burdens, physicians resent demands to justify medical decisionmaking to nonphysician reviewers and object to second-guessing of their decisions by physician reviewers who are not experts in the specialty being questioned.

Physicians also resent cumbersome, time-consuming, duplicative and punitive peer review processes. Detailed recommendations for addressing many of these administrative and regulatory burdens were provided in the May 1992 report of the Advisory Committee on Medicare Physician Relationships chaired by Dr. Nancy Gary at HCFA.

We strongly urge that the recommendations of this report be implemented.

In conclusion, I thank you for the opportunity to highlight a few of the issues involved in primary care and to provide our perspective. As I have indicated, the College and the ACP Task Force on Physician Supply are continuing to explore the ramifications of the many proposed policy changes that are before this subcommittee and would welcome an opportunity to further share our findings as they are developed.

Thank you.

[The prepared statement of Dr. Nolan appears in the appendix.]

Senator DURENBERGER. Thank you all very much.

I have been handed a note that a number of Associations have asked to submit testimony for the hearing record and that the record will be kept open until May 25 for the Subcommittee to receive statements.

Also, that Senator Rockefeller, who as you know for family reasons could not be here today, has a number of questions that he would like most of the witnesses probably to respond to. So I hope you will be able to do that also.

[The questions appear in the appendix.]

Senator DURENBERGER. I have a couple of questions. First, just on the subject of RBRVS. Obviously, before we enacted RBRVS I had a big chart with all of its expectations on it. I went back to Minnesota with this chart of expectations, and I showed everybody how much money in Minnesota they were going to make if we did RBRVS.

Why all of these changes? Obviously my State, an old price, high-quality State was going to benefit, almost across the board. But particularly in some of the primary family care areas it would go up 26 percent or something like that. I guess that has not happened. At least that is what they tell me.

Can either of you two doctors tell me why that has not come about?

Dr. NOLAN. Well, I think we are both general internists and internal medicine did not get the same increase that family physicians did, although it was to be substantial. I think one of the difficulties was that there has been at the same time down coding of the services, so that actually physicians are not getting perhaps what they did in the coding before.

And lastly, the administrative costs have continued to go up, so that the overhead and practice for generalists has really become so significant that the total income regardless of the RBRVS for general internists has really decreased significantly.

Dr. NELSON. And the conversion factor was set by an inaccurate formula in the first place, based on the assumption that physicians would game the system, that there was an asymmetric transition and other factors. There were assumptions in setting the base line conversion factor that caused it to be set at a value lower than it really should have been set at.

Then the budget difficulties have not provided updates the way they should be and having separate conversion factors and separate volume performance standards for surgical and nonsurgical services has disadvantaged primary care specialties.

And finally, the practice cost expense part of the formula was set based on traditional charges. The current formula has resulted in primary care services not being valued upward properly because it is skewed in the favor of the proceduralists or the hospital-based services.

Senator DURENBERGER. Why were the standards separate for surgical/nonsurgical? Why did that become a problem? I am assuming that there is only so much surgery you can do. So you cannot sort of game the system at the surgery side, but you can game it at the nonsurgical side.

Dr. NELSON. There was an assumption of gaming that I think was probably inaccurate and unfair in the first instance. But the trend lines were showing, I believe, that fewer surgical services of some types were being done, fewer operative gall bladder removals for instance.

But also some of the fastest growing procedures were placed in the nonsurgical category—some of the endoscopic procedures and the balloon dilation of coronary arteries and so forth. They were arbitrarily placed in the nonsurgical category. So areas of proper technologic growth came back to haunt the evaluation and management physicians.

Senator DURENBERGER. Have the two Associations made recommendations to us and to PPRC about changes that ought to be made?

Dr. NELSON. Yes.

Dr. NOLAN. Both organizations have.

Dr. NELSON. We think there ought to be a single volume performance standard, a single update. Or if not, if there are separate updates, then office, nursing home, and home visits ought to be carved out and treated better as a separate category, valued upward so that reimbursement for those services approaches their true value in terms of work.

Dr. NOLAN. We have the same position, Senator.

Senator DURENBERGER. Let me ask you, the other question is on credentialing changes, I will bring Ms. Harrison in on this as well. I guess there are two or three ways you can go about expanding the pool of professionals available to do primary care, to do gatekeeping, and all of the rest of these sort of things.

If you watch the advertising from associations—from the nursing profession, the chiropractic and so forth—everybody is advertising their availability for providing primary care services.

Obviously, there are credentialing barriers, license barriers, that sort of thing, for a whole lot of people, that have been built into the system. I am quite curious about your observations on what needs to be done, particularly at the State level and maybe with some advice from PPRC about credentialing changes, removal of licensure barriers that would facilitate this.

The second would be that the role that integrated networks can play in making those decisions, rather than having us make the decisions, or the reimbursement system making the decisions. Why not leave it to an integrated network to make those decisions? Particularly, if in this new future of ours that we at least are contemplating, that accountable health plans of which networks will

be a part are going to be put at some financial risk to do better or less.

And would not some combination of changes in the way we do the credentialing, regardless of other changes, need to take place to ensure that integrated networks can take the responsibility for making the decisions, to achieve the desired outcomes. Would that be a preferred direction to move this health care system if we are looking for greater value, which implies at least the high quality and the lower price?

Maybe I can start with Ms. Harrison.

Ms. HARRISON. I think that one problem the nurse practitioners have is throughout all the States there are many different nurse practice acts. Whereas, I can practice in New York one way, I can provide comprehensive histories, physical exams, labs. I do have prescriptive privileges. My counterparts in even surrounding States, New Jersey and Connecticut have more restrictive practice acts which does not allow them to have the same ability to provide the same comprehensive care.

Even though we might be equally trained, our credentials are the same, but due to the State mandates, we are not able to practice and many children do not have access to care because of that.

The second issue on credentialing, I think it is very important in this change that we cease the opportunity not to forget the credentials, for example, of all of the health care team members, that we maintain the quality of education and the credential system and not look for a quick fix and find other providers creeping in and not having the same credentials and not be able to provide the same comprehensive care.

So I think we need to be concerned about that.

Senator DURENBERGER. That is very helpful.

Dr. NELSON. I believe that the other health professions certainly will continue to find their role in the new system. But our job is to produce adequate numbers of well-trained primary care doctors. And there is not anything that can take the substitute. I say our job is to produce enough primary care doctors and there is not anything that can substitute for that, given the fact that other professions will continue to find their collaborative role in this whole thing.

In integrated systems, we are, I think, going to have to find better use for clerical personnel and free doctors up to do the kinds of work that doctors can do. So I see the economies in organized delivery systems being ones in which the administrative burden is lifted off our shoulders and we have more time to take care of people, which is what we want to do.

Dr. NOLAN. Senator, I would just add one more thing about credentialing because I think it is important and it has not been mentioned. That is that the present hospital privileging tradition in this country, particularly in major cities, is actually a disincentive to generalist careers because general interests, for example, who are trained to do many things and many procedures during their residency, and do them, the very next day that they go into practice they are not allowed to do them in the hospitals in which they practice.

So we feel very strongly that the whole credentialing area has to be looked at if we are going to make primary care much more attractive to our students.

Senator DURENBERGER. Well, I thank you all and everyone who has been here does. I think for a free day around this play we got a pretty good turn out, on the occasion of the interest that everyone has on the subject.

So thank you for your full statements and your presentations and your responses.

This hearing is adjourned.

[Whereupon, at 12:16 p.m., the hearing in the above matter was adjourned.]

[The prepared statements of Senators Pryor, Baucus and Hatch appear in the appendix.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR MAX BAUCUS

Mr. Chairman, controlling health costs and improving the quality of care are two key goals of health reform. I firmly believe that we will fail to attain either of these goals unless we are able to change current trends in our physician workforce.

Our country simply has too many specialists and not enough generalists. Only one-third of all U.S. physicians are generalists. Moreover, just 15 percent of medical school seniors are interested in pursuing primary care careers.

Studies abound documenting the negative effects this situation causes. Specialists order more tests, perform more procedures and hospitalize more patients than primary-care doctors treating similar symptoms. Many experts contend that we will never get a handle on health costs until we restructure our physician workforce.

The decline in the proportion of primary care physicians particularly harms rural areas, where people depend on generalist physicians for most of their care. As managed care continues to grow, so does the demand for primary care physicians in urban areas. This demand is already reducing the number of primary care physicians choosing to practice in rural areas.

I'm especially concerned about the effects of national health reform on this situation. If reform increases managed care, as many predict, then our current physician workforce will be unable to meet the projected need in primary care. It will exacerbate the physician shortages that already exist in rural areas.

Some say that greater demand for primary care physicians will, by itself, encourage people to choosing to train as generalists. I would like to believe that would be the case, but I am not convinced. There is already a strong demand for generalists, yet our teaching institutions continue to increase the number of specialist residency slots. These slots come no where near to meeting our health care needs. For example, we have far more neurosurgeons and neurologists than needed to treat the number of brain tumors and serious head injuries that occur in the U.S. population.

I do not believe that increasing demand for generalists is a strong enough incentive to actually increase the number of generalists. We need a much more aggressive and comprehensive national policy.

PREPARED STATEMENT OF DAVID M. BROWN

Mr. Chairman and members of the subcommittee, I am pleased to appear before you to discuss initiatives to increase the supply of primary care physicians. I am David Brown, M.D., dean of the University of Minnesota Medical School. Accompanying me this morning is Richard M. Knapp, Ph.D., senior vice president of the Association of American Medical Colleges (AAMC). The AAMC represents all of the nation's medical schools, 92 academic societies, over 350 major teaching hospitals that participate in the Medicare and Medicaid programs, and over 140,000 men and women in medical training as students and residents.

Mr. Chairman, I am not here this morning to discuss the impact of the administration's Medicare payment proposals on teaching hospitals. Testimony on these issues was presented to the Senate Finance Committee on April 1, 1993 by AAMC Chairman Spencer Foreman, M.D. I do wish to take this opportunity to comment on Physician Payment Review Commission (PPRC) recommendations on graduate medical education (GME). These recommendations are found in the chapter entitled, "Reforming Graduate Medical Education" in the PPRC Annual Report to Congress released March 31, 1993. I will conclude my testimony with a description of our ef-

forts to educate and train more primary care physicians in Minnesota and to meet the health care needs of rural Minnesotans. First, however, I wish to outline the AAMC position on increasing the number of generalist physicians.

AAMC POSITION ON GENERALIST PHYSICIANS

Our present system for graduate medical education and its financing has much to commend it. However, the system needs to change. The Association recognizes the present system has failed to produce the number of generalist physicians that society believes it will need in a reformed health care system. To that end, the AAMC has committed itself to identifying ways to reverse the significant underrepresentation of generalist physicians among practitioners in the United States. A recent Association policy statement calls for:

> an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The policy document identifies and recommends strategies for the Association, schools of medicine, graduate medical education programs and the practice environment to facilitate reaching the goal. It also calls for private sector organizations and governmental bodies joining together in a partnership to eliminate the many barriers that exist to meeting the need for more generalist physicians. Among the recommended strategies at the undergraduate level, medical schools should:

- adopt an institutional commitment to help correct the imbalance between generalist and non-generalist practitioners;
- adjust admission criteria to increase the matriculation of applicants who wish to pursue generalist careers; and
- provide appropriate academic recognition for scholarship, teaching and role modeling among faculty in the generalist specialties.

At the graduate medical education level, the report recommends that residency programs for generalist physicians should:

- be designed explicitly to ensure acquisition of the knowledge, skills and attitudes required for practice; and
- maintain their current capacity for training residents while initiatives to increase the attractiveness of these specialties are implemented.

The policy statement also stresses the importance of changes in the practice environment to encourage more students to enter the generalist specialties. One of the most obvious impediments to increasing the number of generalist physicians is the marked disparity in income expectations resulting from our current system of physician payment. Although the Medicare resource-based relative value system (RBRVS) promised to narrow the income gap between generalists and non-generalists, implementation of the new system has thus far not produced the anticipated gains in payments to generalist physicians. The AAMC supports an accelerated transition to the resource-based fee schedule and an expansion of the RBRVS concept to all other third-party payers.

PPRC RECOMMENDATIONS FOR GRADUATE MEDICAL EDUCATION

Some changes in the funding and structure of GME will almost certainly be required to courage the shift toward more generalists, stimulate more residency training in non-hospital sites, and provide the resources for other initiatives designed to make generalist training programs more attractive to medical students. Strategies for GME will be crucial in shifting the balance of the physician work force to achieve the goals of health care reform. The AAMC believes that the PPRC chapter entitled "Reforming Graduate Medical Education" analyzes these issues well and that the commission has formulated its recommendations based on thoughtful and extensive deliberation. As part of its charge, the AAMC's Advisory Panel on Strategic Positioning for Health Care Reform currently is debating many of the policy issues discussed in the PPRC report to Congress, in particular the need for a stream of revenue separate from patient care funds to support GME, and the need for and the potential role of a central body in establishing work force goals. Although the AAMC debate pertaining to these and other related issues is not complete, offer the following comments on the PPRC recommendations for changing the structure and financing of GME.

All-payer pool. The AAMC agrees with the PPRC that all public and private health care payers should provide their appropriate share of support for the direct

costs of GME. Society needs to understand that supporting GME provides fully-trained physicians to meet its health care needs and must encourage all health care payers and other sources to participate in that support.

However, the AAMC also recognizes that it is becoming increasingly difficult to persuade payers to provide sufficient funding for GME. In a price conscious environment teaching hospitals and other physician training sites will be at a disadvantage because they offer special services, such as medical education, that increase their costs. Hospitals have traditionally incorporated these costs in their charge or price structures, but as new payment methods—such as capitation and discounting—are adopted, hospitals' ability to pass along or shift these costs to payers who are willing to pay will be severely limited. This has clearly been our experience in Minnesota. In addition, ambulatory settings and other practice sites will have even more difficulty absorbing these costs.

Like the PPRC commissioners, many in the academic and policy making communities believe a single national fund should be created to finance GME separately from patient care revenue. A separate fund for the added costs of physician training would enable teaching hospitals and other training sites to compete for patients more readily in the newly emerging price sensitive environment. A separate pool would provide comprehensive funding compared to the current revenue base for training which is incomplete and in flux. However, with a national pool, training would depend on a single source of revenue that would be one of many competing priorities in the annual debate over health care spending priorities. The AAMC also recognizes that many complex issues would need to be resolved before establishing such a fund, including the size of the pool, how funds should be raised and distributed, and the composition, governance and staffing of the entity responsible for the fund.

Congressionally determined limits on the number of first-year residency positions. The AAMC views this recommendation as intermingling two separate but related issues: the overall supply of physicians and the specialty distribution of the physician work force. Limiting the number of first-year residency positions to an aggregate amount will not necessarily ensure that students will choose generalist careers. To achieve this objective, a number of specialty training positions will have to be eliminated. In addition, there are three different paths through which graduating medical students enter their residencies: students may enter generalist specialties with the intention of practicing generalist medicine; or students may enter a generalist training program with the intention of completing one-year before moving on to another specialty (a transitional year); or students simply may enter a first-year generalist training slot with no specific career choice yet in mind. Thus, this first-year limitation on the number of residency training slots is not necessarily related to the specialty distribution of residents.

The AAMC concurs with the PPRC in acknowledging that all graduating medical students should have the opportunity to complete their initial board residency training program. Current AAMC policy states that funding for GME should be limited to graduates of medical schools approved by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA). The accreditation process of these two bodies assures that the medical or osteopathic school is preparing its graduates to accept the responsibilities of residency training programs conducted in the United States. Additionally, the Association believes that only residents in programs approved by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association's Committee on Postdoctoral Training should be funded. Accreditation by the ACGME or the AOA ensures that residency training programs are of high quality and that residents receive appropriate and adequate supervision and education so that upon completion of their training they may practice independently.

Federal allocation of residency training slots by specialty. As indicated earlier, the need for and the potential role and structure of a body that would allocate training slots is being debated within the Association. This debate focuses on the need for such a control mechanism if, as many believe, the market forces inherent in managed competition will realign the career choices of graduating medical students toward the generalist specialties. An additional issue the Association is considering is the relationship of a body that controls residency training positions to the potential role of regional, state and/or local bodies in work force planning.

The PPRC analysis of alternative structures for the proposed national body capture very well the nature of our AAMC internal discussion. Important issues include the role, composition and staffing of a federal body. An advisory commission, composed of private citizens representing various constituencies, would reflect the public/private partnership of the current system of physician training. The AAMC

agrees with the PPRC that one promising model is the Defense Base Closure and Realignment Commission.

Funding of residency slots by accrediting bodies based on educational quality. The AAMC does not support the PPRC recommendation that the bodies that accredit the educational quality of residency training programs should make decisions regarding which specific positions in each specialty should be funded. The AAMC believes that the ACGME and AOA should accredit programs solely on the basis of whether the programs meet the established educational criteria.

Program accreditation and health work force planning should be separate activities for two reasons. While the ACGME and its residency review committees (RRCs) have expertise to evaluate graduate training programs, there is no method for ranking program quality above the normative standards that all approved programs must meet.

Alternatively, the PPRC suggests that "the RRC would have the flexibility to . . . spread cuts across all programs (p. 70)." Given their current composition, organization and structure, the ACGME and the RRCs are not suitable entities for making funding decisions for specific positions. Substantial reorganization of the ACGME and the RRCs would be necessary. Additionally, since these are private sector, voluntary bodies, all sponsors of the organizations would have to agree to assume this responsibility.

Transitional Relief. The AAMC supports the PPRC recommendation to make temporary transitional relief funds available to teaching hospitals that lose residency positions as a part of the recommended fundamental changes in the structure and financing of GME. There is no doubt that teaching hospitals' service needs would be affected if the PPRC recommendations were adopted. The commission suggests that teaching hospitals would be expected to respond to the loss of residents by eliminating services or substituting highly skilled nonphysician practitioners or community physicians. Questions regarding how much funding is provided, under what circumstances and the period during which funds are available are serious issues that must be resolved. Some problems may not be solved easily. For example, some hospitals that have major service responsibilities to patient populations who are unable to pay may not be able to attract physicians or other health professionals to offset the loss of resident trainees.

PRIMARY CARF INITIATIVES AT THE UNIVERSITY OF MINNESOTA

The PPRC recommendations notwithstanding, a number of medical schools currently are successful in training generalist physicians. Among them is the University of Minnesota which has defied conventional wisdom that a "research-intensive" medical school cannot provide an environment to foster primary care training. According to the AAMC's "Institutional Goals Ranking Report," the University of Minnesota Medical School ranked sixteenth (of 126 schools) in producing primary care physicians and ranked twenty-third in the amount of money awarded for federal research grants and contracts. While Minnesota is not alone in providing evidence that both objectives can be achieved, I am very proud of our accomplishments. Our most recent achievements in producing primary care physicians are presented in the table attached to this testimony (Appendix A).

As indicated earlier, the AAMC's policy statement on the generalist physician suggests a variety of strategies schools of medicine may adopt to encourage the production of generalist physicians. The University of Minnesota already has implemented many of these strategies throughout its medical education system. As noted in the policy document, the success of medical schools in primary care physician work force development is founded in an individual institution's commitment to generalist training. The University of Minnesota has maintained a long term commitment to placing family practitioners throughout the state. As a result, more than 35 percent of Minnesota's family practitioners work in non-urban settings compared to a national average of 26.9 percent.

The two-year school of medicine in Duluth was established in 1969 to address the continuing need to train physicians for family practice, particularly in rural areas. Today it draws nearly 70 percent of its students from communities of 20,000 or fewer. Since 1972, 75 percent of the 700 students who have completed their basic science training in Duluth have entered primary care after graduation, with 60 percent of them practicing in non-urban settings.

The AAMC policy statement, noting most students make their choice of specialty before the end of their third-year of medical school, advocates the early introduction of positive patient-related experiences for students, particularly in ambulatory settings. Funded by the legislature in 1971, the Rural Physician Associate Program (RPAP) provides an annual opportunity for third-year medical students to spend an

academic year in rural settings under the supervision of local physicians who share the cost of the program. Since the beginning of the program, 582 students have participated in the experience; 66 percent of those have chosen to be family practitioners in non-urban settings. In 1990, the state legislature provided more funding to expand the program to accommodate additional students.

In spite of these accomplishments, however, Minnesota has not yet met its needed objectives. State health reform legislation passed last year directed the university campuses in Duluth and Minneapolis to increase the supply of primary care physicians. Specifically, the medical school was asked to develop programs to increase the number of residency program graduates who practice primary care (family practice, internal medicine, pediatrics) in Minnesota by 20 percent by the year 2000, and to encourage graduates to establish practices in areas of rural Minnesota that are medically underserved.

The medical school has responded to this challenge by developing several initiatives, including curriculum reform at the medical student and primary care residency levels. You may note that my description of our efforts is lengthy, complex and at times perhaps even tedious. However, it is important to understand that implementing changes to educate and train more primary care physicians is also lengthy, complex and at times tedious! The process takes a long time, and changes need to occur at many points along the education continuum.

To provide the appropriate leadership and visibility throughout the institution, a Dean's committee was established to oversee new primary care activities, and a Task Force on Primary Care Education has been formed. The Task Force will conduct an in-depth review of goals and desired primary care skills of medical school graduates, as well as those of graduating residents and practicing physicians. Methods will include interviews, focus groups, surveys, site visits and a primary care conference. Existing primary care curricula will be reviewed with the aim of coordinating primary care education and developing a curriculum within which primary care is integrated into all four years in a skill building fashion.

The Task Force also will suggest modifications to the third- and fourth-year medical student curriculum to seek a rapid impact on medical student career choices. Simultaneous work will begin with first- and second-year students to identify meaningful primary care educational experiences. A demographic study also is in progress to measure student characteristics associated with choice of a primary care career.

Based on the above and in concert with the Educational Policy Committee, a policy-relevant timeline will be developed for assuring that essential elements are incorporated into the curriculum. Many of the strategies broadly outlined in the AAMC's generalist physician statement, such as ensuring students have adequate opportunities to encounter role models among faculty in the generalist specialties, and creating meaningful curricular experiences (clerkships, preceptorships) in the generalist specialties, likely will be implemented. Specifically, attention will be given to:

- Recruiting additional primary care physician mentors, and identifying pre-clinical mentors for students potentially interested in primary care;
- Establishing relationships between students and mentors prior to the beginning of medical school, e.g., by expanding the rural observation experience (now offered by family practice) to include urban sites and all primary care disciplines;
- Incorporating components of primary care and population-based knowledge into basic science training;
- Developing an ambulatory care rotation in the third-year, and the creation and feasibility testing of continuing primary care experiences for third- and fourth-year students, both at University-affiliated and community practice sites;
- Creating additional Rural Physician Association Program (RPAP)-like experiences of 4 to 12 weeks in both rural and urban sites in pediatrics and general medicine, which will have both clinical practice and community-based/public health responsibility components. A component will be based at the Duluth school;
- Creating a required or elective family practice clerkship;
- Identifying and developing additional intellectual/scholarly experiences for students interested in primary care; and
- Developing a fourth-year elective and/or continuing medical education course tying developments in basic science to primary care.

We expect to complete the study and planning process over the next year, and to have some curricular changes in place by January 1994. No curricular changes will be implemented without evidence to support their effectiveness and without

evaluation of their impact. To that end, these activities may be modified if there is evidence suggesting the need to do so.

In addition, the departments of family practice, pediatrics and internal medicine also are implementing specific primary care initiatives.

FAMILY PRACTICE

The Department of Family Practice has developed a new rural residency program to train 12 family practice residents in rural community and regional medical center settings. A major objective of this proposal is to establish rural family medicine as a viable professional career option for medical students. Eventually medical student rotations will be developed within the rural residency program in an effort to interest students in choosing a career in rural family practice.

The program incorporates many of the strategies known to be successful in encouraging generalist career choices. As suggested in the AAMC's generalist physician policy statement, the program will:

- provide opportunities for students to meet, interact, and develop relationships with rural faculty role models;
- offer opportunities for academic research in the fields of family medicine and community health; and
- provide frequent patient-related experiences early in the medical school curriculum.

First-year residents will train in the Twin Cities clinic and hospital facilities presently used in this department's University Affiliated Community Hospitals Residency Training Program in Family Practice and Community Health, which has graduated 749 family physicians over the past 20 years. Through this new rural family practice residency, the Department will increase the number of family practitioner graduates each year.

The incoming first-year residents will participate in orientation during the last week of June. After courses in basic emergency services training, there will be a two-week orientation at the rural community site and regional center. During this time the residents and their families will have the opportunity to meet rural faculty, become familiar with the regional medical center, the rural hospital and its medical staff, and begin participating in the training program at the rural family practice center.

After the two-week orientation, the first-year residents will return to the Twin Cities site to complete their first-year of training in the basics of surgery, internal medicine, pediatrics, psychiatry, and emergency room medicine. At midterm of the first-year there will be another two-week visit to the rural site for the purpose of maintaining contact with the residents' physician teachers, other health care professionals and the community. A third two-week visit will occur toward the end of the first-year. Thus, there will be a total of six weeks of family medicine service at the rural site during the first-year of the residency.

In the second- and third-years, residents will live in the rural community and spend five half-days per week at the rural family practice center, one-half day in academic pursuits, i.e., community health research projects, and four half-days per week at the regional medical center. They will rotate with faculty from the center through various subspecialties such as orthopedics, cardiology, radiology, obstetrics, community psychiatry and behavioral medicine, surgery and pediatrics.

PEDIATRICS

The Department of Pediatrics' new primary care initiatives include curriculum revision with nearly a 400 percent increase in outpatient clinic training time, development of a new primary care clinic network, new rural and urban community-based primary care training electives, a new general pediatric post-residency fellowship in academic general pediatrics, and faculty development in primary care teaching.

Pediatrician training time in clinics has increased from 15 to over 50 percent to meet the health care needs of children. However, hospitals and health care payers, who traditionally supported and continue to support pediatric training focused on hospitalized children, have not been willing to support outpatient training. Just as the Minnesota legislature solved an identical problem in funding the education of family practitioners in outpatient clinics 20 years ago, a new appropriation for primary care education of general pediatricians has been essential to the Department of Pediatrics in developing new primary care pediatric training experiences.

Curriculum changes in both the medical school and the residency program have been made to increase student exposure to ambulatory experiences in rural and underserved areas. A one-month "non-metro" pediatric training elective was recently

established in three rural communities (Red Wing, Virginia, Willmar) to give third-year residents a rural pediatric practice experience.

A one-month urban training elective was added to the Curriculum in October 1992 to give residents a health care experience in underserved areas, including the Hennepin County Homeless Assistance Project, Hennepin County Medical Center, and the Community University Health Care Clinic. Improved pediatric care is essential in these underserved populations given their disproportionately high infant mortality rates.

Curriculum changes in the residency program made this year mandate six months of primary care training in ambulatory pediatrics, behavioral and developmental pediatrics, developmental disabilities, adolescent health, and emergency medicine. In addition the Primary Care Clinic Network has been expanded. The Network includes public and private sector practices in over 40 sites, including private pediatricians' offices, HMO's, and community clinics. Pediatric residents now spend one-half day each week of their three-year training in a Primary Care Clinic following a group of children continuously during their growth and development. As part of the Primary Care Clinic Network program, the Office of Medical Education is developing a Primary Care Symposium Series, which will provide a core curriculum in primary care to all pediatric residents.

INTERNAL MEDICINE

During the current academic year (1992–93) the Department of Medicine has undertaken several new initiatives for ambulatory care training of medicine residents. These include the addition of a community-based clinic site for medicine residents to gain experience in the delivery of longitudinal care in an underserved setting, and the development of a new ambulatory care elective at the Interstate Clinic in Red Wing. In addition, there has been an expansion of the involvement of primary care internists from the community as attending physicians in residents' longitudinal care clinics.

In collaboration with the Medical School's Office of Curriculum Affairs and the Task Force for Primary Care Education, the Department of Medicine will initiate several studies to further delineate those factors that contribute to residents' career choices (primary vs. subspecialty care) and the effectiveness of new initiatives and training experiences in influencing these choices.

The Department of Medicine also is planning several initiatives for the 1993–94 academic year: They include:

- Developing additional community-based sites for ambulatory care training of residents. Negotiations are currently underway with several other health care providers in the community, including managed care providers and providers in underserved areas. By July 1, 1993, these additional sites should be able to accommodate up to 12 residents taking ambulatory care electives.
- Increasing ambulatory care training for interns, such as the possible extension of the continuity clinic experience to their second-year of training; and
- Negotiating with community providers to increase their involvement as preceptors for residents' ambulatory care experiences at the University of Minnesota Hospital and Clinic and affiliated hospitals.

I recount in some detail the initiatives underway to provide an understanding of the complex environment and the level of effort required to bring about substantial change. We are doing all that a school might do to help achieve state and national goals. Yet, we know that it also will take substantial change in the environment external to our school to create the successes society wants and expects. Thank you for the opportunity to testify and I would be pleased to answer any questions committee members may have.

APPENDIX A

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL—1993 MATCH RESULTS

Type of residency	No. placed	Percent
Family practice	53	22.5
Medicine	47	19.9
Pediatrics	20	8.5
Transitional	18	7.6
Surgery	15	6.4
Obstetrics/Gynecology	14	5.9
Radiology	12	5.1

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL—1993 MATCH RESULTS—Continued

Type of residency	No placed	Percent
Pathology	11	4.7
Psychiatry	9	3.8
Orthopaedic surgery	6	2.5
Ophthalmology	6	
Anesthesiology	5	2.1
Medicine/Peds	5	2.1
Medicine/Pre	5	2.1
Neurology	4	
Emergency medicine	3	1.3
PM&R	3	1.3
Surgery/Pre	3	1.3
Radiation/Onc	1	0.4
Urology	1	0.4
Neurosurgery	1	0.4
Taking year off	5	2.1
Research	1	0.4
Total	[1] 242	100

[1] 224 G–1 Matches plus 18 G–2 Matches.

[In percent]

Type/Internship	1993	1992	1991	1990
Medicine	20	21	22	16
Family practice	23	26	20	23
Pediatrics	9	6	8	11
Surgery	6	6	7	7
Emergency medicine	1	2	4	3
Psychiatry	4	3	4	8
Primary care [1]	53	54	51	58
All Other	47	46	49	42

[1] Includes Family Practice, Medicine, Pediatrics and Medicine/Peds combined

PREPARED STATEMENT OF ROGER J. BULGER

Mr. Chairman, I am Roger Bulger, President and Chief Executive Officer of the Association of Academic Health Centers (AHC). The AHC consists of those institutions having either an allopathic or osteopathic medical school and at least one other health professional school and associated teaching hospital. The CEOs of these institutions therefore tend to have a broad perspective of health work force problems and issues, a perspective that mirrors the breadth of their responsibilities. We have had a Task Force on Human Resources for Health which has been considering for more than two years the work force implications of a health care reform effort aimed at providing universal access to health care. One product of this 22-member task force's efforts is appended as a report under the title, Avoiding the Next Crisis in Health Care. A second product is also included which proposes some possible legislative approaches to solutions to the problems we have identified. My comments today will briefly summarize these reports as follows.

1. Universal financial coverage will not guarantee universal access to health care.

2. The major shortfall in access is in the domain of comprehensive primary care in geographically underserved rural and inner city areas.

3. The solution to that shortfall is not only more primary care doctors, although that is clearly a part of the solution; the complete solution, in any reasonable timeframe, must be multiprofessional in nature and must also involve systemic organization overhaul.

4. This overhaul must begin with existing resources, to which must be appended the additional physical, human, communication, and organizational linkages necessary to provide the basic infrastructure for an organized delivery system (ODS) capable of serving the people throughout the underserved area. Prominent among the many possible contributors to such an organized delivery system would be existing community health centers, rural and migrant worker health centers, academic health centers, Area Health Education Centers (AHECs), other state, public health, school-based, and private clinics serving the underserved, as well as a rejuvenated

National Health Service Corps. We see wonderful opportunities for the President's Service Corps of college students in this sort of activity. We envision an educational network bringing primary care students to these sites and the latest information resources to the fingertips of the providers through real-time clinical consultation through televised communication and other devices. It is important to note that we see the control of these entities in the hands of a community-based consortial board involving all the relevant constituencies, but controlled by the patients or their designated representatives.

5. Realizing that dollars are extremely limited in the short term for such new initiatives, we nevertheless believe that a long-term commitment must be made; we therefore suggest funding five or ten such ODSs now in addition to requiring the Secretary of HHS to analyze and evaluate the performances of these entities in the development of a plan to be presented to the Congress in five years time which would stipulate how to finish the job over the subsequent five years of building organized delivery systems in all the geographically underserved areas of the nation. In this way, we believe the country can look forward to a time ten years hence when every American can in fact have access to basic health care services.

Finally, I would like you to know that we have endorsements of this approach from all of our health professional educational association colleagues as well as the National Association of Community Health Centers and the Rural Health Center Association.

Thank you for your attention.

Attachments.

ACADEMIC HEALTH CENTERS AND NATIONAL SERVICE: KEYS TO HEALTH CARE REFORM

SUMMARY

Policymakers are likely to reach agreement in the near future about how to provide financial access to health care for the currently 37 million uninsured Americans. The Task Force on Human Resources for Health of the Association of Academic Health Centers (AHC), a group of more than 20 chief executive officers of academic health centers, is concerned that health professionals will not be available or properly distributed to meet the increased demand for health services, especially for primary care, when that time comes. The task force is alarmed that human resource issues-specifically the need for health professionals in underserved areas—have received limited attention in the health care reform debate and examined national service for health professionals as one way to resolve this impending crisis.

The task force concluded that plans for health care reform that only address health insurance coverage cannot ensure universal access to health care services. Therefore, the task force recommended that:

- Policymakers specifically address health professional shortages of all types in developing health system reform.
- Steps be taken to expand and improve existing national service programs, including the AHEC program and the National Health Service Corps, to ensure that the health care needs of all medically underserved populations are met.
- The U.S. Secretary of Health and Human Services convene an advisory council to reassess the criteria used to designate medically underserved areas and health professional shortage areas.
- Academic health centers play an aggressive role in addressing health professional shortages and in developing more rational organizational structures for health care in their respective areas.

Recognizing that the nation has traditionally relied on academic health centers to guarantee the future supply and training of health professionals, the task force singled out these institutions to take a leadership role to resolve these issues as well as to address organizational structures and delivery mechanisms that are essential in any reformed system.

The task force concluded that rather than attempt to create a new national service program for health professionals, the most appropriate approach for the short term would be to build on existing programs. This conclusion was reached after consideration of a number of issues regarding national service including:

- whether national service should be voluntary or mandatory;
- which individuals should be targeted for participation and at what point in their careers;
- length and type of service;
- the consequences of national service participation for career development;

- budgetary and administrative considerations, including the roles of government, academic health centers, and other organizations, and
- alternatives to the creation of a new national service program aimed at addressing current and future health professional shortages.

ASSOCIATION OF ACADEMIC HEALTH CENTERS

Academic Health Centers and National Service: Keys to Health Care Reform and A Proposal to Ensure Delivery of Primary Care Health Services to our Nation's Citizens

(AVOIDING THE NEXT CRISIS IN HEALTH CARE, reports by the AHC Task Force on Human Resources for Health)

KEY MESSAGES

1. Health care reform proposals only address the financing of care; attention to human resource issues is noticeably absent.
2. When universal access is achieved the nation will face a second health care crisis because shortages and maldistribution of health professionals, especially with regard to primary health care and prevention.
3. The AHC Task Force on Human Resources for Health recommends that:

- Policymakers address human resource issues in the context of health system reform;
- Academic health centers play an aggressive role in addressing these issues;
- For the short-term, a national service approach should be adopted that builds on and expands existing national service programs, including the National Health Service Corps and Area Health Education Centers;
- The National Health Service Corps and Title VII programs receive increased appropriations as well as Medicare reimbursement for practitioners in health professional shortage areas.

4. To meet the increased demand for primary and preventive care in a designated region the task force proposes a grants program for academic health centers to establish Area Centers for Health Access, which are partnerships between academic health centers and community-based providers.

- The program would not be financed through appropriations dollars but with funds that are earmarked in the health care reform process.
- Academic health centers would conduct regional assessments, establish support systems for health care professionals who serve in underserved and shortage areas. coordinate local resources, and develop and evaluate prototypes for configuring health professionals to better deliver needed services.

LEGISLATIVE PROPOSAL OF THE ASSOCIATION OF ACADEMIC HEALTH CENTERS

Act to Provide Organized Delivery Systems for the Underserved ("ODSUs")

Section 1. PURPOSE

To marshall the resources and commitment of academic health centers to assist in the provision of quality primary care services, particularly to persons in medically underserved areas, and to develop long-term, structural solutions to the shortage and training of primary care personnel, the Congress establishes this Act to provide Organized Delivery Systems for the Underserved ("ODSUs"). The ODSU program would allow the federal government to expand upon existing resources and personnel *immediately* to improve the delivery of quality primary care services, while requiring the Secretary to develop a plan within 5 years to ensure the delivery of such services to all Americans.

(a) An ODSU program would involve a network of community-based health care providers and academic health centers and other locally appropriate health professional schools committed to working together to help ensure (1) that all of the citizens of a geographic region have access to state-of-the-art primary care, (2) that service delivery is improved through expanded collaboration, coordination, and telecommunications networks, and (3) that health professions students have an opportunity for community-based training in the provision of state-of-the-art primary care.

(b) The availability of support through this program shall be coordinated with pre-existing programs in the area, such as academic health centers, the National Health Service Corps community health centers, Area Health Education Centers, community mental health centers, migrant health centers, and local private practitioners to make optimal use of existing resources, personnel, and networks.

(c) The ODSU network shall consist of any academic health center (and perhaps other local health professions schools) working with local health care providers in an underserved geographic area that agree to participate, including, but not limited to: National Health Service Corps sites and personnel, community-based clinics (including, but not limited to, community health centers, migrant health centers, and school-based clinics), Area Health Education Centers, private practitioners, ambulatory clinics, and rural hospitals.

(d) Each regional ODSU shall have a governing board consisting of at least five individuals from health care settings, no more than two of whom work in the same type of setting, plus two representatives from the community. A typical board might consist of two representatives from the academic health center, the administrator of a community health center, a dentist in private practice, the nurse who runs the school-based clinic program and two local community leaders. At least one board member must represent a health professions school of an academic health center.

Section 2. FUNDING

Funding for the ODSU program shall be $25 million over a five-year authorization period.

Section 3. ODSU GRANTS

ODSU grants shall be awarded based on applicants' proposals for creating and improving primary health care delivery systems. Priority in funding grants shall be given to applicants who present a plan utilizing existing providers, resources, and networks to achieve the dual ODSU objectives of providing quality primary care services to all citizens within a region and providing state-of-the-art training for new and existing primary health care providers.

(a) Applicants for an ODSU grant must:

(1) Demonstrate the foundation of a service support network among existing health care providers in the region to provide quality primary care services.

(2) Assess the current primary care delivery system of the region.

(3) Describe the demographic and health status characteristics of the region's population.

(4) Assess the unmet primary health care needs in the region.

(5) Identify and assess the needs of the current primary care providers in the area.

(6) Develop a service plan to meet the needs of the citizens and the primary care providers through an organized health care delivery system.

(7) Develop an evaluation plan to assess and evaluate the ODSU's impact on access and health status.

(8) Develop a plan to incorporate the training of health professions students in community-based, primary care settings.

(9) Develop a plan to improve the current communications network among regional health care providers so that all providers in the ODSU can have access to state-of-the-art medical knowledge and practice through online consultation and information repositories.

(b) Organization.—Applicants must submit a proposed governing board, a provider network, and a proposed service region for approval by the Secretary. Priority shall be given for ODSU grants in those areas most underserved in the provision of quality primary care services.

(c) Service plan.—The Applicants shall provide a detailed health service plan for in the region. The plan shall be designed to deliver quality primary care health to the region's citizens by building on existing resources and to meet the needs of the primary care providers in the region. It may include, but need not be limited to:

(1) Enhancing the ability of existing clinics or clinic sites (such as mobile vans, school-based clinics, senior center clinics, well-baby and prenatal clinics, disease screening and health education programs, vaccination programs, etc.) to meet the primary care needs of the population by improving access, continuity, coordination, and quality.

(2) Organizing and staffing referral and back-up systems for primary care providers in the region.

(3) Ensuring the availability of timely and effective trauma care and emergency psychiatric care for all areas of the region.

(4) Developing a computerized information system (and acquiring technology and staff)

a. for shared medical records and/or claims processing capabilities

b. to link community providers to specialty consultation and library resources

c. to monitor/assess patient outcomes and improve the quality of care

(5) Developing a logistical plan to provide outlying clinics, community hospitals, and practitioners' offices with access to state-of-the-art diagnostic capabilities and technology.

(6) Arranging for group purchasing of malpractice insurance for primary care providers in the region and developing arbitration systems for settling malpractice claims where these needs are not met by the Federally Supported Health Centers Assistance Act of 1992, P.L. 102–501.

(7) Developing, implementing, and evaluating practice guidelines for cost-effective primary care.

(8) Developing and implementing effective programs of continuing education for primary care providers in the region.

(9) Developing effective channels for providing follow up care for patients diagnosed at primary care sites.

(d) Training plan.—The Applicants' training plan shall include requirements for the ODSU providers to:

(1) Place students enrolled in area health professions schools of academic health centers in traineeships at participating community and migrant health centers, school-based health clinics, other community-based clinics, mobile clinics, private practitioners' offices, HMOs, and/or third party administrators' offices,consistent with the primary care needs of the region.

(2) Develop integrated, multi-professional educational programs at ODSU sites.

(3) Develop a cadre of community-based preceptors.

(4) Supervise the training provided to each student by the placement site.

(5) Evaluate the student's work.

(6) Evaluate the site for future participation as a training placement site.

(7) The academic health centers shall be expected to coordinate the training/education for the ODSU among the participating health professions schools in the region.

Section 4. GRANT AWARDS

(a) Priority in awarding ODSU grants shall be based on the service and training plans promise for achieving the ODSU objectives and the potential for meeting the needs of citizens in underserved areas as identified by the Secretary.

(b) Priority will be given to ODSUs whose academic health centers are able to secure commitments from 20 percent of their medical students to serve in the National Health Service Corps (NHSC). Such institutions will be better able to focus, integrate, and perhaps telescope the undergraduate and graduate medical education experiences so that a higher proportion of students entering the NHSC will be assigned to the ODSU in the underserved area and may therefore remain in the region as a mature practitioner.

(c) The Secretary shall award no less than 10 ODSU grants. The Secretary may determine that multi-year grants are appropriate for administering the ODSU program, but no grant shall exceed 5 years.

(d) The Secretary shall develop a formula for allocating funds among eligible ODSU applicants in a given year. The formula shall consider the needs in the underserved areas and the nature of the proposed plans.

Section 5. DEVELOPMENT OF UNIVERSAL ACCESS AND DELIVERY PLAN

The Secretary shall within 5 years of the enactment of this Act present a plan to Congress that ensures that all citizens have access to quality health care services within 10 years of the date of enactment. The Secretary shall base this plan on an analysis of the results of ODSU grants that have been funded.

Section 6. ENHANCED FUNDING FOR NATIONAL HEALTH SERVICE CORPS

Section 7. ENHANCED FUNDING FOR AREA HEALTH EDUCATION CENTERS

Section 8. ENHANCED FUNDING FOR COMMUNITY AND MIGRANT HEALTH CENTERS

Section 9. ENHANCED FUNDING FOR HEALTH PROFESSIONS LOAN PROGRAMS

RESPONSES OF DR. BULGER TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. I'm glad to hear that you had a Task Force studying these work force issues for two years now. I'm curious why after years of study your major recommendation is a demonstration project, however comprehensive, to increase care in underserved areas. Are there other more immediate solutions that you think we can adopt?

Answer. I should note that for years many academic health centers, including those in the states of Kansas, Kentucky, Arkansas, West Virginia, Washington, Alaska, Montana and Idaho have had innovative programs that provide training for students in the health professions in community sites. The academic health center models are founded upon the multidisciplinary team concept that successfully operates through strong networking with the home institution. We have learned that retention of health professionals requires networking and an infrastructure that includes social and professional support.

An immediate answer would be to incorporate this education/service model into any health reform proposal now on the table or to provide the flexibility in funding to permit our academic health centers not only to expand these programs but also to assist the National Health Service Corps in incorporating this concept in its operations.

With the emphasis on a managed competition model that took little account of the educational arena our Task Force on Human Resources for Health, which is comprised of more than 30 CEOs of academic health centers throughout the nation, recommended a demonstration project. The task force anticipated that many policymakers will take the position that managed competition will in fact so alter the "market" that it will cause organized delivery systems within the private sector to form to serve the chronically underserved. Most people I know do not believe that will occur. Therefore, we propose a parallel track, if you will, wherein the federal government undertakes to require that its own resources, currently being spent on somewhat fragmented care activities in these underserved areas, be coordinated with these other players in these geographic areas. In fact, we recommend that the various fragments be stitched together in a new fabric of care in an organized delivery system serving an entire population identified as geographically underserved. We would love to see the government do as many projects as it can reasonably afford. At the end of five years, the Secretary of HHS can evaluate what has been accomplished, compare those results with whatever the market place and the general thrust of health care reform has produced in other areas, and then decide what more needs to be done to ensure access of every American to basic health care. We frankly believe that it will require the combined efforts and leadership of both the federal and state governments to get this done and to bring organized systems of care into all of these underserved areas. I can assure the committee that our task force does not regard these activities as demonstration projects in that we are certain they can and should be made to work, because we frankly see no better alternative.

One immediate solution is the expansion of the National Health Service Corps (NHSC) with certain encouragements that it links creatively with educational institutions to connect service with some residency credit, thus creating the possibility of having undergraduate medical students connect their medical school training with NHSC and postgraduate residency training. This sort of linking of service sites through undergraduate and graduate training to the NHSC could serve to achieve in those selected sites the sort of educational and service environment that would both enhance the services available to the community and create an environment more compatible with keeping professionals in the area after NHSC obligations cease.

Question No. 2. In your testimony you endorse both increasing support for the National Health Service Corps and reliance on the President's proposed service corps for college students. Could you tell us about the relationship between members of the Corps and the academic health centers that are in the area of their assignment.

Is there more that we can do to improve that collaborative relationship? Aren't there steps that you could take that would enhance the experience of professionals in the National Health Service Corps?

Answer. We know that many members of the NHSC have links with academic health centers in their area, whether through faculty appointments, information service networks or work with staff of the academic health center.

I certainly do believe that there are many steps that can be taken to enhance the experience of those in the NHSC that involve collaboration between the corps, the sites in which they work and the academic health centers in the local environs. They say that all politics are local; the analogy to this issue is that each of these relationships needs to be worked out locally, with the particular people involved.

I personally believe that the administration of the NHSC here in Washington and the Association of Academic Health Centers ought to be able to sit down and hammer out a relevant agenda for collaboration from which individual institutions can begin discussions with NHSC people in their area.

In 1992 we met with leaders of the NHSC and offered to assist in providing support to Corps members and thus link them with the activities of our institutions. This would require, for example, that the NHSC provide the names of Corps members serving in our communities to the vice presidents of health affairs of our member institutions. Academic health centers in turn could ensure access to information services, could consider faculty appointments, or could provide mentoring and technical assistance.

The Association of Academic Health Centers, for example, would be happy to be involved on the advisory board to the NHSC and to provide expertise in site selection and evaluation.

I have offered such support in the past and will do so again with the knowledge that significant expansion of the Corps is in the offing and that the Corps may find an alliance of some use. Thank you for asking that question. We shall act on its implications.

Question No. 3. Can you tell me what the current obstacles are to setting up the educational network that you testified about, one that would like up teaching hospitals and community sites, like community health centers and school-based clinics? It seems to me that these kind of linkages should exist today and should be able to be fostered even without investment of more federal dollars.

Answer. In fact, more of these linkages do exist today than I had previously thought. And more and more such linkages are being established almost daily. Certainly, if the government does nothing, the current trends will encourage such linkages and an increasing number will occur. However, it is one thing to have a teaching hospital line up a number of existing community health clinics to in effect become feeders of soon-to-be-paying patients to the extent necessary to ensure the viability of the teaching hospital and to provide some ambulatory training sites for residents. It is quite another thing to assess the health care needs of an entire underserved population to determine both the needs currently being met by existing disparate and uncoordinated entities as well as those that are simply not being met by anyone and then to determine a plan for providing all the services in a coordinated way. The latter approach, which we support, goes on to declare that success will depend upon an overarching organizational entity under the community's control, and some new infrastructure emphasizing telecommunications and electronic information transfer in order to maximize the existing intellectual, professional and physical resources in the population's interests.

Question No. 4. Could you please tell us a little more about what you mean by the ultimate solution to our primary care problems being multiprofessional in nature?

Answer. Physicians alone cannot solve the primary care shortfall within the next twenty or thirty years, especially in the chronically underserved areas. In any organized delivery system, including Kaiser Permanente, the delivery of comprehensive primary care involves a coordinated and cost effective mix of physician assistants, nurse practitioners, genetic counsellors, pharmacists and public health professionals. Throwing more doctors out into the market place as solo practitioners is highly unlikely to make much of a dent upon the urban inner city and rural populations; whereas a multiprofessionally staffed organized delivery system ought to be able to deliver effective care efficiently.

Question No. 5. You have focused your testimony on the need for increasing primary care professionals in underserved areas. As our system is restructured I am convinced that the primary care practitioners that are in underserved areas today will be heavily recruited by new managed care entities. What is the role of the academic health centers in addressing this need? Doesn't that argue for being more comprehensive in crafting solutions to this problem?

Answer. That is a very perceptive and important question. I believe the evidence strongly supports your view. As you know, last year in California, Kaiser apparently recruited as many new primary care physicians as were turned out by all of the primary care training programs in the state. Part of Kaiser's appeal is that it offered good salaries, but the most important part of its appeal is a viable organized system that takes away many of the negative dimensions of practicing medicine in our current environment. That is precisely why our task force concluded that setting up such systems aimed at the chronically underserved with all the interconnections and support that could be provided (as described above) was the best way to go. Clearly, academic health centers have to become much more deeply and effectively involved in the solutions to these matters. In the name of our members, I believe I can assure you of our growing appreciation of the roles we can and ought to be playing and of the special place of institutions built upon the premise that nurses, doctors, dentists, pharmacists and public health and allied health professionals should learn and serve together.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, I am pleased to be here today to discuss a crucial issue. We all know the vast number of issues that are considered part of health reform. The list is long—medical liability, antitrust, workers compensation, insurance reform, long term care, etc. Just look at the dark circles under the eyes of the health staffers here if you have any doubts about the enormity of the undertaking!

However, I don't need to tell you, Mr. Chairman, that some issues are simply more fundamental than others and simply cannot be overlooked if we want successful reform. The numbers of physicians, the kinds of specialties they choose, and where these doctors practice, represent such a core issue. If we do not solve these problems, we will not succeed in health reform.

It is that simple. Or so it seems, until we begin to look at this problem in more detail. I have served in the Senate since 1978, and problems of physician supply were addressed by our predecessors in the 1960's and early 1970's.

So why then are we still grappling with this issue now? Because federal policy failed to define the overall problem and failed to articulate a workforce policy that would meet future needs. instead our medical education, our health care delivery infrastructure, and our reimbursement system all gang up to discourage students who wish to be primary care physicians or physicians who wish to practice in underserved areas.

Congress first became concerned about specialty and geographic maldistribution in 1970. We passed the Comprehensive Health Manpower Training Act of 1971. This bill assisted schools in addressing these problems on a voluntary basis. It authorized payments based on mutually agreed upon targets for primary care residency programs. The goal was 35% primary care for 1977 and was to reach 50% by 1980.

There is no question that we failed. In 1981, 37.3% of graduates entered primary care. That number has fallen in 1992 to 14.6%. In other words, we are farther than ever away from realizing our goals.

We had a hearing on this issue last July. At that time, I said that we needed three things to solve this problem: vision, leadership, and some action. We now have a vision of what our national health care system should look like. With President and Mrs. Clinton we have leadership. Therefore, it is time for action.

Physician workforce is the pivotal issue in health reform. Congress' attempts to reform the health care delivery system will not succeed unless a national policy directed at encouraging more primary care physicians is developed. Workforce is an essential piece in making the system more productive. Availability of primary care has a leading role in cost containment, access to services and quality of care.

We can't assume that price controls, global budgets, or reimbursement freezes are going to contain our rate of cost increase in the wake of health reform. Physician supply has a direct relationship to utilization of specialty services.

Physicians generate about 80% of all the costs for care. It is not Just what they are paid—but the costs of all the services that they perform. Having more physicians than you need, and especially more specialists creates tremendous pressure for expenditures. Physicians are the entree to our delivery system.

As health reform expands access to care for the uninsured, the already strong demand for primary care will increase. We saw utilization levels jump after Medicare and Medicaid were enacted in the 1960s. This will happen when we extend coverage to the currently uninsured.

When we reform the delivery system, the forces of the market may help correct our current imbalance of specialists. Integrated delivery systems or accountable health plans will actively recruit primary care physicians. This increased demand will boost interest by graduates in primary care fields.

Oversupply of specialists affects the quality of care. If there is no federal policy redirecting our workforce, primary care services will increasingly be provided by subspecialists who will have had little or no education for primary care. Likewise, subspecialists providing more generalist services will devote less time to their areas of expertise. In addition, primary care physicians contribute to patient education, preventive care, decrease the amount of unnecessary services and prevents more serious problems from being deferred until major symptoms appear and a specialist is needed.

Maldistribution of physicians affect access to care. Increasing specialization will result in a growing discrepancy between the rural and urban physician workforce because specialists tend to practice in urban areas.

Although the market could correct the mix of physicians over time, physician oversupply will likely impede the transition to managed competition. While I am reluctant to propose government solutions, it is clear that we must in some way assist in the transition. Unassisted, it will be difficult for individual physicians to make the necessary adjustments to meet the market's demand.

If we want to achieve health reform, we must begin. Tackling this problem is not easy. At the end of last July's hearing, both the Chairman and I expressed a great deal of frustration about the lack of solutions offered by the witnesses who testified at that time. I am pleased that the PPRC has responded with a detailed proposal. I am very interested in hearing Dr. John Eisenberg's testimony. I am pleased that Dr. Eisenberg has agreed to serve as the PPRC's new chairman. It is difficult to fill the shoes of Dr. Phil Lee, who served with distinction in that capacity. I am confident that Dr. Eisenberg will continue the tradition of leadership and service to Congress.

I am also looking forward to the comments and proposals of the other witnesses, who represent the best in the business of medical education and medical practice.

I am especially pleased to welcome Dr. David Brown, Dean of the University of Minnesota Medical School. Under his direction, the Minnesota program has been recognized repeatedly for its success in turning out primary care physicians and keeping them in rural areas. The University has maintained a near equal primary care—specialty care mix. It is us who must learn from them.

However, in spite of their accomplishments, Minnesota has not yet met its own objectives. State health reform legislation passed last year directed the university campuses in Duluth and Minneapolis to increase the supply of primary care physicians by 20 percent by the year 2000. To help do this a Task Force on Primary Care Education has been formed.

We have the talent and creativity among our medical educators, our practitioners, and I hope our legislators to tackle this problem. If we do, we can reach our goals of health reform. If we do not, we cannot hope to accomplish our goals of higher quality care at a lower cost.

PREPARED STATEMENT OF JOHN M. EISENBERG

Mr. Chairman, I am pleased to be here today to present the Physician Payment Review Commission's recommendations for restructuring graduate medical education (GME). Our deliberations have been guided by concerns that growth in aggregate physician supply and imbalance in the distribution of physicians across specialties contribute to the rising costs of health care and may present barriers to broader reforms to contain costs and to encourage delivery of more cost-effective and appropriate care.

In its *Annual Report to Congress 1993*, the Commission made a series of recommendations intended to make graduate medical education more responsive to societal needs. This policy is designed to limit growth in residencies, shift the balance between subspecialists and generalists, and facilitate training in ambulatory settings. While past policy initiatives have also tried to achieve these goals, the national debate on health system reform offers the potential for more effective solutions. In fact, the success of other reforms to rationalize the delivery of medical care and slow the growth in health expenditures may actually be undermined unless accompanied by some limits on system capacity. System reform thus presents both the opportunity and the need to coordinate supply and training policies with those affecting physician payment, access to care, and cost containment.

In my testimony today, I will briefly describe the context for change and then outline the major elements of the Commission's policy. In addition, I will describe the reasoning used by the Commission in developing these recommendations.

THE CONTEXT FOR CHANGE

The Commission based its initial work concerning graduate medical education and physician supply on three working assumptions:

- The number of physicians exceeds, or will soon exceed, that required to meet national health care needs.
- The nation is training too many medical subspecialists and too many specialists in some surgical fields relative to the number of primary care physicians
- Many physicians in both primary care and other specialties lack appropriate training experiences to prepare them for practice in ambulatory settings.

Current and past federal policies have had limited impact on these problems. First, the U.S. physician-to-population ratio will continue growing through the year 2020, reflecting both the results of past federal and state efforts to increase the number of physicians and the expanded pool of college graduates interested in medicine. This unchecked growth in physician supply may undermine other efforts to bring health care costs under control. The experience since the mid 1960s shows that a growing supply of physicians can drive up the volume of services provided, with only a limited effect on prices, thereby increasing expenditures for health services.

Second, the proportion of physicians trained in generalist fields, which is already lower in the United States than in other industrialized nations, will continue to decline. The trend towards specialization raises concern about the quality of primary care provided by physicians trained in other disciplines and is thought to contribute to excessive growth in expenditures. Third, despite discussion about the need for more training in ambulatory settings, mechanisms for financing graduate medical education have made it difficult to move training out of the hospital.

Spiraling growth in the number of residencies, primarily to meet the service needs of teaching institutions, has frustrated efforts to limit growth in supply and to shift specialty mix. Over the past decade, the number of residents has increased by about 24 percent while the number of U.S. medical graduates has held relatively stable.

Some have suggested that market forces will reverse these trends, pointing to the increasing demands of managed care organization for primary care physicians. On the other hand, more aggressive purchasing of hospital services may make GME financing more vulnerable, particularly that for primary care training. These conflicting developments suggest that a more competitive health care system will not lead to needed changes.

Substantial changes in the financing of graduate medical education will be required to reverse these trends and these should be considered a necessary element of broader health system reform. Policies that create weak incentives for change will not succeed in securing the supply and distribution of physicians suited to meet the population's health needs. Moreover, given the length of the training pipeline, it will take many years before the failure of such efforts becomes apparent. Bold actions that bring together those making the decisions about the creation of residency slots with those financing training are essential.

RECOMMENDATIONS FOR REFORM

The Commission has envisioned a new system of graduate medical education that limits future growth in supply, rationalizes the allocation of residency positions, and makes entities sponsoring training more accountable to the nation's health care needs. It includes five components:

- a congressionally set limit on the total number of residencies to be funded;
- a federal body that, using both objective data and input from interested parties, would determine the distribution of these slots by specialty;
- decisions by accrediting bodies to select those residency slots to be funded on the basis of educational quality;
- payments for the direct costs of graduate medical education to approved residencies from a national financing pool to which all payers would contribute a percentage of premiums or payments for medical care services; and
- mechanisms to provide transitional financial relief to teaching hospitals that lose residents but still must meet essential service needs.

Limits on the Number and Mix of Residents to Be Funded

An often-criticized feature of the current GME system is the absence of a link between decisions about financing and those determining the supply and mix of residency positions.

Financing is provided predominately through inpatient revenues (both hospital payments and faculty physician fees) and a complex mix of federal and state government funds. The federal government is the largest single explicit financing source for graduate medical education through the Medicare program, support of residencies by the Departments of Veterans Affairs and Defense, and grants under Title VII of the Public Health Service Act for primary care training. Other payers have less explicit mechanisms for financing graduate medical education. Teaching hospital charges to private payers, for example, reflect the direct costs of graduate medical education although these payers do not identify and separately pay for these costs. Some Medicaid programs recognize direct medical education costs in their hospital payment systems. In addition, some states provide direct support for some residency programs, particularly those in family practice.

These payers do not have a role, however, in determining the number and mix of residents. Such decisions are made by a complex process involving the decisions of private accrediting bodies, training program directors, administrators of teaching hospitals, and state and federal governments. Because this process is fragmented, there is no effort to ensure that the number and mix of residency positions meets national health needs. Instead, the residency approval process has been primarily driven by the service needs of teaching institutions that can develop programs of acceptable quality.

After considering several alternative mechanisms for creating a link between financing and the number and mix of positions, the Commission determined that a limit on the total number of residency positions is essential. Moreover, deliberate decisions should be made about the distribution of these positions across specialties. All positions approved as part of an open, deliberative process should be funded for the full length of training.

Before reaching this decision, the Commission considered several alternative mechanisms for creating a link between financing and the number and mix of positions including weighting payments for primary care positions. It rejected this approach primarily because given the number of unfilled positions in primary care, an effective policy to change specialty mix should be targeted not at creating more positions in primary care, but at reducing the number of those in more specialized fields. In addition, weighting would likely have little impact on the decisions of hospital administrators and residency program directors. This is because financial incentives for faculty and to hospitals for training residents in procedural specialties (in the form of increased productivity, relatively low wages, and higher faculty billings) would likely overwhelm those associated with increased weights for primary care residents.

Ultimately, the Commission determined that limits on the total number of residency positions are essential both for mitigating the impact of the growing number of physicians on health care costs but also to meet specialty distribution goals. It further recommends that deliberate decisions should be made about the distribution of residency positions across specialties. All positions approved as part of an open process should be funded for the full length of training.

Paying for a fixed number of residents would be similar to policies of other Western nations. In Britain, for example, the government finances all residency slots and controls the number of training positions by specialty. In Canada, most residency positions are funded by provincial ministries of health with the number of positions funded determined in annual negotiations among medical schools, associations representing physicians, and provincial governments.

The experiences in these systems suggest that when GME financing is used to support policy objectives, patterns of training meet those goals. Even though the trend toward specialization in Canada during the 1960s was similar to that in the United States, changes in the financing and control of GME during the 1970s (combined with other health system reforms) have led to markedly different career choices between Canadian and U.S. medical students. About half of Canadian medical graduates become primary care physicians, compared with less than one-fourth of their American peers.

In this country, a similar policy could be established with three elements: a congressionally determined limit on the total number of residency slots, allocation of these slots across specialties by a federal body established for this purpose, and allocation of slots to individual residency programs by accrediting bodies.

Congressionally Determined Limits on Total Number. The Congress should set in statute a limit on the total number of residencies to be funded and achieve this by sequencing reductions over successive classes of first-year residents. Reductions in the number of first-year positions combined with limits on the number of positions by specialty will limit the number of trainees in every postgraduate year. Sequencing cuts would provide for a transition period and avoid the possibility that residents already in programs will not be able to complete training due to elimination of positions. If implemented in 1992, a policy that limited the number of first-year residents to U.S. graduates plus 10 percent would have required cutting about 2,500 positions. Over time, this policy would reduce the current number of residents by about 11,000 to around 75,000.

Although the Commission has concerns about the number of medical students graduating annually and the long-term impact this will have on the stock of physicians, it does not recommend setting the limit for first-year residents below the number of U.S. medical graduates. Assuming that medical school enrollment does not increase, all graduating students should have the opportunity to complete their training. There should also be an additional number of slots above the number of U.S. graduates so that the United States can fulfill its obligation to train health professionals from abroad.

Allocation of Slots by Specialty. Decisions about the number of residencies per specialty should be made by a federal body created for this purpose. This would permit more deliberative analysis of the appropriate allocation of slots than would be possible if this were set in statute. It would also allow flexibility to resident allocation over time.

This new decisionmaking body would meet regularly in an open forum, using objective data and input from interested parties in its decisionmaking. It should also have research, planning, and evaluation functions and either fund or conduct analyses to inform future decisions. Issues of interest might include the impact of changing practice patterns and shifting demographics on supply and mix, lessons to be learned from staffing patterns in managed care organizations, and the implications of delivery system changes for the content and length of training in different specialties.

In considering the functions of this decisionmaking body, the Commission looked at several different alternatives for how it should be structured and its relationships to the Congress and the Department of Health and Human Services. It could be a commission that provides advice to the Congress. A promising model is the Defense Base Closure and Realignment Commission. Its recommendations are subject to congressional approval but cannot be amended. If accepted, its recommendations are binding as statute. Alternatively, it could be a commission that advises the Secretary of Health and Human Services. Or decisions could be made by an independent federal agency. This is the model suggested by those advocating creation of a national health board as a key element in system reform; if such a board were created, this body could be one of its subunits.

Accrediting Bodies. Once the decision is made about the number of positions to be funded for each specialty, a second tier of decisions will be required as to which specific positions in these fields should be funded. These decisions should be made on the basis of educational quality by the bodies that accredit graduate training with the goal of protecting high-quality programs, making necessary cuts in more marginal programs. Because concerns have been raised that a limit on residency positions will disadvantage minority students, it may also be appropriate to broaden this criterion to protect programs meeting other important social goals such as enrollment of underrepresented minorities or those with a track record of placing graduates in underserved rural and urban areas.

An example may help illustrate this process. First, the federal body would determine the number of residents to be funded per specialty: for example, 100 residents in Specialty A. This would then be communicated to the residency review committee (RRC) for that specialty (or other accrediting body, as appropriate). If 125 positions were currently available in Specialty A, it would be the responsibility of the RRC for Specialty A to rank programs based on quality measures and then go down that list approving slots until 100 positions were selected. Presumably, the RRC would have the flexibility to fund all positions in the best programs or to spread cuts across all programs.

Making the profession a partner in this process has several advantages. Accrediting bodies, such as the Accreditation Council on Graduate Medical Education and its residency review committees, already have the information and expertise needed to evaluate training programs and would be well-positioned to make informed choices about which should be funded. In addition, it would keep the federal government at an arms' length from decisions about the content and quality of training.

Another important advantage of this approach is its implications for antitrust enforcement. The profession has long argued that it cannot limit the number of residencies because this would be considered a restraint of trade. But this process would be federally sanctioned. Therefore, it is the Commission's understanding that because the federal government would be asking the profession to make these choices, the RRCs and others making them would not be subject to antitrust action. To clarify this relationship and ensure that decisions are made based on policy goals, it may be desirable to draw up a contract that specifies responsibilities and expectations.

Payer Pool

All payers should share the costs of graduate medical education, reflecting the principle that all who benefit from graduate medical education should contribute to its costs. Currently, some payers may escape from supporting GME by excluding teaching hospitals from their plans. This could be exacerbated under some approaches to system reform if plans seek a competitive advantage by directing patients to hospitals that charge less because of the absence of teaching costs.

All payers, including self-insured employers, should contribute a percentage of their payments for medical care to a national pool. For example, a 1 percent set-aside would generate about $8 billion per year to support training. The funds in this pool would be used to pay for the direct costs of graduate medical education for residency positions approved as part of a process in which policymakers, the medical profession, and other interested parties participate. Because Medicare would contribute to this pool like all other payers, it would no longer make direct medical education payments to hospitals.

Experiences at the state level suggest that where there are explicit and predictable sources of funding for graduate medical education, these have been successfully used to leverage changes. The identification of explicit GME funds under New York State's hospital rate-setting mechanism, for example, facilitated development of the Graduate Medical Dental Education Consortium of Buffalo. Member institutions, seeking a way to make their GME funding go farther, have contributed a share of their GME funds into a common fund for special initiatives such as training more primary care physicians, developing ambulatory training sites, and reaching out to minority students. Rate setting has also enabled the state of New Jersey to set strict caps on the number and mix of residencies funded.

Breaking the link between payment for hospital services and the financing of graduate medical education creates two additional questions: who should receive the payment and what methodology should be used for determining payment amounts. Because local circumstances will determine the effectiveness and desirability of making payments to either the hospital, medical school, consortium, or training program, payments could be made to any of these entities. Making payments available to programs and medical schools would facilitate training in ambulatory settings.

In addition, Medicare's current payment methodology, based on hospital-specific historical costs, should be replaced by a new standardized payment per resident. Current Medicare payments vary substantially across hospitals due to accounting practices, payments to supervisory physicians, and historical inefficiencies. This method effectively penalizes efficient hospitals and those that did not report all potential direct costs in the 1984 or 1985 cost reporting year.

Meeting Hospital Service Needs With Fewer Residents

Reducing the number of residents and shifting positions from subspecialty fields to primary care and from inpatient settings to ambulatory sites will be disruptive to some teaching hospitals. Because these institutions' reliance on house officers to meet clinical service needs has impeded changes in resident supply, specialty mix and the site of training, an effective policy should also address these needs. Transitional relief funds should be made available to teaching hospitals that lose residency positions as a part of this process. Preference should be given to those hospitals with a disproportionate share of indigent patients.

Teaching institutions could respond by eliminating services or by using a mix of highly skilled nonphysician practitioners (NPPs) and fully trained physicians. There is a growing literature documenting the favorable experience teaching hospitals have had using NPPs. Under certain circumstances, NPPs may actually be preferable to residents because they have lower turnover, greater familiarity with departmental procedures, and more clinical experience than junior residents. Using NPPs may also ensure that residents have richer educational experiences by freeing them from routine tasks that quickly lose their pedagogical value.

There are, however, clinical, financial, and practical reasons that caution against relying too heavily on NPPs as substitutes for residents. Some may require additional training to assume responsibility for patients whose care requires more advanced medical decisionmaking or technical skill. Additional attending physicians may be needed to assume the responsibilities that require medical training.

The view that NPPs are more expensive to hire than residents may also make them a less attractive alternative. First, unlike residents who bring Medicare GME payments to the institution, hospitals do not always receive an explicit payment for the services of NPPs. Second, NPPs command far higher salaries than residents and work many fewer hours. Finally, it is unclear whether a sufficient

number of NPPs will be willing to step into new jobs created by the loss of residents. This will depend upon the competitiveness of salaries and the attractiveness of these positions relative to other opportunities.

A number of teaching hospitals have tried different strategies to ensure service coverage for units previously staffed by residents, either to enhance the educational experience or to continue to meet service needs when the number of residents or residents' work hours are constrained by external forces. But the transition to new staffing and scheduling arrangements, however, does take time and money.

Funds from the payer pool should be made available to institutions that downsize or close residency positions but still have essential service needs that must be met, at least in the short term. The Commission's estimate of the impact of limits on the total number of residents on the Medicare program indicated that, if this policy had been fully implemented in 1992, it would have saved about $483 million in Medicare payments to hospitals (about 10 percent of GME payments). Of this, $165 million would have been saved in direct medical education payments and $318 million in indirect adjustments. Making a portion of these funds available to teaching hospitals for several years would provide a cushion during which teaching services could be reconfigured, restaffed or closed.

Transitional relief funds could be channeled by a formula related to the number of residents per occupied bed or by extending payments for the initial complement of an institution's residents (even though some or all of those positions would be eliminated) for a time-limited period. To be effective and equitable, relief should be available only to certain institutions. Payments should be made only to those that actually lose residents, not just those that have positions that were not funded. Hospitals serving the indigent should be given preferential consideration.

In addition, it may be desirable to expand existing federal programs that support nonphysician training to increase the supply of nonphysicians trained to staff tertiary care centers. These include institutional grants, student loans and scholarships, and the National Health Service Corps. Many of these programs lost substantial funding during the early 1980s and have not yet been restored to their previous funding levels.

ACHIEVING POLICY GOALS

Federal policies are needed that not only signal preferences but also lead directly to reductions in resident supply, changes in specialty mix, and enhanced training opportunities in ambulatory settings. A process that restricts the total number of residents and links the power of public financing with informed decisionmakers within the medical profession will help achieve these goals.

There are limits, however, to what these proposed reforms in GME financing may accomplish. Goals could be subverted if residencies not approved for funding from the payer pool are financed from other revenue sources. This has already happened in New Jersey, where, under the state's all-payer hospital rate-setting authority, the number of residencies was capped at 2,610 in 1986. Since then, 200 additional positions have been created, all financed from faculty practice plans and grants.

Steps could be taken to prevent programs from financing positions beyond the statutorily set limit. Ideally, only positions funded from the payer pool would be accredited. Students would accept unaccredited positions at their own risk as they would be unable to sit for specialty board examinations. There is no obvious legislative lever, however, to compel accreditors to do this. Financial penalties could be imposed on institutions creating or continuing positions not approved for funding from the pool. Funding could be reduced for every unapproved slot, for example. This would be similar to the approach used in Quebec, where the number of ministry-funded positions has been reduced for each nonministry-funded position created. Similarly, the state of New Jersey has plans to reduce payments to hospitals that exceeded state-set caps. Other options include making programs that fund residencies outside the system ineligible for any funding from the pool or making the institutions where these residents train ineligible for Medicare participation. The Commission has not made a specific recommendation on this issue and will continue to explore the alternatives.

Moreover, graduate medical education financing is only one of many factors affecting the supply and specialty mix of physicians. Although the availability of training in any field will clearly influence students' career decisions, specialty choice and practice location are also affected by factors such as expectations of income; perceptions about the prestige, intellectual content, and quality of life aspects of particular fields; other educational experiences; and sociodemographic characteristics and personality traits. Thus, achieving policy goals will also require changes in both medical education and the practice environment to complement reforms in graduate medical education financing.

Of concern to many is the need for policies that will make primary care careers more attractive. These include rewards for primary care practice in the form of equitable payment and for primary care academicians in the form of sufficient research funding. Such policies will be necessary to ensure that primary care careers are viewed as intellectually challenging, financially rewarding, and important to society as those in subspecialties.

The federal government can clearly effect change in some of these areas. Adoption of a resource-based method for calculating the practice expense component of the Medicare Fee Schedule, for example, will improve payments for primary care physicians. Adoption of the fee schedule by other payers will also enhance income for primary care specialties.

Other changes are less amenable to federal policy, particularly given the limited resources available for new initiatives. Medical educators thus must take it upon themselves to foster student and faculty development in primary care. Promising strategies include preclinical exposure to primary care, family medicine clerkships, preferential admissions policies, and appointment of primary care faculty to key administrative posts.

Finally, changes in GME financing will take many years to affect the national stock of physicians. This is because physicians have unusually long work lives; the average 35-year-old physician can expect to practice almost to the age of 70. The length of time required to change specialty distribution suggests that efforts to retrain physicians already in practice may also be needed to achieve policy goals within a reasonable period.

RESPONSES OF DR. EISENBERG TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Senator Rockefeller: Have other less regulatory approaches and congressional prodding made any difference [in the supply and distribution of physicians needed to meet population health needs]?

Dr. Eisenberg: It is the Commission's view that current and past federal policies have had limited impact on these problems. Some past policies may have been ineffective because they were underfunded, because they had insufficient political support, or because the policy problems they were intended to address were no longer considered priorities. But these efforts were also unsuccessful because they were undermined by other policies that created incentives for continued growth in residency positions, particularly in subspecialties. These policies include financing graduate medical education through the hospital as well as payment for physicians' services that overpaid surgical and technical procedures relative to evaluation and management services.

While the Commission considered less regulatory approaches (such as weighting), it decided that such strategies would be ineffective in meeting supply and specialty distribution goals. This is because residents, particularly those in procedural fields, are a relatively inexpensive source of highly skilled labor. Slight reductions in payments for these positions would not outweigh the financial benefits that residents bring to teaching institutions.

Senator Rockefeller: How different is the United States' workforce policies from what other countries do to make sure they have the kinds of health care professionals their citizens need?

Dr. Eisenberg: A fundamental difference between this nation and other countries is our lack of a national workforce policy. In other nations, such as Germany, Canada, and Britain, there are clear links between decisions about financing and those determining the supply and mix of residency positions. For example, the British government finances all graduate medical education slots and controls the number of training positions by specialty. In Canada, about 85 percent of residency positions are funded by provincial ministries of health. The number of residents to be funded is determined in annual negotiations among medical schools, associations representing physicians, and provincial governments. In Germany, strict limits on the number of residency positions combined with broad access to undergraduate medical education has resulted in a situation where every graduate is not guaranteed a residency training position.

The experiences in these systems suggest that when GME financing is used to support manpower policy objectives, physicians train in those fields. In fact, even though the trend toward specialization in Canada during the 1960s was similar to that in the United States, changes in the financing and control of GME during the 1970s (combined with other health system reforms) have led to markedly different career choices between Canadian and U.S. medical students. About half of Canadian medical graduates become primary care physicians, compared with less than one-fourth of their American peers.

Senator Rockefeller: Your recommendations propose that this new workforce commission would be used to collect and analyze data provided by accrediting bodies to determine the distribution of these slots by specialty. You emphasize that the funding of slots should be made on the basis of quality. Do you have any concerns about the integrity of this process? Should we be worried that quality might not be the most important criteria for funding? Would the power of certain specialties inappropriately influence this process?

Dr. Eisenberg: First, let me clarify that the Commission has envisioned that the federal workforce commission would use data from a variety of sources, not just information provided by accrediting bodies, in its deliberation. In addition, this commission's charge would be to determine the distribution of slots by specialty. Under our policy, accrediting bodies would then take this information to determine which specific slots would be funded.

The Commission has suggested that the Accreditation Council on Graduate Medical Education and its residency review committees are well positioned and have much of the information necessary to make these decisions. This recommendation reflects the view that such decisions should be made within the medical profession rather than by the federal government. Other bodies (existing or new) may be better candidates for this role. In any case, it is the Commission's view that with sufficient federal guidance, a process could be created that is open, deliberative, fair to all specialties, and meets policy objectives.

Senator Rockefeller: There seems to be a great deal of agreement that some sort of all payer pool should be created to finance the direct costs of medical education. Do you think this level of agreement is a recognition of the fact most payers are paying these costs, even if they are not as explicit as Medicare's GME payments? Insurance companies, for example, know that they are paying for this cost through other charges, don't they?

Dr. Eisenberg: Some private payers support graduate medical education by making higher payments for care in teaching hospitals than they would for care in other institutions. It is the Commission's view, however, that identifying a specific GME funding pool strengthens our ability to use those funds to meet policy goals. Moreover, competitive approaches to health system reform might make payers less willing to support the additional costs associated with training as they seek a competitive advantage.

Senator Rockefeller: You have recommended that Congress cap the number of residencies to the total number of U.S. medical graduates plus 10 percent. If implemented, that would cut about 2500 residency positions initially and will eventually reduce the current number

of residents by about 11,000 to around 75,000. Is there any reason to believe these cuts would hurt us, result in less care? Why should Congress set the limit in statute? Would this weaken our ability to adjust our policies to meet newly recognized or evolving workforce needs? Does allowing the Commission to determine the specialty slot allocaton leave us with enough flexibility?

Dr. Eisenberg: The Commission has envisioned a system with both an overall limit and limits by specialty. This is because both the aggregate supply of physicians and their specialty distribution have important consequences for health care expenditures and the delivery of appropriate care. Addressing specialty mix only ignores the impact that each additional physician (whether trained in primary care or in the most specialized fields) will have on the nation's health bill.

It is the Commission's view that tying the limit to medical school graduates creates a measure of flexibility. For example, if it is determined in the future that there are too few physicians, then increasing medical school class size would be an appropriate response. Under this policy, the number of residency positions would increase accordingly.

Senator Rockefeller: In the next panel we will hear from the International Coalition of Women Physicians that are concerned that even without a cap we have an underrepresentation of minority physicians in the subspecialty and in medical school faculty. Is there any reason to believe that a cap would exacerbate this problem? Don't you think that the representation of minorities, residency programs' records on recruiting and retaining minorities could be used as a criteria in allocating slots? Wouldn't this serve to enhance opportunities for minorities in graduate medical education, rather than limit them?

Dr. Eisenberg: Clearly there is a need to create greater opportunities for minorities in all medical fields and additional efforts should be made to interest minority youth in medical careers and to develop interest among minority medical students in academic and research careers. It may be appropriate to include minority representation in the criteria for allocating residency positions.

Senator Rockefeller: Later witnesses will testify that they are concerned that we may be forcing physicians into primary care by requiring that we limit specialties. Right now, physicians are not automatically guaranteed that they will be able to specialize or subspecialize. Could you please talk about how much greater the competition for slots might be and how it would work at the residency level?

Dr. Eisenberg: Limiting the number of residency positions by specialty will likely increase competition for some types of training. To ensure that primary care does not become viewed as the field of last resort, other policies should be implemented to increase the attractiveness of primary care careers. These include rewards for primary care practice in the form of equitable payment and for primary care academicians in the form of sufficient research funding. Such policies would reinforce the view that primary care careers are as intellectually challenging, financially rewarding, and important to society as those in subspecialties.

Senator Rockefeller: Elaborate for us why it is so important to pay for training in nonhospital settings. Should we continue to make the payments to the hospital and allow them to contract with clinics and HMOs that train, or should we pay the sites themselves? Why?

Dr. Eisenberg: The shift of health delivery to settings outside the hospital has created a need for ambulatory training as an integral part of GME. As more services are provided on an ambulatory basis, hospital stays shorten, and only the most acutely ill patients are admitted, the inpatient environment offers an increasingly restricted range of educational experiences.

Training in ambulatory sites gives residents an opportunity to acquire skills that span a continuum of care, including health promotion and preventive medicine, managing chronic disease, and making decisions about when hospitalization is necessary. This training should also expose residents to the mix of patients and the range of problems they will likely encounter in practice. Both specialists and generalists need to learn these skills in order to be adequately trained for practice in the community.

A variety of barriers have impeded expansion of GME to nonhospital sites. Significant among these is the reliance on residents to meet institutional service needs. While there is some flexibility to send residents out to other settings, most institutions put their own service needs first.

Insufficient financing has also impeded expansion of ambulatory training. Current GME financing mechanisms provide only limited support. For example, Medicare will only acknowledge (and thus pay) costs associated with residents' time in ambulatory settings if the hospital incurs "all or substantially all" of the cost of training. In sites other than teaching hospitals, there are no mechanisms to pay resident and faculty salaries or to support administrative overhead.

The Commission's policy is intended to overcome these barriers by allowing payment to flow through a medical school, consortia, or the training program itself. This would allow educational objectives to be the top priority in designing rotations for residents.

Senator Rockefeller: Changing the flow of Medicare graduate medical education payments is a big deal because it will affect teaching hospitals, especially those that care for a disproportionate number of poor patients. Should we target our transitional relief to those institutions? Once we achieve universal coverage does this need for additional relief disappear? Why is it so important that transitional relief be targeted?

Dr. Eisenberg: The Commission's policy would target transitional relief to those teaching hospitals with a substantial commitment to serving the poor. Such funding would be important to cushion these institutions if they lose residents so that they may continue to meet essential service needs. Universal coverage may ease the financial pressures on urban public teaching institutions that have relied heavily on residents to care for patients who have no insurance and no other source of medical care. It could, for instance, make it easier for these hospitals to hire nonphysician practitioners or community physicians to meet service needs, freeing residents to develop skills in other sites.

Senator Rockefeller: The Commission did not have the opportunity to fully explore how we might make better use of nonphysician providers to provide primary care services. Could you tell me what you think about reimbursing advance practice nurses and physician assistants for their primary care training with Medicare dollars? Shouldn't we be considering this option as we expand the types of training sites for residents? Don't these providers provide a lot of care in the noninstitutional settings that the PPRC recommends we begin to reimburse? Might they need additional primary care training?

Dr. Eisenberg: As you note, the Commission has not had a chance to consider either the financing or content of training for nonphysician providers. It is therefore difficult for us to comment on whether using Medicare dollars to train these providers would be appropriate. In the year ahead, the Commission will be considering these issues in greater depth with a particular emphasis on how nonphysicians and physicians work together in organized systems of care. The Commission has not recommended expansion of direct payment to nonphysician providers.

PREPARED STATEMENT OF MARILYN GASTON

Mr. Chairman and Members of the Committee, I am Dr. Marilyn Gaston, Director of the Bureau of Primary Health Care (BPHC) in the Health Resources and Services Administration of the Public Health Service. With me today is Dr. Donald Weaver, Director of the Bureau's National Health Service Corps Division, and Dr. Norris Lewis, Director of the Division of Scholarships and Loan Repayments.

The Bureau administers programs that play a key role in decreasing the many barriers to health care access for underserved populations. We accomplish this through supporting systems of primary health care including Community and Migrant Health Centers (C/MHC), Health Care for the Homeless Programs, and Primary Care in Public Housing Programs, services for special vulnerable populations, e.g. people with substance abuse problems, infected with HIV, mothers and children, the elderly, Native Hawaiians and others. We also assure access to health care through the recruitment, placement and retention of primary health care professionals (family physicians, pediatricians, internists, obstetricians, psychiatrists, nurse practitioners, certified nurse midwives, and physician assistants) through the National Health Service Corps (NHSC).

I am here today to describe briefly the needs of underserved areas and the role the NHSC must continue to play in assuring primary care providers to the neediest areas of the country.

We estimate that approximately 43 million people are without access to a primary care physician. Of the total, 22 million are in urban areas and 21 million are in rural areas. As you know, lack of access to primary health care heightens the risk considerably for poor health care outcomes—including high infant mortality rates and low immunization rates. Many health problems which could be prevented, or diagnosed and treated early, are seen in the advanced and severe stages.

We have a map that shows States by percentage of underserved population. The NHSC currently has only 1,209 providers in the field serving a total of 1.8 million people, a significantly small portion of the millions of needy people.

Depending on the form health care reform takes and the timeframe in which it is implemented, the existing primary care physician shortages in underserved areas would grow because of increased demand for primary care services. Even if medical schools graduate more physicians pursuing careers in primary care, underserved areas will continue to have difficulty in attracting primary' care providers. There is no question that expanded systems of care for the underserved will be required and will need increased assistance from the NHSC to recruit and place primary care providers.

NATIONAL HEALTH SERVICE CORPS (NHSC)

The NHSC assists communities to recruit primary health care providers through the Federal Loan Repayment, Federal Scholarship, State Loan Repayment, and Community Scholarship Programs. Loan repayment allows the NHSC to recruit providers to serve underserved populations as they complete their training and is central to meeting some of the current need. Scholarships are used to build up a pipeline of primary care providers who will be available to provide services to people in the neediest areas of the country. In return for this educational financial assistance, the providers agree to serve the underserved for 2 to 4 years. The NHSC also recruits individuals who do not need a scholarship or loan repayment but who wish to serve the underserved. The NHSC also provides direct technical assistance to communities to help them determine appropriate provider staffing and to enhance recruitment and retention programs appropriate to the local area.

Since the start of the program in 1972, over 17,000 people have served in the NHSC. From an initial volunteer cadre of providers, Congress started a scholarship program and in 1977 the first scholarship recipients were placed in health professional shortage areas (HPSAs). The number of available providers continued to grow until 1986 when scholarship placements reached their peak and the NHSC field strength was in excess of 3,000 health care providers.

In the early 1980s, the NHSC experienced a severe decline in funding. It was expected that the increased numbers of physicians being graduated would out of necessity "diffuse" to the neediest areas.

However, physicians did not go into the neediest areas and did not select the primary care specialties most needed by medically underserved people. The opposite occurred—physicians chose highly specialized areas of medicine, which further decreased the number of primary care physicians available for placement in needy areas. This limited supply of primary care physicians was recruited by private organizations including HMOs that were able to offer more competitive salary and bene-

fit packages than many of the community-based programs that serve the underserved.

REVITALIZATION OF THE NHSC

In 1990, in response to growing demands for health professionals in underserved areas, Congress reauthorized through the year 2000 the legislative authority for the NHSC program. At that time funding was authorized to revitalize the NHSC scholarship and loan repayment programs to meet the growing needs.

In addition to supporting primary care (family practice, general internal medicine, general pediatrics, and obstetrics/gynecology) the training of nurse practitioners, nurse midwives, and physician assistants was also mandated.

We have several programs and activities supported by the NHSC to enhance recruitment of health professionals into underserved areas. I would like to review them briefly.

- *NHSC Loan Repayment Program*

Up to $35,000 per year of student loans are repaid in return for each year of service in a HPSA. The total number of awards made has increased from 75 in 1990 to 161 in 1991 and 326 in 1992. It is expected that approximately 500 awards will be made in 1993 to make up for the underfunding of scholarships in the 1980s.

- *NHSC Scholarship Program*

The NHSC Scholarship Program awards scholarships to students pursuing primary care careers—363 students received NHSC scholarships in FY 1992.

The statute requires that 30 percent of the appropriations be used for new scholarships and that 10 percent be obligated for first year nurse practitioner, physician assistant, and nurse midwife students.

The total number of awards will increase from 72 in 1990 to 387 awards expected in 1993.

- *State Loan Repayment Program*

The State Loan Repayment Program, which began in 1988 with 7 States, provided greater collaboration between Federal and State programs focused on the recruitment, placement, and retention of primary health care practitioners. Currently 27 States are participating in this activity with a total of 303 new providers assigned to HPSAs within these States. States are required to match Federal funds on a dollar for dollar basis.

- *Community Scholarship Program*

Currently, 11 States are participating in the Community Scholarship Program with a total of 90 students committed to returning to their communities upon completion of their primary care training. This program is in the third year of a 3-year demonstration and will require reauthorization to continue.

ADDITIONAL RECRUITMENT ACTIVITIES

A number of efforts were initiated a few years ago to enhance recruitment of health professionals into careers to serve underserved populations. These programs for students would foster compelling interest in professional careers in services to the underserved. The efforts include:

1. over 1000 health professions students participated in educational experiences in underserved areas through a Student Training Extern Program of the PHS Commissioned Corps;
2. Maintenance of 4 advocacy networks that focus on the recruitment and retention of Family Physicians, Osteopathic Physicians, Nurse Practitioners, and Physician Assistants;
3. The National Minority and National Hispanic Mentor Recruitment Network linked 1700 medical students and practicing physicians to foster a mentoring relationship and provide supportive role models; and
4. The start of a Junior National Health Service Corps will expose junior and senior high school students to primary health care opportunities within underserved areas.

NATIONAL HEALTH SERVICE CORPS—THE FUTURE

We fully expect the NHSC to play a major role in meeting the increased demand for primary care providers. The NHSC will be a major force and provide a strong incentive to students to pursue careers in primary care specialties and to serve underserved populations.

The NHSC has an outstanding track record of serving underserved populations for over 20 years. The NHSC has placed health professionals and primary health services in some of the neediest rural communities and inner urban areas in the Nation where others would not serve. The NHSC has years of experience and can successfully meet the needs of those who will continue to have access barriers to care.

PREPARED STATEMENT OF LEAH HARRISON

Mr. Chairman and distinguished Members of the Subcommittee, my name is Leah Harrison. I am a Certified Pediatric Nurse Practitioner (CPNP), a Registered Nurse (RN), and have a Masters of Science in Nursing (MSN). Currently, I am the Assistant Director of the Child Protection Center Montefiore Medical Center, The University Hospital for the Albert Einstein College of Medicine in Bronx, New York. In addition to my administrative responsibilities, I provide clinical care.

I am pleased to be here today representing the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) and its 4,000 members who specialize as pediatric, family or school nurse practitioners. On behalf of our members, I would also like to express our deep appreciation for the support the Senate Finance Committee has given us over the years.

WHO ARE PEDIATRIC NURSE PRACTITIONERS (PNPS)?

Pediatric Nurse Practitioners are registered nurses with advanced education who specialize as pediatric or school nurse practitioners. They provide a wide range of primary pediatric health care services for infants, children, and adolescents and practice as an interdependent member of the health care team. As a member of this team, the PNP provides primary health care through direct nursing care, consultation, collaboration, coordination, and referral.

Within a PNP's scope of practice, a PNP performs a wide range of professional nursing functions, as well as functions that were traditionally in the domain of medicine and physicians. For example, PNPs conduct physical exams, take medical histories, diagnose and treat common pediatric illnesses and injuries, manage chronic illnesses, order and interpret lab tests, and counsel and educate patients. PNPs are often considered advanced practice nurses, mid-level providers, nonphysician providers, or primary health care providers.

PNPs have been in existence for over 25 years providing high quality health care in this country. To date, virtually all studies have demonstrated that the quality of care rendered by PNPs is at least equivalent to that provided by physicians for comparable services. In the context of reforming the health care system, we believe that there is a genuine opportunity for a greater role for PNPs in delivering primary health care services.

PRIMARY HEALTH CARE SERVICES

Optimally, primary health care includes the following elements: first contact care, comprehensive care, coordinated or integrated care, and care that is longitudinal over time rather than episodic. More often than not, the emphasized aspects of primary health caregiving focuses on "first contact care" which is accessible, comprehensive, coordinated, continuous and accountable. (Institute of Medicine, A Manpower Policy for Primary Health Care: Report and Study.) The patient oriented rather than disease-oriented focus of primary care emphasizes preventative measures, such as immunizations and health assessments, as well as diagnosis and management of commonly occurring conditions such as acute and chronic illnesses—like otitis media, child abuse and neglect, and asthma.

Much of today's debate has focused on improving the individual's first contact with the health care system, the stage at which we can hope and expect to improve access to health care, to promote the enhancement of health and prevention of illness, and to improve the efficiency and effectiveness of the delivery of care. Another important aspect of primary care is the provision of continuous or chronic care: given the increase in the number of our impaired newborns, HIV patients and others, there is a growing need for this kind of care.

It is well recognized that most Americans, and especially children, need primary health care services. NAPNAP believes that primary care must be incorporated as a basic component into the health care delivery system and made available to children and families. Primary health care services are a way of ensuring a comprehensive array of support services across the health spectrum regardless of the delivery

site. In addition to clinics and health care provider offices, primary care sites may include such places as the workplace, schools, churches, and mobile units.

A primary health care system allows clients to become more informed about their health care and provides for increased participation and better health care management. A primary health care system increases the proportion of people who receive complete sets of essential preventive services at recommended intervals, thereby emphasizing the importance of a coordinated and holistic approach to preventive primary care.

EMPHASIS ON PRIMARY CARE PROVIDERS

Nurse Practitioners (NPs) are primary health care providers. Primary health care providers are necessary partners in the maintenance of good health, the treatment of minor acute illness, and the management of stable chronic health conditions. NPs play an important role in identifying individuals at risk for conditions for which interventions aimed at prevention are appropriate—like patient education, counseling, and screening services.

Because primary health care is what PNPs are all about, we are in a unique position to play an integral role in a new system that focuses on primary health care. However, in order to be players in the new system, we will need a "level playing field" and will need to be specifically recognized as a provider of care in the new health care system. It will be essential to adopt a plan that gives the consumer the freedom of choice of providers. A plan should not be able to exclude or discriminate against a class of providers—for example—one that only uses physicians.

FLEXIBILITY

Health care reforms must be flexible enough to enable each community, locality, region or state to meet its own unique health care needs. The system should allow for new models of health care to be tested and utilized as appropriate. NAPNAP believes that there is no single program that would meet the needs of every community. To provide efficient care, the system must allow for flexibility in the laws and regulations governing new programs of health care delivery. As an example, various agencies have successfully arranged health care delivery at school sites. Others have provided mobile vans to deliver health care at diverse sites in order to reach out and make health care services more accessible. Important to note is that when PNP services are provided in these non-traditional delivery modes, they are often not reimbursed by health care plans.

Changing our health care delivery system and focusing on primary care will require a new way of thinking about the health care system and the integration and utilization of other health care providers, like nurse practitioners. In order to increase the utilization of PNPs, we believe that some of the current barriers to practice will have to be removed. We do not view this as a turf war between physicians and nurse practitioners, but a partnership that can more effectively deliver health care services. Nor do we seek to get services covered that otherwise are not covered by any plan. PNPs are merely seeking to ensure that when they provide services or offer their services, the health care plan cannot discriminate or deny reimbursement.

PROBLEMS AND SOLUTIONS TO PRIMARY CARE WORKFORCE ISSUES

Recent studies indicate that there are about 30,000 nurse practitioners (including 6,000 PNPs) and about 25,000 physician assistants, for a combined total of 55,000 primary care providers in the United States. Consequently, millions of Americans rely on NPs and PAs as their primary source of health care. For certain, NPs and PAs are already an integral part of our nation's health care system.

What follows are some of the problems with the current health care system and our recommendations for your consideration to increase the utilization of PNPs, NPs and other primary care providers like PAs in a new health care system that focuses on primary care.

(1) Workforce Projection Needs & Educational Incentives

To date, much of the focus has been on changing the ratio of physician specialists and physician primary care providers. It has been suggested that as a national goal, we should strive to have 50% of our physicians practicing in primary care. This percentage is often justified by the fact that this is the case in most other developed nations. However, we would point out that the nurse practitioner and physician assistant professions do not exist in most other countries and, as a result, other countries are overly reliant on physicians for the provision of primary care. We believe that there may not be as great a need for primary care physicians, if nurse practi-

tioners and other primary care providers are integrated into the mix and workforce projections.

The Council on Graduate Medical Education (COGME) and the Division of Nursing usually have the task of projecting and recommending the workforce needs for physicians and nurses. Heretofore, both entities have worked in isolation, not taking into account the integration of each kind of provider and how we as a nation can best meet our primary care workforce needs. Recently, COGME and the Division of Nursing have planned to work together in projecting the workforce needs that will include physicians, nurse practitioners, and physician assistants. We are hopeful that the nursing and physician communities can work together in identifying the kinds and numbers of providers that are needed in the future. Once these projections are made, Congress can use this data to better determine incentives to attract more primary health care providers. For example, the Graduate Medical Education program could be restructured to provide payments to support student nurse practitioners.

Looking at the system as a whole, it is less costly to educate and train a PNP than a physician. Once the individual has completed a baccalaureate education and obtained a license as a Registered Nurse, it takes two years to complete a PNP education program at the Masters level—compared to four years for medical school plus a residency.

Currently, there are about 44 PNP education programs in the country that are able to graduate about 400 PNPs per year. When federal support is provided, the bulk of the money comes from the nurse educational training programs, primarily from Title VIII funds. This program provides grants to assist eligible institutions to meet the costs of educating nurse practitioners. Grants are used for programs to train nurse practitioners to work in primary health care settings and other institutions.

The original purpose of the legislation, dating back to 1964, was to increase enrollments in various nursing schools to assure the financial viability of schools offering these programs. Over the years, financial support for this program has declined although the need and demand continue to exist. Historically, it has been demonstrated that federal financial support provides the incentive to expand and increase our PNP educational programs.

Currently, the demand for PNPs in the workforce far exceeds their number. PNP education program directors and NAPNAP receive numerous requests for PNPs to work in a number of settings such as Health Maintenance Organizations (HMOs), schools, private practices, rural, and medically underserved areas. Additionally, there is evidence demonstrating increasing needs for PNPs in urban areas. For example, in the Los Angeles-Orange Country area, there are currently 15 open positions for PNPs and in New York City, there are at least a dozen vacancies.

Little, if any, support is provided through the Graduate Medical Education funds although nursing has long argued for this support. Traditionally, such funding has focused on the hospital in-patient setting. The majority of our programs utilize the out-patient and other non-traditional settings to train our students—as this is where primary care is centered. We believe that the GME program should be restructured to provide support in other settings to other kinds of primary health care providers like nurse practitioners.

As the medical schools move to restructure their educational training programs and clinical sites, another problem has developed concerning the clinical training sites. As indicated earlier, we have traditionally used out-patient, community and/or rural settings for the clinical rotations of student PNPs. Anecdotally, we have been encountering some problems in losing our clinical training sites because of the competition between the medical and nursing schools. We believe that there is room enough for all of us, but also believe that there needs to be a level playing field in terms of the financial incentives that are provided to each student and facility.

Recently, some people have expressed an interest in combining the educational program of nurse practitioners with physician assistants. By and large, these discussions have not involved the nurse practitioner or physician assistant communities. While we are always open to suggestions to improve our educational training programs, we believe that our PNP educational programs have been proven to produce high quality and effective pediatric primary care providers. We do not feel that our educational programs should be changed at this time. Further, it is important to note that the nurse practitioner programs are based on nursing science and theories that incorporate medical components. It is the nursing component that brings forth the unique aspect of the nurse practitioner.

(2) Reimbursement Policies & Need for Uniform and Consistent Policies

(a) Limited Service Areas

Federal and state laws regarding the reimbursement of PNPs, NPs, and PAs are inconsistent and fragmented. Originally, the recognition of PNPs in federal programs was envisioned as a significant part of the effort to alleviate the impact of physician shortages in disadvantaged populations. Thus, federal payment policies for NPs are often targeted to underserved and disadvantaged populations and dependent on location, sites or facilities, such as rural health clinics, community health centers, family planning clinics, or programs like the National Health Service Corps, Indian Health Service, and Migrant Health.

Congress has been reluctant to provide payment in all settings and locations, despite the need for such services. For example, a metropolitan urban area, like New York City, may have as much of a need, if not greater, for primary care providers and services as that of a rural area.

We recommend continued incentives to attract NPs into these programs and expansion of the service delivery areas to all settings and locations.

(b) Reimbursement Levels

PNPs are recognized and reimbursed for their services in the Federal Employees Health Benefits Program (FEHBP), CHAMPUS, Medicaid and, in limited circumstance, Medicare.

Federal law mandates direct Medicaid reimbursement for Certified PNPs and family NPs where they are legally authorized to practice under state law . . . whether or not they are under the supervision/direction of a physician. The actual reimbursement levels in each of these states was determined by the states and more than half of the states reimburse PNPs at 100% of the physician Medicaid rate. However, it is important to note that the states do pay attention to Medicare payment levels. For example, when the Senate Finance Committee provision to provide for 85% reimbursement to NPs and others in all outpatient settings under the Medicare program was considered last year, some states were ready to take action to reduce the 100% Medicaid payment rate for PNPs to 85%. While our PNPs are eager to provide services to Medicaid clients, lowering the Medicaid reimbursement rates—from a rate that is low to begin with—causes problems.

Under the Medicare program, PNPs are able to receive reimbursement if they work in rural areas. The rate of reimbursement depends on the setting, providing 75% reimbursement if the NP provides services in an in-patient hospital setting and 85% if the NP provides services in the out-patient setting. Any other time, if the NP works in a physician office, he/she may be able to bill out his/her service through a mechanism known as "incident to a physician's service." Such persons must be an employee of the physician and the reimbursement is provided to the physician. Under the "incident-to" provision, there is no mechanism that identifies who actually performed the service.

Recently, Senators Grassley and Conrad introduced legislation (S. 833 & S. 834) that would provide Medicare reimbursement to nurse practitioners and others at a rate of 97% of the physician rate in all locations and settings. This rate was based on resource costs that include: work, practice expense and malpractice expense. Under these bills, all services provided by these providers would be identified on claims forms according to each specific provider category. In addition, bonus payments applied to physician services provided in Health Professional Shortage Areas (HPSAs) would also apply at the same percentage rate to payments for nurse practitioners and others. We are hopeful that these bills will be enacted into law this year.

It is well known that there is a tendency among the states and private third party insurers to follow the federal government's lead on reimbursement matters. We believe that the federal government can and should take a leadership role in this area by enacting federal laws that encourage and allow PNPs to practice in the least restrictive manner and in all appropriate settings and locations at an adequate reimbursement level. Although there is a tendency to allow such services to be provided in the underserved and rural areas, we believe that public policy should promote the widest utilization of PNPs, NPs, and PAs.

(3) Federal Requirements for Direction / Supervision / Collaboration

Some laws, rules and regulations require physician direction or supervision. Sometimes, these terms have been used to mean that the physician need not be on the premises when the PNP/NP practices or that the physician must be available on the premises and within vocal communication range, either directly or by a communication device and/or that the physician must be physically present in the room and either performing the actions or guiding the actions of the PNP/NP.

Provisions like these are detrimental, and unnecessary because PNPs, like physicians, are trained and educated to use their professional judgement in providing care. Like other health professionals—physicians—NPs know the boundaries of their competence. Nurse Practitioners know when to consult with and refer to other health care providers and they know that they have both an ethical and legal duty to do so when appropriate. To legislate such matters seems to be duplicative and restrictive especially since most of the state nurse practice acts address these issues. Further, such provisions undermine the practice capabilities of PNPs and create a bias.

(4) Direct vs. Indirect Payment

We have long promoted direct as opposed to indirect reimbursement to PNPs. In some instances, under Medicare, the facility or physician is reimbursed directly for the services provided by the nurse practitioner. Generally, the nurse practitioner, like many physicians, will turn over his/her billing rights to the facility or administrator in charge. However, direct reimbursement allows the nurse practitioner to see his/her billings and realize his/her work effort. We do not believe that payments made directly to the PNP affects the quality of care provided by PNPs. However, mandates for indirect payment tie the PNP to working for a physician or in a facility that may not be located in an areas where the PNP wants to practice. For example, a PNP may want to provide services in an underserved area where no physician or facility is available. Therefore, when it is appropriate, we recommend that federal policies provide payment directly to the PNP.

(5) Cost Implications vs. Outcomes

Congress must acknowledge that no matter how efficiently our health care resources are managed and restructured, providing increased access to health care for the 37 million Americans who do not have access to health care will increase the costs. Often, when we are promoting legislation to recognize the services of a PNP, we are caught up in the cost debate which is counter to the access debate. We believe our cost-effectiveness is not determined by the amount paid for a service, but rather the overall costs to the system including education and training and, more importantly, patient outcomes or changes in the health status of individuals. In this regard, numerous studies have indicated that our patient outcomes are as good as physicians, if not better in some instances. However, CBO and others do not do their cost estimates in this context.

SUMMARY

Throughout the last 25 years, PNPs have helped to make a difference in children's health. But there are only about 6,000 PNPs available to provide this care. In 1991, the Graduate Medical Education National Advisory Committee (GMENAC) Final Draft Report (HRSA 240–89–0041, 1991, pg. 5) highlighted PNPs as a potential contributor to the delivery of child health care. It also suggested, "the balance of care (child care) is felt to be ideally provided by non-physician professionals while medical needs would be roughly 50% higher if no care was ever delegated." Further, the report concluded that there was a need for more mid-level providers and primary care nurse practitioners.

PNPs provide access to health care; however, nurses need access to education programs to obtain the necessary credentials to provide care as well as a level playing field with uniform and consistent federal policies in order to practice.

We believe that PNPs can help to lead the way in providing primary health care services to our nation's children. However, we will need your assistance to truly bring about the fundamental changes in our health care delivery system as well as incentives to educate and train more PNPs. Over the years, PNPs have proven themselves, despite numerous obstacles and challenges. We stand ready to improve the current system, provide more primary health care services, and increase access to care to our nation's children.

RESPONSES OF LEAH HARRISON TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. I am glad you are here today. We must remember the contribution of nurses and physician assistants as well as physicians to the health care system. I am concerned, however, that we build a system of cooperation and coordination among providers as opposed to contentious competition. I was dismayed to learn of efforts in California by nurses to restrict the scope of practice of physician assistants. Would not efforts such as these only undermine otherwise constructive programs? How can we build teams of health care workers as opposed to factions?

Answer. Efforts in California last year to restrict the scope of practice of physician assistants were unfortunately undertaken by the California State Nurses Association. Once the nurse practitioners in California learned about this, the nurse practitioners worked with the physician assistants to oppose this legislation.

Despite factions of nurses who do not work with physician assistants, there are many examples, particularly in the last several years, where the nurse practitioners and physician assistants have worked successfully together. One such example, are the efforts of NAPNAP and other national nurse practitioner organizations and the American Academy of Physician Assistants, working together to seek passage of legislation that has recently been introduced by Senators Grassley and Conrad. The bills, S. 833 and S. 834, would provide Medicare reimbursement to nurse practitioners and physician assistants in all locations and settings.

On a state level, there are many other examples of nurse practitioners and physician assistants working together as well as the leadership of each organization advocating such action. To illustrate a history of collaboration, I would like to bring to your attention the article, "My Opinion: NPs and PAs Should Work Together," that appeared in the *New Jersey Nurse,* 22(4), pg. 12, July/August, 1992.

NAPNAP believes that we all need to work together in order to provide access to care for all of our nation's citizens. With the numerous citing calling for the need for more primary care health care providers, there is plenty of room for all of us to work together in helping to solve our nation's health care problems.

Question. No. 2. What are the appropriate limits on the practice of nurses? Surely the differences in training of physicians and nurses would lead one to conclude intuitively that the two groups might be different in what they are trained to do. Perhaps the more fundamental question is, what is the difference between a physician and a nurse?

Answer. NAPNAP believes that nurse practitioners should be allowed to practice according to their education and training as well as their Scope of Practice as determined by State laws, rules and regulations. With respect to Pediatric Nurse Practitioners (PNPs), generally they are registered nurses who have additional formal education in the form of a certificate or master's degree. It usually takes two years to complete a masters program. PNPs perform a wide range of professional nursing functions, as well as functions that traditionally have been in the domain of physicians. These functions include: assessing and diagnosing; performing physical examinations; ordering laboratory and other diagnostic tests; developing and implementing treatment plans; prescribing medications; monitoring the patient's status; educating, teaching and counselling the client's and their families; consulting and collaborating with other providers as necessary. In sum, PNPs advanced education and training include the diagnosis and management of common acute illnesses, disease prevention and management of stable chronic diseases.

Rather than focusing on the way the nurse practitioner or the physician is trained and educated, we believe that the focus should be on the outcomes. For over 25 years, the patient outcomes of PNPs is at least equivalent, if not better in some instances, to that of the care provided by a physician for comparative services. In delivering care, the PNP is able to bring the combined skills of the nurse and some "medical" skills. In this way, the PNP would generally spend more time with their clients, educating, teaching and counseling patients more on prevention and health promotion activities.

Question No. 3. I am fascinated by the fact that 10% of National Health Service Corps participants are nurses. I expect not many people are aware of that. What kind of expanded role do you see for nursing in NHSC efforts? Are there nurses ready to join? What other forms could you see national service taking shape?

Answer. Several years ago, NAPNAP worked with key Congressional members and staff to obtain the provision in the law in 1990 that provided for a minimum of 10% of the National Health Service Corps money to be directed to mid-level providers like nurse practitioners, nurse midwives and physician assistants. Through our various publications, journals and newsletters, we were able to increase the awareness of our membership about the program. Since then, we have worked with the National Health Service Corps in a number of ways to increase the awareness of the program among PNPs.

As an example, many of our members who are faculty in PNP programs have participated in a project sponsored by the American Association of Colleges of Nursing and the NHSC to increase the number of NP applicants and to increase utilization of NHSC sites for NP training. This project, "The Faculty/Mentor Program," recently completed its second year, and it has been quite successful in increasing the number of NPs who have received NHSC scholarships or loan repayments in return for service.

The NHSC could help in facilitating communication with communities and states to better understand the role and utilization of NPs as primary health care providers. As an example, the state cooperative agreement agencies and primary care associations could undertake more educational activities regarding the role of mid-level providers like NPs in serving a community's health care needs.

As indicated previously, the 10% is a minimum of funding for the mid-level provider program. The NHSC could increase the funding level, which would help in these efforts.

Question No. 4. Scope of practice acts are state-level statutes. How can we justify the federal government imposing federal standards on what has traditionally been state prerogative?

Answer. Many licensed health care professionals, such as Doctors and Registered Nurses, are expected to function similarly no matter what state they are licensed in. Their educational programs meet national standards and they take national tests to prove their competence before beginning practice. For nurse practitioners, there is great variability in the scope of practice describe for them by the various states despite the fact that their programs are quite similar due to standards developed by the national professional organizations like the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP), the National Association of Nurse Practitioner Faculties, and Association of Faculties of Pediatric Nurse Practitioner Programs for pediatric nurse practitioners. Further, national board examinations are available for various nurse practitioner specialties to clarify and assure the expertise among peers.

It is unfortunate that nurse practitioners in some states are unable to practice using the full array of skills and knowledge which they have. Restrictive state nurse practice acts have been cited as one of the many barriers to practice.

Increasing access to care for the 37 million uninsured Americans, many of whom are children, will require that all available primary care providers are able to practice within their full scope of skills and knowledge. Nurse practitioners have been recognized as an effective quality primary care provider that would be able to assist in this matter.

However, for this to occur, many of the state practice acts will need to be expanded to allow nurse practitioners to practice within their full scope of skills. Given the history of restrictive and anticompetitive practices at the state level by other providers in regard to expanding the role of nurses to provide primary care and the precedent for the federal government to provide incentives to the states to encourage certain actions (e.g., 55 mph speed limit laws) it may be appropriate to encourage states to enact practice acts which encourage the full scope of nurse practitioner practice. Such an arrangement leaves the state the prerogative to regulate professional practice, but it would ultimately assist in increasing the number of primary health care providers in the system thereby increasing access to care and encourage a more level competition among providers.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Mr. Chairman, today's hearing examines an issue that is critical to our health care delivery system, be it the system we know today or some new scheme that will emerge from our health care reform deliberations. That issue quite simply is the need to ensure an adequate workforce to meet our nation's primary care needs.

Primary care is not a partisan issue. I believe there is unanimity within this committee, and indeed the Senate, on the need to improve our supply of primary care providers. This is as true in rural Utah as it is in urban New York.

The question then turns to the appropriate government role in fostering development of the workforce we will need to make certain all Americans have access to quality health care at an affordable price. Primary care is central to that debate.

Federal hospital reimbursement policies and health manpower assistance programs have been a traditional source of support for primary care training and retention. The National Health Service Corps; whose director we will hear from today, is another excellent program which has produced real results, benefiting rural and urban areas alike.

Even so, as members of this committee are well aware, we are faced with shortages of primary care providers and oversupplies of the more costly specialty providers. All we have learned about America's health care delivery system suggests that these trendlines are moving in the wrong direction.

I applaud the committee for its focus in this hearing. Primary care, whether it is delivered by a physician, a physician assistant, nurse practitioner, or other profes-

sional, is a critical component of our health care continuum. It will be a crucial focus of our reform efforts, and I look forward to reviewing the testimony of our witnesses.

PREPARED STATEMENT OF WANDA HUFF

Good morning, I am Wanda Huff, MD, Chief of Medicine at North General Hospital in New York City. I am representing the International Coalition of Women Physicians, in the place of Jessie Sheerod. On behalf of the coalition, I am pleased and honored to have this opportunity to discuss issues of minority physicians related to anticipated changed medical manpower needs and enhancement of primary care services.

Our membership aligns itself in purpose with the 16,000 African-American physicians of the National Medical Association and the 516 members of the National Black Caucus of State Legislators.

Although a need for more primary care practitioners exists, what is true for the majority is not true for African-American and other underrepresented minority physicians. In fact, African-American physicians have been forward thinking their predominant choice of primary care specialties and their commitment to serving high-risk, poor and underserved populations. As David Satcher, President of Meharry Medical College, stated , while "Blacks have no 'obligation' to service the poor but they identify with this group and share a unique history. It is experience, not pressure, that gives them the orientation to serve the underserved."

Several studies have documented this commitment to primary care and service to minority and indigent populations. Keith et al, in 1985 reviewed the experience of the 1975 graduates and found that for minority graduates 55% versus 41% of non-minority graduates chose the primary care specialties of family practice, Internal Medicine, Pediatrics, and OB/GYN Additionally, minority physicians were more likely to practice in manpower shortage areas and care for Medicaid recipients. The comparison was 31% to 14%.

In 1985 a New York State survey revealed that almost 45% of minority graduates planned to serve in socioeconomically deprived areas versus 15.6% of all surveyed.

The Council of Graduate Medical Education (COGME) noted in its Third Report that African-Americans have been shown to be more likely to follow through with initial plans to practice in primary care medicine than other racial ethnic groups.

Despite this record of provider career choice, health status statistics have worsened for the African-American community. In 1985 60,000 excess deaths were documented, by 1992, the number rose to 75,000. The U.S. census data for 1980 and 1990 reveals much lower ratios of physicians to population for African-American than majorities; 51/100,000 compared to 198/100,000 in 1980, and 71/100,000 compared to 251/100,000 in 1990.

We all know it is clear that more African-American physicians are needed. We are concerned that the vehicles to increase minority physicians number will place an unfair pressure on these students to choose only primary care careers. While we recognize the value to primary care and preventive services. We also recognize the need to continue efforts to improve representation of African-Americans in all the specialties and on medical school faculties.

In 1981 less than 2% of medical school faculty were African-American, by 1990 the census data revealed of 2.5%, 14% of the clinical faculty reside in 3 predominantly African-American schools. While this underscores the special value of these schools, it also demonstrates the need to protect opportunities for minority physicians to choose careers in all spheres of medicine. Restrictions that decrease minority representation in faculty and specialty positions would have negative repercussions down to the student level. Physicians must become specialists before they can choose to seek specialty faculty positions and appointment. Minority faculty members are critically important in mentor and support roles for minority medical students development.

It is only the last decade a substantial number of African-Americans have begun to have representation in specialty areas, academic medicine, research and health policy. The negative effects of the underrepresentation among faculty on recruitment, enrollment, and graduation of minority students and the development of all students was reported in 1990 by COGME.

The health care needs of the minority community cannot be met in the near future by minority physicians alone. Culturally sensitive practitioners are needed. Minority faculty are valuable to serve as role models for all students. Financial incentives to increase primary care physician numbers must not become roadblocks to alternate career choices for minority physicians.

The practice of exclusion of African-American primary care providers by some organized physician provider groups is a topic that requires further review. This I raise as an issue today. After self-directing themselves to these primary care specialties, African-American physicians find they are not desired or admitted because of the high cost of care associated with their high risk clients, who also require additional resources for health education.

In conclusion, first, special circumstances exist for minority providers that require consideration in any health reform model. Minority physicians are currently providing primary care services at a greater level than the majority physician population. Systems to increase primary care participation should not be permitted to undermine the small gain in minority physician representation in subspecialties and faculty positions.

Second, minority physician participation in the reform efforts is critical, if redress is to be achieved for the current underrepresentation

Third, the ICWP supports flexible loan repayment schedules to facilitate minority student training in all specialties, subspecialties, research, and health policy positions across the board.

Fourth, we endorse the 3000 by 2000 Project of the AAMC.

And finally, practicing physicians must have equal access to the vehicles of health care delivery under managed care. Monitoring of the process is necessary to document outcome.

I thank you for this opportunity to present these issues before this committee.

RESPONSES OF DR. HUFF TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. I am glad you are here. It's important to recognize that improved representation of minorities in graduate medical education should be one of our goals in reforming the system. The statistics you shared with us in your testimony make that case very plain. I think your recommendation that we target minorities during their primary education speaks to the fact that to really improve the likelihood of significantly increasing the representation of minorities we need to focus our efforts early on. Medicare GME dollars aren't designed to complete this task. What type of programs do you suggest we support and do you have recommendations about where those programs should be located in the federal, state or local government?

Answer. Thank you for this opportunity to present our concerns about the potential changes in incentive programs and training opportunities as reform of the health care system proceeds. It is true that Medicare GME dollars are not directed at minority medical student recruitment and retention efforts, but other Federal funding provides major support for medical schools. Continued pressure to comply with equal opportunity mandates, to maintain this funding, is necessary to insure that schools have equitable minority student representation. At present the Association of American Medical Colleges (AAMC) has one program in place to improve minority medical student representation. The program, 300 by 2000, focuses on improving primary school science education, so that minority students can enter college with a science and math background that will promote success in completion of the college science course prerequisites for medical school. Similar programs have been organized by school districts and private groups or universities. Targeting students at these early stages will be the only way to have properly prepared applicants. The efforts could be better coordinated with federal assistance. Successful programs would be identified and funded for duplication at a local governmental level to insure that no geographic disadvantage occurs.

Question No. 2. I'm a little concerned that you believe an overall cap on physician supply and mix would contribute to discrimination. Shouldn't we do our best to alleviate existing discrimination and improve recruitment and retention regardless of whether or not there is a cap? Isn't that the only way to fix the whole system? Not everyone in America is qualified to be a doctor today, I don't believe capping the number of residents will change the requirements for physicians (or access to training) in any measurable way. As you may have heard me ask the PPRC, we could use recruitment and retention performance of programs a part of the criteria for allocating the slots. What do you think of that proposal?

Answer. Eliminating discrimination in all aspects of American life must remain the goal. However, realizing that a lack of equity in opportunities for minority physicians still exists, as documented by the data in my testimony, any program that seeks to limit options for anyone creates the probability that minority citizens will be unfairly impacted by the limitations. I have also shown that African-American physicians do not have the same maldistribution of practitioners among the specialties that exists for other groups. This should be recognized by the corrective proce-

dures that are developed. We agree that criteria should be established and performance monitored for programs at all levels of medical training.

Question No. 3. You suggest flexible loan repayment schedules will help facilitate training. I agree, but aren't most loans available with very long term rates?

Answer. Educational costs are quite variable between schools and regions of the United States. Students often use a variety of funding sources to meet their costs. The loan conditions can differ in both interest costs and timing for repayment. Many loans do have options for long term rates, but students would prefer more alternatives that create service opportunities which result in loan forgiveness.

Question. No. 4. Wouldn't the loan repayment programs offered by the National Health Service Corps be a powerful tool for increasing minority physicians?

Answer. The National Health Service Corps, discussed by Dr. Gaston, has been a very popular program for minority students. As stated most minority medical school students are choosing primary care specialties as careers and see the Corp as an opportunity not a limitation. However, efforts should increase to make students, even in high school, aware of this as a funding source, so that talented but needy students with the desire to become doctors realize this option exists. We hope that other programs will be available for minority students who wish to pursue non-primary care specialties or academic careers. They are needed.

Question No. 5. Could you tell us about what kind of economic sanctions you think would be appropriate to use to discipline programs that discriminate?

Answer. The most effective sanction would be the possibly of exclusion from participation in any type of federally supported reimbursement or award system for any program shown to discriminate. In addition, programs should be expected to demonstrate the absence of discrimination by having appropriate representation from underrepresented minority groups.

Question No. 6. I am especially sympathetic to your pointing to our need to increase mentoring of minority physicians. What kind of programs exist today? What is the appropriate role for federal support of this effort?

Answer. The National Medical Association has a mentoring program for minority medical students and its minority physician members. Certain universities, such as my alma mater, have developed programs for minority undergraduate students and minority alumni who are practicing professionals. These programs foster relationships that do not often develop spontaneously, because of the limited number of minority professionals and the demands of their work. The mentors provide both practical guidance and encouragement. There is a need for funding of the administrative costs associated with recruitment, notification and tracking. Programs are not equally successful at defining the mentor role. Formalized guidelines and advice could be developed from review of successful programs as a federally funded project.

Question No. 7. You suggest the federal government should do more to support black health professionals schools. I understand a great many of those institutions are heavily subsidized by the federal government, you mentioned Meharry as an example in your testimony. How much more do you think the federal government should increase their already dramatic financial support?

Answer. It is true that the federal government has been a source of funding for minority health professional schools. However, these schools have not been equally successful in competition for the sustained funding that results, for example, from designation as a provider at a VA facility. There is a need to consider these institutions in all medical care roles funded by the government.

STATEMENT OF JESSIE L. SHERROD, M.D., M.P.H., F.A.A.P. ON BEHALF OF INTERNATIOINAL COALITION OF WOMEN PHYSICIANS

OVERVIEW

Chairman, members of the committee, I am Jessie L. Sherrod, M.D., M.P.H., a pediatrician and hospital epidemiologist at the Charles R. Drew University of Medicine and Science, Los Angeles and Vice President of the International Coalition of Women Physicians. today I am representing the membership of ICWP, and the 16,000 African-American physicians of the National Medical Association and 514 members of the National Black Caucus of State Legislators.

In that the African-American community has not been adequately served by the current system of health care, the ICWP applauds the government's intent to reform our health care system. However, we are concerned that the new system may not adequately address the circumstances and needs of our communities. We appreciate this very important opportunity to amplify some of the major issues we face for both minority consumers and providers in the area of access.

ACCESS

Access - the affordability, availability and acceptability of health care, has been documented to be a major factor in improved health outcomes. Eliminating financial barriers by guaranteeing insurance coverage for all is without a doubt one of the most significant steps toward assuring access. However, eradicating financial barriers only will definitely not lead to full access in minority communities.

Consumers

Numerous non-financial barriers exist in our society varying in extent and impact, influenced by the culture of the affected group(s). They maybe manifested by the health care provider, the consumer and/or the institution. More generically, they can be characterized as governmental, geographic, institutional, cultural, personal, educational, political and legal.[1]

Lack of education, poverty, low self-esteem and lack of trust and, faith in the system contributes to our health problems. Poor compliance with therapeutic regimens results in poor health outcomes. Mistrust of the traditional medical system leads to fear of participation in clinical trials and limits access to medical innovations. The consequence of poverty is the need to address the problem of inadequate housing, insufficient food and hazardous environments before seeking preventive health care.

Racism, and classism, are barriers to access. As Blum and Blank states in AJDC, May 1991, " Racism and classism make it easier to ignore children in poor neighborhoods, indeed, racism and classism may even make it more attractive to care for babies in the highly technological professional neonatal environment than in the communities to which they return".[2]

Provisions must be made to educate the consumer on how to effectively access the health care system , use preventive health services and promote and maintain healthy lifestyles. Any reform in the health care system should provide support for culturally relevant preventive health programs in minority communities.

Geographic Isolation: Dispersed rural populations and clustered urban/inner city populations present a great challenge to the delivery of adequate health care. A number of impediments must be addressed to encourage the location of health professionals in these underserved areas. Barriers include: limited availability of

medical resources, location of health care facilities; access to allied health professionals, and tertiary care subspecialists; and poor language skills.[3]

Research should be conducted into systems of health care provision on a societal level; that will facilitate reliable access for the poor. Funding should be made available for intervention programs to focus on specific needs of underserved populations. We also support incentives to attract and retain dedicated professionals to underserved areas. Such incentives should include, more favorable reimbursement rates, expansion of the National Health Service Corps, and a loan forgiveness program.

Small business tax credits and banker incentives for loans to minority-owned and operated health care practices will reinforce community infrastructures and address unmet health needs. Minority hospitals, so historically important in the training of African-American physicians and care of African-American patients must be preserved and supported.

Providers

African-American physicians ar confronted with several problems of access. Three critical access issues are: (1) access to medical education and training, (2) and access to medical faculty positions, subspecialties, research and policy development, (3) access to the vehicles of a managed health care delivery system.

Medical Education and Training

Medical Students: The rapid expansion of medical student enrollment from the mid-1960's to the mid-1970's provided a unique opportunity to increase the proportion of African-American and Hispanic medical students without reducing the total majority students enrollment.[4] Despite these efforts African-American and Hispanic representation in the physician population is far below half their proportion of the U.S. population and is now declining.[7] AMC 1990 census data show African-American constituting only 4.1% of the physician population but 12.4% of the general population.

The AAMC task force initial goal of achieving a minority medical student enrolment of 12% by 1975, to establish population parity has not been met to this date. African-American student first year enrollment peaked at 7.5% in 1974 and had dropped t 6.8% by 1984-85. This decline had occurred despite the fact that the applicant pool from which to draw minority students was still increasing and would continue for another decade. Between 1974 and 1986, despite a 27 % decline in overall applications to medical school, the proportion of minority applicants rose from 7.3 to 10.2 % of all applicants. Ironically, during these same twelve years the acceptance rate for minorities, especially for blacks, declined. African-Americans acceptances declined from 43 to 40 %, stayed at the level and jumped back to 43 % only in 1986. At the same time the acceptance rate for majority students rose from 35 to 55 %.[4]

In 1990, 51 % of minority applicants were accepted compared to 59 % of all applicants showing some improvement.[12] AAMC 1991 data indicate an increase of almost 14 % in the number of medical school applicants, the largest increase since 1972.[12]

Analysts conclude that today's lower acceptance rate for minorities cannot be attributed simply to lower qualifications. Admission rates have declined even among minority students with the highest MCAT scores. Between 1979 and 1983 the acceptance rate for black applicants with MCAT score of 8 or higher fell 1.5 %, whereas the acceptance rate for majority applicants with comparable scores rose 2.9 %.[4] Apparently, commitment of medical schools to affirmative action, while minimal in the past, has been severely eroded.

From 1975 to 1989 the proportion of minorities in the population increased by 18.5 %, while the portion in medical school increased by only seven %.[12]

Our four traditionally black medical schools representing 3% of the nation's medical schools continues to graduate 20% of African-American doctors.[4] In addition, other studies have shown that more than 60 % of the graduates of Meharry and Howard medical schools practice in medically underserved inner cities and rural areas. Although adhering to the same high standards of medical education and accreditation applied to all other schools, black medical schools have operated with inadequate financial resources and without access to the clinical facilities available to other medical schools.[9]

As the former Secretary of Health and Human Services, Louis Sullivan, M.D. succinctly stated in the New England Journal of Medicine, 1983, "Black health professions schools should be strengthened by increased financial support for their programs from governmental sources (federal, state, county, and municipal) and from the private sector (foundations, corporations, associations, and individuals). Black health-professions schools should have equal access to tax-based municipal and veterans administration hospitals and other clinical facilities for their teaching and service programs and for the opportunities to contribute to the nation's biomedical-research enterprise. The National Institutes of Health, the National Science Foundation, and other public and private research agencies should work with these schools to strengthen their research capabilities, drawing on their unique perspectives and their ability to focus on the health problems of blacks and other minority groups".[9]

Residents: Data from the AAMC National Resident Matching Program(NRMP) over five years, 1984-88, reveal that individuals from underrepresented minority groups have been less successful than others in the matching process. The unmatched rate for minorities was 17.7% versus only 6.7% for all students. For subsequent years, the rate of unmatched underrepresented minorities decreased, but it went up again in 1988, to 12.3%.[10]

We encourage affirmative action policies by residency programs to ensure continued progress for minorities in the NRMP. Clearly the evidence shows a need to produce more minority physicians.

Medical Faculty: Parity of African-American physicians is deficient at every level of medical education and training. It has been only in the last decade that a substantial number of African-American physicians have begun to train in subspecialty areas, academic medicine, research and health policy. Crucial to the success of African-American medical students is that they have mentors and role models that are visible at all levels of education and training. There is a special commitment and a special understanding when mentors are also minorities.[12]

The Council on Graduate Medical Education concluded in 1990 that minorities were severely underrepresented on the faculties of U.S. medical schools. It stated that this underrepresentation had a negative effect on both the recruitment, enrollment, and graduation of minority students, and the professional development of all medical students.[12] Let us examine the already grim statistics.

In 1981, less than 2 % of the faculties of our medical schools were African-American. By 1990, AAMC census data revealed only 2.5 % of U.S. medical school faculty as African-Americans. Even more disturbing is the severe underrepresentation of African-American in the various subspecialities of U.S. medical schools faculty.

Representation in all of the basic sciences (anatomy, biochemistry, microbiology, pathology, pharmacology and physiology) is less than 2.0 %. And 43 % of that 2.0 % is located at one of three African-American medical schools. Of the clinical faculty positions at all U.S. medical schools, African-American faculty are less than 3.0 % in all areas with the exceptions of, obstetrics-gynecology - 4.1%, physical medicine - 3.4%, and public health - 4.1%. Three African-American medical schools house 14% of the clinical faculty positions.

These figures document the shortage of African-American health resource personnel and reflect several needs. First, African-American medical students and trainees should be allowed and encouraged to pursue careers in all areas of medical specialties and subspecialities, including primary care, academics, research and health policy. Medical trainees should be made more aware of research opportunity. Academic career discussions must increase in frequency, content, and quality to increase the number of minority medical faculty.[12]

Secondly, the continuous contribution of predominantly African-American medical schools to the education of African-American physicians is critical to the survival of a medical infrastructure in our community. The ongoing underrepresentation of minorities in medicine means that many minority communities may be deprived of the much needed leadership that these professionals have traditionally provided to their communities.[12]

Medical Vehicles: Increasing the representation of minority physicians in the health professions was motivated by a desire to improve access to health care and ultimately the health status of underserved minority populations. African-American physicians have been futuristic in their predominant choice of primary care specialties and their commitment to serving high-risk, poor, underserved populations. David Satcher, President of Meharry Medical College, stated that "Blacks have no 'obligation' to service the poor, but they identify with this group and share a unique history. It is experience, not pressure that gives them the orientation to serve the underserved".[4]

This same dedication to serving "needy populations" has begun to work to the detriment of many providers and their patients. Many African-American providers are being systematically excluded from panels of practitioners organized under the auspices of managed care, i.e., IPA's, PPO's, HMO's. Patients traditionally served by African-American physicians consistently discover that their doctors are not included on the list of preferred providers offered by their employer's plans.[6] These physicians have been excluded because of the high risk nature of the patient population served, and fear by the health plan that the more complicated modes of treatment required by more severely ill patients will pose a financial risk to the health plan.

Beyond the financial considerations is also the probability that racism impedes full access to the health care delivery system for both consumers and providers. It is crucial that African-American physicians continue to have an equal opportunity to provide culturally sensitivity health care to their patients. Policies should be developed to ensure that patients are allowed to maintain their existing providers as a function of enrollment in any system adopted.[6]

The concept of "community rating" must include a large enough universe and socioeconomic cross section of the population to spread and diminish risks. The criteria for exclusion and inclusion of physicians in provider groups should be designed to ensure the delivery of quality care and at the same time, maximize equal access and affirmative action. Through open enrollment periods, African-American health care provider's and patients should have equal access to existing managed health care plans.[6]

African-American professionals, providers and policy makers must be involved at all levels of decision-making in the health care reform process. The reformed system should continue efforts to achieve equity in representation of African-Americans in the institution of managed care or other entities, and as contractors empowered to organize physician/provider groups.[6]

Decreasing the gap between the health status of minority and non-minority populations cannot be accomplished by minority physicians alone. The rapidly increasing diversification of the American population coupled with the underrepresentation of minority health care professionals necessitates training of all physicians to be culturally proficient in their delivery of health care. More caring, concerned physicians who are involved in primary care and who are providing health care for minority populations can affect their health status.

We support service demonstrations to develop and test new models of care, research to improve the knowledge base and assess the efficacy of its service demonstrations, and culturally proficient training in residency programs to better prepare health care providers to address the needs of the poor and underserved. Institutions could develop exchange programs to allow for greater exposure of housestaff to different under-served populations. Examples of such rotations would include the homeless health care, migrant populations, and inner-city health care.[1]

PRIMARY CARE ISSUES

Efforts to improve access to health care services will be doomed to failure, if we do not have sufficient numbers of primary care physicians to diagnose and promptly treat most medical illnesses.[3]

It has been a widely held assumption that minority health personnel would be more likely to serve minority and indigent populations.[4] Several studies have documented the underlying assumption to be true. Keith, et al, showed in 1985 that a larger proportion of minority medical school graduates (55% versus 41%) class of 1975, chose primary care specialties of family practice, internal medicine, pediatrics and obstetrics and gynecology. Significantly more minority physicians practiced in federal health manpower shortage areas, and had more Medicaid recipients in their patient populations (31% versus 14%). In addition, they served disproportionately more patients in their own ethnic community.[5]

In 1989, a survey revealed that almost 45 % of minority graduates of New York State medical school compared to 15.6 % of all surveyed students indicated that they planned to practice in a socioeconomically deprived area. The 1991 AAMC Graduate Questionnaire (GQ) indicates that 34.1 % of underrepresented minorities versus 7.5 % of all other students plan to practice in underserved areas.[12] African-Americans and Mexican Americans have been shown to more likely follow through with initial plans to practice in primary care medicine than other racial/ethnic groups.[12]

Therefore, we support the efforts directed at increasing the supply of primary care physicians through education financing incentives such as, flexible lean policies for students entering primary care careers, loan forgiveness in return for service in underserved areas, forbearance and deferment of low interest loans, Title VII for Primary Care Residency Training Grants, and initiatives designed to attract and select medical school applicants who are most likely to seek careers in primary care. Additionally, we concur with the need to enhance reimbursement rates for primary care services.

The current physician tracking system does not adequately document the activities of practicing minority physicians. therefore, accurate monitoring and measurement of changes secondary to health care reform would be impossible. To realize the effects of a new system, it is imperative that this data collection and analysis be instituted before and after health care reform.

CONCLUSIONS

1. Special circumstances of minority consumers and providers exist that require consideration in any health reform model. Minority physicians are currently providing primary care services at a greater level than the majority population of physicians. Systems to increase primary care participation by the majority, should not be permitted to undermine the small gains in minority physician representation in specialties, subspecialties and faculty positions.

2. Disparities in minorities health status and number of minority providers relative to population proportion are well documented in the data sets of the government and medical schools, but to date have not been adequately addressed.

3. Minority physician participation in the reform efforts is critical, if redress is to be achieved. If this representation is absent, the current situation can be expected to worsen.

4. The solutions must include nonminority physicians who are deemed culturally competent/proficient.

RECOMMENDATIONS

The ICWP supports increased intensive efforts in combination with the allocation of more federal funds for the recruitment, retention, graduation and promotion of African-American medical students, trainees and faculty. Students should be targeted in grade schools.

Flexible loan repayment schedules should facilitate minority students training in all specialties, subspecialties, research and health policy positions across the board.

We endorse the AAMC Project 3000 by 2000 campaign's goal of doubling the number of first-year entering minority medical students by the year 2000.

The residual bias creating disparate unmatched rates of minority versus majority residents should be addressed by economic sanctions against programs which continue patterns of discrimination.

Our practicing physicians should have equal opportunity to participate in the reorganizational process of the health care system and equal access to the vehicles of health care delivery under managed care. Monitoring of this process is necessary to document outcomes.

We must again emphasize the importance of mentoring by minority physicians in faculty positions and their significant role in facilitating the achievement of the aforementioned goals i.e., recruitment, retention and graduation of African-American students.

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INTERNATIONAL COALITION OF WOMEN PHYSICIANS
ICWP HEALTH CARE REFORM PROPOSAL

CONSUMER ISSUES

I. **Universal Access: affordability, availability and acceptability**

A. Eliminate Financial Barriers

1. Cost reimbursement systems should facilitate access through
   a. flexible or no co-payments
   b. no deductibles
   c. reduced paperwork
2. Employer-based system must include
   a. job mobility-portability of coverage
   b. elimination of pre-existing conditions exclusionary clauses for insurability
3. The under and unemployed should receive standard benefit

B. Eliminate Non-financial Barriers

1. Geographic isolation
2. Isolation of providers
3. Lack of culturally proficient providers
4. Consumer education
   a. traditional and alternative health care
   b. informed consent, confidentiality
5. Prison Health standards

II. **Quality of Care**

A. Process measures

1. Encourage the integration of non-physician clinical care providers into the health care delivery system to provide comprehensive health in a collaborative manner for all populations.
   a. However, avoid the creation of two tier systems that substitute these providers for physicians as the main source of care.
   b. Avoid discrimination with the use of high technology.
2. Provider choice
3. Education of consumers on utilization of any system.

B. Content measures

1. Standard Benefit Package
   a. Health Maintenance
      (1) Routine physical examinations and well-child visits
      (2) Health education, i.e. nutrition and dietary counseling
      (3) Prevention and screening i.e. mammogram, pap smears, lead toxicity
      (4) Immunization for seniors, infants, children, adolescents and adults
      (5) Prenatal care and family planning services
      (6) Mental health
      (7) Reduction in environmental health risks
      (8) Reduction of occupational hazards
      (9) Injury prevention
      (10) Dental
      (11) Vision and hearing
   b. Ambulatory Services: emergency room visits, surgical procedures
   c. Abortion Services
   d. Hospitalization
   e. Rehabilitation
   f. Home/Hospice
   g. Unrestricted access to prescription drugs
   h. Mental Health
   i. Substance dependency treatments (in-patient, residential and out-patient treatment programs)

j. Special care needs
   (1) HIV disease
   (2) Tuberculosis
   (3) Transplantation
   (4) Chronic conditions
      (a) Prostate cancer
      (b) Breast cancer
      (c) Sickle cell anemia
      (d) Systemic lupus erythematosus
      (e) Developmental disabilities
      (f) Physically challenged
      (g) Mental retardation

2. Continuity of Care
3. Long term care and extended care facilities
4. Demonstration projects - allow flexibility to determine effectiveness of intervention programs, primary, secondary and tertiary.
5. Coordination of non-traditional health care delivery systems.
6. Improve standards of institutional health care.

C. Outcomes

1. Reduce morbidity and mortality due to preventible and modifiable risk factors
2. Favorable health status outcome measures
   a. Reduced emergency room visits
   b. Reduced number of acute care hospitalization for targeted diseases such as diabetes, hypertension and arthritis.
   c. Reduce teen pregnancy rate
   d. Reduce number of infant deaths and low birth weights.
   e. Reduce sexually transmitted diseases.
   f. Reduce number of deaths due to homicide and suicide.
   g. Reduced days lost from work
   h. Increased productivity.
3. Patient satisfaction
4. Parity of life expectancy

PROVIDER ISSUES

I. **Access**

A. Comprehensive training at all levels of medical education.

1. Although currently, 60% of African American physicians are in primary care, we are under-represented at all levels of training i.e. primary care, specialty care, faculty positions, academics, policy positions and research.
   a. Therefore we recommend that a full range of choices in medical careers be available to under represented minority physicians.
   b. Financial incentives that shunt minorities solely into primary care should be avoided.
2. Eliminate barriers that exclude full participation in various health care delivery systems based on race, gender or board certification status.
3. Full participation in education research and policy.
4. Appropriate representation of minority physicians at all levels of decision making affecting health and health policy, inclusive of health provider organizations.
5. Culturally competent training for all medical students.
6. Access to wellness maintenance for health care providers.

II. **Quality of Care**

A. Process Measures

1. Physicians antonomy
   a. Diagnosis and treatment decisions
   b. Medical referrals
2. Care decisions should be cost appropriate.
3. Cost incentives should not compete with quality.

B. Content Measures

1. Continuing medical education
2. Viable community and county hospitals and community health centers (Special attention to needs of minority run institutions).
3. Tertiary care access
   a. Ongoing relationships among primary care providers, community hospitals and tertiary care facilities that will facilitate access of patients to tertiary care services.
   b. Tertiary care outreach and information services must be available to community providers.
4. Physician Profiling
   a. Physicians should be full informed of all citations and negative information compiled by various sources.
   b. Appropriate notification for rebuttal should proceed the inclusion of reportive data in physician files.

C. Outcome Measures

1. Improved community health status and health outcomes.
2. Patient satisfaction
3. Providers career satisfaction.
   a. Home
   b. Environment
   c. Personal time
   d. Reduction in paper work burden
4. Parity of life expectancy for African American physicians as compared to caucasian physicians.

III. Cost

A. Physician Overhead

1. Reimbursement
   a. Should be adequate for preventive services.
   b. Should enable independent minority practitioners to compete with larger health plans in rendering care and thus avoid exclusion of providers.
2. Eliminate excessive unreasonable reviews by bureaucrats.
3. Torte reform
   a. Decrease in malpractice insurance premiums.
   b. Liability risks must be shared.

B. Medical Education

1. Decrease cost of training
2. Increase financial support services to individuals.
   a. Scholarships
   b. Loan support
      (1) low interest
      (2) longer repayment schedules
3. Avoid catastrophic indebtedness resulting in interruption or cessation of training
4. Guarantee parity in funding of minority institutions.
5. Increase financial incentives for physicians to locate in underserved areas
   a. National Health Service Corp.
   b. Other

C. Develop clinical practice guidelines

1. To control cost in the appropriate utilization of technology.
2. To ensure quality
3. To more clearly delineate malpractice infractions.

D. Cost-effective use of prescription drugs

E. Review and monitor allocation of certificate of needs and use of costly technology.

F. Improve information management

1. Data systems should enhance communication to avoid duplication of services.
2. Allow for more accurate documentation.

G. Risk adjustments of community ratings to control for more severely ill patients.

PREPARED STATEMENT OF ALAN R. NELSON

Introduction

I am Alan R. Nelson, MD, Executive Vice President of the American Society of Internal Medicine (ASIM). I am pleased to present the views of internists nationwide on policies to encourage physicians to enter and remain in primary care practices.

ASIM greatly appreciates the opportunity to participate in this hearing, and for the leadership that has already been demonstrated by this subcommittee in developing policies to support primary care. We particularly commend Chairman Rockefeller and Senator Durenberger for their sustained commitment to this goal. With Congress about to embark on consideration of proposals that may finally lead to meaningful reform of the health care system, we now have an historic opportunity to also change the environment that is now driving physicians away from primary care. We strongly believe that there is an urgent need for Congress to enact legislation this year to begin rebuilding primary care, both as part of the Medicare reconciliation act and as a component of any broader proposals to reform the health care system.

Creating incentives for primary care is critical to the success of health care reform. Primary care is the foundation of the health care system, but it is a foundation that is crumbling due to years of neglect. Unless that foundation is rebuilt, health reform will fail to expand access, control costs, and improve quality.

Providing coverage for primary care will not improve access, if there are too few physicians available to provide primary care. Costs will not be lowered and quality will not be improved, if there aren't enough physicians in primary care to manage, coordinate, and guide their patients through the health care system.

In March, ASIM released a white paper titled "Rebuilding Primary Care: A Blueprint for the Future." It lays out why primary care is in trouble and what must be done about it. It presents 44 specific recommendations for alleviating an economic, regulatory and training environment that is unremittingly hostile to primary care.

I don't intend today to discuss all of the findings and recommendations presented in that paper, copies of which have already been provided to the subcommittee. What I do want to do is to present a recommended approach for crafting policies to rebuild primary care to achieve the goal of having 50 percent of physicians trained in and practicing primary care.

The approach recommended by ASIM is based on what physicians themselves have told us will, and will not, work. In preparing our paper, we asked hundreds of internists to tell us what they like, and don't like, about primary care practice today. We asked established physicians to tell us what is required for them to feel more positive and optimistic about primary care. We asked younger physicians in training what it will take to convince them and their colleagues that primary care is a viable and attractive field of practice.

We also researched the data on factors that influence choice of specialty and type of practice, and reviewed the recommendations of many others. The studies and data generally supported what the physicians in practice and in training both told us. Policies to rebuild primary care by reforming the educational system will not be successful, in the absence of other changes to tackle the economic and regulatory disincentives for choosing primary care.

A Multi-faceted strategy

What is needed is a multi-faceted strategy to improve the economic, regulatory, and yes, training disincentives for primary care. From the day people first decide to become physicians, and throughout their education, and to the day that they retire, the message that primary care is highly valued by society should be reinforced.

This means that young physicians in training must be exposed to positive primary care role models. It means that they must learn what primary care practice is really like, by increasing their exposure to primary care as practiced in office and other ambulatory settings. Utilizing Area Health Education Centers can be a valuable part of effective training in ambulatory care. And they and the programs that train them must get sufficient financial support from the federal government and other payers. But it also means that when they enter practice, the economic and regulatory environment should also reinforce the value of primary care. It does little good to tell physicians in training that primary care is a fun and rewarding field, if their observations of their colleagues in primary care practice tell them this is not so.

The unfortunate reality is that primary care is commonly perceived by physicians as requiring "Longer hours for less pay and more hassles." As long as this perception exists, ASIM is highly skeptical that enough physicians will choose primary care, no matter what reforms are made in the education system.

ASIM believes, however, that the primary care crisis is not simply one of numbers. It may be possible to coerce more physicians into going into primary care, by restricting residency positions in other specialties. But even though such a policy may produce an adequate number of primary care doctors, the quality of primary care may decline. If physicians feel that they have been forced into a field that they otherwise would not have chosen--or for which they lack the clinical, scientific, and interpersonal skills that are uniquely required to be a good primary care doctor--they won't be good at what they do.

Even those who start out in primary care with enthusiasm will quickly lose it if their experience in practice is unfavorable. As long as primary care practice continues to be underpaid, overregulated, and micromanaged, the level of dissatisfaction among primary care physicians will worsen. So even if the right number is attained, the quality of primary care will suffer if those providing it are frustrated and disillusioned by a hostile economic and regulatory environment.

ASIM's Recommended Approach

Rebuilding primary care won't come easy. But ASIM is confident that this country can achieve an adequate number of physicians who go into primary care.

To accomplish this, ASIM believes that public policy should:

1. Improve the economic, regulatory, and training environment for primary care, rather than focusing exclusively or primarily on educational reforms.

2. Emphasize approaches that will make doctors want to go into primary care, rather than measures to force them to do so.

Let me elaborate on our recommendations for implementing this approach.

Reforms in the Educational System

ASIM believes that it is important to reform financing of graduate medical education (GME) to place the appropriate emphasis on primary care. Current Medicare policies have clearly encouraged the growth of programs that emphasize specialty training over training in general internal medicine, family practice, and pediatrics. In addition, the lack of exposure to positive primary care role models, inadequate training in--and exposure to--primary care as provided in office and other ambulatory settings, and high debt also discourage physicians from going into primary care.

ASIM's paper "Rebuilding Primary Care: A Blueprint for the Future" includes ten specific recommendations for placing a greater emphasis on primary care in training programs. We advocate that primary care training programs receive a substantially larger share of Medicare GME funding. This should be accomplished by greatly increasing the weight given to residents in three-year internal medicine and other generalist programs, while reducing the weight assigned to residents in all other programs. We believe that the differential should be larger than contemplated under previous proposals considered by the Congress. New York state, for example, treats residents in three-year family practice, pediatrics, and internal medicine training programs as 1.5 full-time equivalents; internists and family physicians being trained as geriatricians as 1.27 FTEs; emergency medicine, preventive medicine and obstetrics-gynecology as 1.0 FTEs; all other three year residencies as 1.0 FTEs; and all other residents as .9 FTEs.

As part of comprehensive health reform, ASIM also supports a requirement that all payers contribute to a pool to finance GME, with the funds from that pool also distributed according to a weighting formula that benefits primary care.

ASIM's approach differs from that recommended by the Council on Graduate Medical Education (COGME) and the Physician Payment Review Commission (PPRC), both of whom favor a more restrictive policy on funding GME. Rather than increasing the emphasis on primary care training by changing the weights assigned to those and other programs, the PPRC instead would establish a commission to determine the number of positions within each specialty that will be

funded, subject to an overall limit on residency positions to be established by Congress. Funding would then be allocated based on the specific quotas for each specialty. COGME recommends a similar approach.

ASIM shares the PPRC's and COGME's goals to increase the number and proportion of primary care physicians, in part by providing more financial support to primary care training programs compared to other programs. Where we differ, however, is on whether this should be accomplished by creating incentives so that physicians are encouraged to choose primary care, or by making primary care the only training that is available to most physicians.

Our concern is that by directly limiting the total number of slots in other specialties that will be funded by Medicare and other third party payers, physicians will go into primary care not because they want to practice in the field, but because they are coerced into doing so. If the choice is between going into primary care, or not practicing medicine at all, many may end up selecting primary care. But they will do so unenthusiastically. They will resent the decision. They may not be best suited, by skill or temperament, for primary care. The skills and temperament that may make a person a good neurosurgeon, for example, are not the same as those that make a good primary care physician.

ASIM believes that physicians who go into primary care because they believe they are forced to, not because they want to, will not make good primary care physicians. A policy that is designed to make primary care more attractive to physicians will be far more successful in producing not only the right numbers of physicians in primary care, but also the kinds of physicians who are best suited for primary care.

We also believe that until an approach that provides substantially greater weighting for primary care--in conjunction with policies to improve the economic and regulatory environment--is given a fair chance to succeed, it is premature to conclude that the only thing that will produce enough primary care physicians is to set strict quotas on the positions that will be funded in each specialty.

ASIM is also not confident that a commission is capable of predicting the precise number of physicians needed in each specialty. Previous experience with the federal government's efforts to determine precise physician workforce requirements suggests that one must tread carefully in regulating the number of physicians in each specialty. The Graduate Medical Education National Advisory Commission, for example, in the early 1980s failed to anticipate the current shortage in primary care physicians, despite conducting the most extensive study of workforce requirements to date. It could also not anticipate the increased demand for infectious disease specialists that has resulted from the AIDs crisis.

If we now assign a new commission with broad regulatory authority to set limits on the total number of slots in each specialty, it may also miscalculate future demand, no matter how well-intentioned the commission may be in setting such limits. If the inherent difficulties in accurately forecasting physician workforce requirements for each specialty causes residency programs to be eliminated in fields that are later determined to require the production of more physicians, it will take years to rebuild those programs and correct the damage that was done.

We believe that a method that weights funds from an all-payer pool to increase support for primary care has the advantage of being far more flexible than the more regulatory approach recommended by the PPRC. It will be easier to revise the weights if it turns out that the need for some specialties is greater than originally anticipated. And, as noted earlier, ASIM believes that it is better to create incentives for physicians to choose primary care, rather than to coerce them into doing so.

Other educational reforms recommended in "Rebuilding Primary Care: A Blueprint for the Future" include increasing the stipends given to residents in generalist programs; funding training in office based and other ambulatory settings; establishing programs to expose medical students to positive primary care role models; expanding the National Health Services Corps; changing the tax code to make funds given to physicians through the NHSC loan repayment program tax free, and to create a tax credit for qualified primary care physicians in designated rural health professional shortage areas for three years based on a five-year service incentive, as proposed in S. 241, the Rural Primary Care Shortage Act of 1993, introduced by Sen. David Pryor; and increasing funding for the National Institutes of Health and the Agency for Health Care Policy and Research on research in primary care, health services delivery and patient outcomes, and for the development of research faculty in the primary care disciplines.

ASIM also favors creating loan forgiveness programs for physicians who enter and remain in primary care. Most efforts to induce medical students to go into primary care in exchange for lower-interest loans and scholarships have been of limited effectiveness, because few students are willing to commit to a specialty or field of practice so early in their training. ASIM believes that a better approach is to grant loan forgiveness once a physician actually enters primary care practice, by forgiving a portion of the loan for each year that he or she remains in primary care.

ASIM believes that these reforms will help create stronger incentives for physicians to go into primary care practices. But as we've already stated, such measures by themselves will not succeed in producing the right number--and/or the right kinds--of physicians needed to meet the primary care needs of the American people, without also attacking the disincentives that exist in the practice environment.

Improvements in the Practice Environment

Visits and other primary care services provided by physicians in primary care continue to be compensated far less for the work involved than other services. By paying far more for the services of physicians who go into fields other than primary care, society is clearly saying that primary care is not valued as highly as other medical disciplines. Until these economic inequities are truly reversed, the rhetoric about society wanting more physicians to go into primary care will not square with the economic reality.

Because Medicare has a disproportionately larger impact on primary care than other health programs, and because it is likely to continue to be a model for other payers, many of the proposals in "Rebuilding Primary Care: A Blueprint for the Future" call for changes in Medicare payment policies.

Let me state clearly for the record that the resource based relative value scale (RBRVS), which Congress decided in 1989 would be the basis for the new Medicare fee schedule, remains an appropriate way of valuing physician services. Had it been implemented properly, it would have helped primary care in the way that Congress--and particularly the members of this subcommittee--intended. But the fact is that the Medicare fee schedule, of which the RBRVS is just one part, has not lived up to its billing, to put it mildly. The overall gains for primary care have been nominal, and many primary care physicians lost ground. The PPRC projects that future gains due to transition to the RBRVS will now be only about 7.2% over the next three years. Even those gains may be placed at risk by other policies.

It is not my intent now to review all of the reasons that the fee schedule as implemented did not result in the promised gains for primary care. Instead, ASIM wants to talk about what can be done to fix it.

One place to start is for Congress to adopt a consistent, ongoing policy of exempting primary care from further cuts in the Medicare budget, and providing preferential fee schedule updates for primary care in the future.

The just-released recommendations from the Secretary of HHS illustrates why it is absolutely essential that Congress act now to provide a fair update next year for primary care services, and to amend P.L. 101-239 (the law which mandated the Medicare fee schedule) to preclude primary care services from falling even further behind payments for surgical procedures. Secretary Shalala has recommended that surgical procedures receive a 10.2% fee schedule update in 1994, compared to only 6.5% for primary care visits and 4.6% for other nonsurgery. The Secretary's recommendations conform to current law, except that the current law update for all services except primary care visits would be reduced by two percent. Nevertheless, payments for primary care services would still fall further behind surgery, which is in direct conflict with the goals for improving payments for primary care and attracting more primary care physicians.

ASIM was heartened when President Clinton proposed a full Medicare fee schedule update for primary care visit services. His plan properly calls for savings to be achieved by reductions in services other than primary care, by lowering the current law update and advocating selective cuts in certain overpriced services. But it is clear from the Secretary's recommendation that as long as the current law method for determining the VPSs and updates is maintained, payments for primary care will continue to fall further and further behind payments for surgery, even with the proposed 1994 full update for primary care and the two percent reduction in the current law update for all other services. This must be changed if there is to be any realistic hope of bringing more physicians into primary care.

Therefore, ASIM has developed several recommendations for legislative changes that should be adopted this year by Congress to provide a higher update next year for primary care, and to permanently change the law to assure that primary care does not fall further behind in the future. ASIM recommends that the Finance committee include the following proposals in its reconciliation package:

1. Provide a 1994 update for primary care that is at least equal to the update for surgery, by providing a bonus for primary care services that is more than the current law update, paid for by lowering the surgery update. At a minimum, the committee should reject proposals that would provide an update for primary care that is even less than called for by current law, including the two year across-the-board freeze in the Medicare economic index adopted by the Ways and Means committee. ASIM is extremely disappointed and frustrated by the decision of your colleagues in the House Ways and Means committee to reject the higher update for primary care, and to instead substitute a two year freeze on the Medicare economic index ("inflation") update for all services. This is precisely the wrong policy for Congress to adopt if it is really committed to eliminating the economic inequities that are turning physicians away from primary care. Also, if the committee rejects other proposed cuts in Medicare Part B payments (e.g. the cuts in practice expenses), needed offsetting savings should be taken from the surgery update, not primary care.

2. Exempt primary care visit services from the administration's proposed reductions in the default VPS [the performance standard adjustment set by statute] and the default "floor" on updates. To assure budget neutrality, the default VPS and updates for other services could be lowered.

3. Mandate that the Secretary propose, beginning in FY 1994, a separate VPS for primary care visit services. Amend Section 1848 (f) of P.L. 101-239 to require that the Secretary recommend to Congress each year separate performance rates of increase for the following categories: surgery, primary care visits, and other nonsurgery. The House Energy and Commerce committee included this recommendation in its reconciliation proposals. Although the PPRC believes that a single VPS for all services is the best policy, it agrees with ASIM that if separate VPSs are to be maintained, a distinct category for visits services should be created.

4. Mandate that the factors to be considered by the Secretary in recommending the VPS and updates for primary care services be expanded. The additional factors to be considered in recommending the primary care visit VPS should include: **changes to encourage more physicians to go into primary care; and appropriate changes in the utilization of primary care visits that may result from efforts to improve access to those services.** The factors the Secretary is required to consider, under section 1848 (d), in recommending the fee schedule update for each year should similarly be expanded to include **changes that are needed to encourage more physicians to go into primary care and to increase access to primary care services.**

5. As recommended by the PPRC, mandate that the higher update for surgery given in 1993 be treated as a one-time bonus payment, rather than as a permanent increase in the fee schedule conversion factor. If surgery is given a higher update next year, it should also be treated as a one-time bonus payment.

We also urge the Finance committee to support implementation no later than January, 1997 (and preferably earlier) of a resource based method for determining practice expenses, as proposed by President Clinton and advocated by the PPRC. The current method is highly disadvantageous to office-based primary care physicians.

ASIM's white paper recommends other reforms to improve payments for primary care services under Medicare and other programs. Those include providing annual bonus payments for primary care services; protecting primary care from reductions that will otherwise occur as more codes and relative values are added to the RBRVS; expanding the criteria for health professional shortage areas to include additional locales, which would then be eligible for a 10 percent bonus payment for all services; increasing the bonus payments specifically for primary care services provided in such shortage areas; expanding Medicare coverage for primary and preventive services; and improving Medicaid payments for primary care services.

Our blueprint for rebuilding primary care also advocates relief from specific regulatory programs that have increased "micromanaging" of primary care practices; prospective examination of new rules based on their likely impact on primary care prior to implementation; coordination of rules issued by different federal agencies to reduce the cumulative adverse impact on primary care physicians; adoption of less intrusive methods to control inappropriate utilization; and exemption of shared in-office laboratory facilities commonly provided by primary care physicians from proposed restrictions on "self-referrals." ASIM also advocates that all payers use the RBRVS--but not the Medicare rates--to determine their own payment schedules, and has released detailed guidelines on how the RBRVS can appropriately be implemented in the private sector without replicating Medicare's flawed implementation.

The Impact of Health Reform on Primary Care

Although health reform offers an opportunity to rebuild primary care, it can also do great harm, if it exacerbates the existing economic inequities or increases "micromanagement" of primary care physicians. That is why ASIM firmly believes that all health reform proposals must first "do no harm" to primary care. But they should also include a comprehensive set of incentives to encourage physicians to enter and remain in primary care.

ASIM is concerned that proposals for global budgets, or expenditure ceilings, that would be enforced by reductions in all-payer fee schedules could do irreparable harm to primary care. Even if initial payment levels for primary care would be higher than today--a doubtful proposition--primary care physicians would quickly lose ground if their payments were repeatedly ratcheted down to enforce spending limits. Adoption of the Medicare rates by all payers, in particular would be disastrous for primary care. According to a recent article that appeared in the New England Journal of Medicine by William Hsiao, PhD, the "father" of the Harvard RBRVS study, adoption of the Medicare rates by all payers would result in the average annual compensation for primary care physicians dropping to $40,000 or less. It simply will not be possible to recruit physicians into primary care if they are paid at those rates, or even a modest percentage above those rates.

We are concerned, however, that market-based reforms such as managed competition could also drive down payments for primary care services or result in increased micromanagement, despite the common assumption that managed competition will increase the demand--and compensation--for primary care. "Rebuilding Primary Care" provides detailed recommendations on how primary care should be protected under any health reform proposal that is built around managed competition.

Conclusion

ASIM believes that a better future for general internal medicine and other primary care physicians may be at hand, if we have the wisdom to craft policies that make primary care the field of choice for America's physicians. We believe the approach and recommendations summarized in this statement--and detailed in "Rebuilding Primary Care: A Blueprint for the Future"--provide a framework for developing effective policies to reverse the economic, regulatory, and training disincentives for primary care. Such policies should reduce the inequities in payments for primary care compared to other services; eliminate micromanaging and other unjustifiable regulatory burdens on primary care physicians; increase support for primary care training and research; expose medical students to positive primary care role models; and increase funding for and exposure to training in ambulatory settings.

We firmly believe that the goal should be to increase the numbers of primary care physicians by making primary care more attractive, rather than trying to coerce physicians into going into primary care. It is important that the country not only produce "more" primary care physicians, but that it produce more physicians who go into primary care because it is really what they want to do.

ASIM looks forward to working with the committee on enacting legislation this year to accomplish this goal, starting with inclusion in your reconciliation package of proposals to provide a fair 1994 update for primary care and to permanently protect primary care from future reductions. Our specific recommendations for inclusion in reconciliation legislation include: provide an update for primary care that is at least equal to surgery; exempt primary care visits from the administration's proposed reductions in the default VPS and the default "floor" on fee schedule updates; mandate that the Secretary propose a separate and higher VPS for primary care visit services; mandate that the Secretary consider changes to encourage more physicians to go into primary care in recommending the primary care VPSs and update; and mandate that the higher update for surgery given in 1993 be treated as a one-time bonus payment, rather than as a permanent increase in the fee schedule conversion factor for surgery. Unless Congress acts this year to begin to change the policies that are resulting in preferential updates for surgery at the expense of primary care, the objective of attracting more physicians into primary care will prove to be more elusive than ever.

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american society of internal medicine

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REPRESENTING
Internists and
All Subspecialists
of Internal Medicine

June 8, 1993

The Honorable Jay Rockefeller
United States Senate
109 Hart Senate Office Building
Washington, DC 20510

Dear Senator Rockefeller:

Thank you for giving me the opportunity to respond to your additional questions about ASIM's testimony at the "Primary Care Workforce Issues" hearing on May 14.

Response to Question #1 (re: Would ASIM agree that the federal government has an obligation to be sure that funds are used in training the physicians we need as opposed to providing open-ended support to teaching hospitals to train whatever physicians they choose?)

ASIM agrees that the federal government should allocate its resources for graduate medical education in a way that furthers the goal of increasing the proportion of primary care physicians. That is why ASIM supports using a formula that would "weight" residency programs in internal medicine, family practice, and pediatrics substantially more than training programs in other specialties. What would this accomplish? It would reward teaching institutions that create a larger proportion of residency slots in the generalist specialties--the more generalist residents that they have, the more funding they will receive. By the same token, it would penalize institutions that choose instead to create more residency positions in the non-primary care specialties. It would, however, give the institutions some flexibility in determining how many residency positions in each specialty will be established. ASIM's proposal is a far cry, though, from the status quo where institutions are in fact rewarded if they train more physicians in specialties other than primary care.

We do believe that this is preferable to the federal government determining, through a commission or other body, the exact number of slots that will be funded in each specialty. Although we support an advisory body to determine workforce needs and provide appropriate planning, we are concerned that the federal government, or even a well-intentioned commission, may err in determining the specific number of physicians in each specialty that will be needed in the future. By comparison, changing the weighting of GME funding to encourage primary care, as ASIM proposes, will help accomplish the goal of increasing support for generalist programs, but with somewhat more flexibility for institutions to change the mix of residency positions as needs change. An arbitrary limit on slots would not permit such flexibility. Further, as ASIM stated in its testimony, we believe that it is important that physicians choose primary care because it is what they want to do, not because they view it as the only choice available to them even though they'd rather do something else.

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Question #2 (re: How do medical students learn about the environment of practice?)

In preparing ASIM's new white paper, "Rebuilding Primary Care: A Blueprint for the Future", ASIM did an extensive literature search on this issue. We also asked young physicians in training what influences their choice of specialty. What we found is that physicians are greatly influenced by the role models they meet in medical school and in residency programs. If the role model is a non-primary care physician, they are more likely to choose to practice in fields other than primary care. If their role model is a primary care physician who tells them honestly that they will work harder for less money and more hassles if they choose primary care, that too will influence them to go into fields other than general internal medicine, family practice, and pediatrics. They are also very much aware of such problems as the income disparity between specialists and non-generalists, which is widely reported in medical and non-medical media, and is apparent to even the most casual observers.

The reality is that from a variety of sources they learn that they will earn less, be hassled more, and work longer hours if they go into primary care. That is why so many physicians who enter practice heavily in debt choose to go into other fields.

Question #3 (re: if HMOs pay primary care physicians substantially more, do primary care physicians need programs such as loan forgiveness?)

Actually, there is little or no evidence that primary care physicians are being paid substantially more by HMOs. Although this has been reported by anecdote, ASIM has seen no data to support this contention. We have heard from many primary care physicians who report the opposite: that when managed care becomes a bigger factor in their communities, at least the initial effect is that all physicians, including primary care physicians, are asked to discount their fees considerably. Since primary care physicians start out learning less than other physicians, any discounts hurt them disproportionately more. And even in those HMOs where primary care physicians may be paid more than has been the "going rates" in the past, specialists still tend to earn substantially more than they do, even though the gap may be not as great as before.

In time, it is possible that increased demand for primary care by HMOs and other systems may increase the earnings for primary care, and reduce or eliminate the gap in compensation between generalists and specialists. But it is not a certainty that this will happen. ASIM believes it doesn't make sense to wait and hope that the market will correct the earnings disparity problem on its own, when we are already facing a shortage of primary care physicians that will take years to correct. That is why more immediate responses, such as creation of loan forgiveness programs, are needed now.

Question #4: How can the National Health Services program be improved?

ASIM supports increased funding for the program. We also endorse legislation introduced by Senator David Pryor, called the "Rural Primary Care Act of 1993", that would provide qualified primary care physicians who are practicing in rural areas that are designated as shortage areas with a tax credit for three years based on a five year service incentive. The bill would also eliminate the taxable status of funds given to physicians through the NHSC Loan Repayment program.

Please let us know if you have additional questions.

Sincerely,

Alan R Nelson MD

Alan R. Nelson, MD
Executive Vice President

PREPARED STATEMENT OF JAMES P. NOLAN

Thank you for the opportunity to present the views of internists concerning primary health care. The American College of Physicians is the nation's largest medical specialty society, with some 80,000 members practicing internal medicine and its subspecialties. Our membership encompasses physicians who are full-time primary care providers, but it also includes highly specialized tertiary care consultants, academicians and researchers, as well as those who engage in a mixed practice involving both primary care and subspecialty services.

I am James P. Nolan, MD, FACP. I serve as Professor and Chairman of the Department of Medicine at the State University of New York at Buffalo. I am here today on behalf of the American College of Physicians as Chair of the ACP Task Force on Physician Supply and as a member of the ACP Board of Regents.

It is our understanding that today's hearing will address some of the many issues involved in assuring that the nation has an adequate supply and distribution of appropriately trained primary care physicians, focusing on the role of the Medicare program. As you are well aware, the issues involved are multi-faceted, including such diverse and difficult problems as how to attract and retain physicians and other health care professionals to careers in primary care; how to finance training; how to develop, implement, and coordinate a national manpower policy; and how to assure that primary care personnel are available in inner city and rural areas. Solutions will require concerted actions by the health professions, academic and accreditation agencies, as well as by the states and the federal government. I will attempt to address just a few of the major issues involved.

For many years the College and others have been sounding the alarm about the declining share of young physicians interested in careers in primary care medicine. More recently, we have also voiced our concern about the increasing numbers of physicians who have become so disillusioned and dissatisfied with the burdens of private practice that they have either joined larger organizations or have retired early or otherwise left the field. Now we are on the eve of enacting major national health system reforms, and there is a looming crisis concerning the availability of primary care physicians.

The most recent AAMC (Association of American Medical Colleges) annual survey of graduating medical students indicates that fewer than 15% are planning careers in any of the three primary care specialties: general internal medicine (3.2%), family practice (9%), and general pediatrics (2.4%) (Petersdorf RG. Financing Medical Education, *NEJM*;1993;**328**:651–54). Ten years ago, a similar survey showed that 36.1% of medical graduates were planning to enter primary care. In every other developed country, 50% to 70% of the physicians are generalists (Schroeder, *Annals of Internal Medicine,* 1992; 116:583–92). However, in the United States, the proportion of generalists has declined from 42% in 1965 to less than 30 percent today. This year, for the eighth consecutive year, there has been another decline in the number of trainees in Internal Medicine programs that lead to careers in primary care. The number of U.S. medical school graduates in these internal medicine training programs has declined by 43% (4,143 to 2,899) since 1985 (*APDIM 1993 NRMP Match Bulletin,* March 17, 1993).

As we seek to expand access to health care services to all Americans, including the 37 million who are now uninsured, there will be a greater need for primary care physicians. It is important to recognize the multiple roles primary care physicians will be called on to fill. They will serve as the patient's initial contact with the health care system. A significant, expanding role is to coordinate services within integrated health care delivery systems to provide comprehensive and continuous care for both acute and long-term illnesses. Primary care physicians are needed who can work with and provide leadership to a team of health care professionals to assure that appropriate health care services of high quality are provided effectively and efficiently. Now and in the future, primary care physicians will be needed who will emphasize disease prevention and health promotion. Subspecialty internists with special training to meet community needs will also continue to play a role in providing some generalist care.

The general internist will play a particularly important role as a consultant to patients with difficult undifferentiated problems. General internists will be needed to diagnose and treat a wide range of health problems and to evaluate and manage the biomedical and social aspects of illness in hospital, office, home, and nursing home settings. General internists will be needed more than ever as the diagnosticians who can distinguish between routine ailments and symptoms of more serious disease.

In addition to being the patient's guide, advocate, and friend in a complex health care environment, the general internist of the future will need to have additional

skills to meet the demands of a rapidly changing health care environment. The general internist of the future will need to be a resource manager familiar with new models of health care delivery. He or she will need to be a clinical information manager able to array clinical data into useful profiles of patient care. The general internist of the future will also need to be a generalist in outlook, but possess the special skills required to meet the needs of a particular medical practice environment, including organ-based specialty skills such as cardiology and gastroenterology and such problem-based skills as the management of substance abuse and disorders of pregnancy.

Yet, as noted last fall by the Federated Council for Internal Medicine, of which the ACP is a member (*Annals of Internal Medicine,* November 1, 1992), "the existing and future supply of general internists is now threatened." Many factors have contributed to this situation: poor reimbursement for primary care services; emphasis during training on subspecialty and inpatient care; inadequate funding for ambulatory care training; medical school indebtedness; longer work hours and greater patient demands during nights and weekends that are more likely to limit the primary care physician's lifestyle; caseloads that are more likely to consist of patients with chronic, long-term or terminal illnesses; the intimidating breadth of an ever-expanding knowledge base to be mastered, and the administrative and regulatory requirements that particularly burden primary care practice.

The ACP and its Task Force on Physician Supply are seeking to develop solutions to help meet the nation's future needs for primary care physicians. We are working within the profession to achieve curriculum reforms to improve the attractiveness of general internal medicine. We have also identified a number of federal policy changes that we would like to share with this Subcommittee.

A NATIONAL WORKFORCE POLICY

Comprehensive health care reform must address the issues of physician work force supply and requirements. The College has long maintained that we need to have a national health workforce policy that articulates national goals and objectives regarding the numbers and distribution of health care professionals. The College supports the formation of a national workforce commission that would assess the need for health care personnel and set targets regarding the supply and specialty distribution of physicians as well as the numbers of other health care professionals. Achieving the targets will require active participation by all of the professions, medical and nursing colleges, training programs, teaching hospitals, and accreditation, licensing and certification agencies.

We understand that this Subcommittee shortly will be considering legislation to create such a commission that would work with the private accreditation agencies. Our task force will be meeting again within the next two weeks to address the possible functions and structure of such a national commission; we would be pleased to share our recommendations with the Subcommittee.

In medicine, there are too many specialists and subspecialists, and not enough primary care generalists. The number of subspecialists should be related to tertiary care needs and academic needs. Not all subspecialties are in oversupply, but there are too many physicians in procedure-oriented subspecialties. We should train only the number of subspecialists required to meet the need for subspecialty care, and training should better match workforce requirements. Reductions in the subspecialty supply should be accomplished by the profession working within the national goals to limit the number of subspecialty training slots. Accreditation agencies should rigorously evaluate the quality of training programs and anti-trust restrictions should be eased to allow these non-governmental agencies to reduce training slots based on quality in accord with national workforce goals.

Achieving more effective use of health care resources will require changes in the utilization of services. We believe that most patients should have a personal physicians who assesses the need for, and refers to, subspecialty care. Subspecialists should continue to play a role in providing some general care for their patients. We anticipate that market forces and reductions in the supply of subspecialists will likely force subspecialists to focus on areas of their greatest expertise, leaving little time to provide other than subspecialty care.

FINANCING GRADUATE MEDICAL EDUCATION AND TRAINING

Medicare pays its share of both the direct and indirect costs of graduate medical education. This source of funding has tremendous financial implications for the types of programs that are offered, the kinds of physicians that are trained, and the location of training sites. Despite this leverage, previous attempts to influence the

specialty mix and distribution of physicians have failed to halt the trend toward greater specialization and away from primary care.

Nevertheless, Medicare GME payments are a very tempting vehicle both for obtaining budgetary savings and attempting to achieve national workforce objectives. However, we urge you to be very cautious about reductions in Medicare allowances for indirect costs, which are currently a 7.7 percent add-on for each 10 interns and residents per 100 beds. These payments now help pay for the added costs of teaching hospitals as well as the cost of hospital services to patients without any health insurance. They should not be reduced until alternative funding sources are found or the need for such funding has been effectively eliminated through the implementation of health care reform initiatives.

Direct payments for GME are more likely to influence the availability of training slots and there by to have an impact on specialty choices. We understand that limiting payments to the national average is one of the items that will be under consideration by the subcommittee. Although we could support movement towards reducing the very large variation in direct payments across the country, we recommend that any changes be implemented on a phased basis, to prevent dislocations among programs. We also suggest that you consider regional averages, rather than a national average, to take into account variations in salary, fringe benefits, and related direct costs. Data on regional and specialty variations in the cost of training must be developed.

We have some reservations about another option: weighing payments to support primary care. Although this would seem to be beneficial, it will have little effect on influencing student career choices unless the differences in weights are substantial. To make a difference for primary care, the weights would have to be dramatically, not incrementally higher. We are not optimistic that adjusting weighing factors for funding payments to institutions will have much direct effect on physicians-in-training, nor will it deter them from pursuing subspecialty careers upon completion of a primary care residency. Stipends vary relatively little among types of residents, despite substantial differences in program funding. They are not likely to be adjusted by differences in Medicare medical education payments. Differences in the revenue potential among services remain much more potent factors influencing the numbers and distribution of residency slots.

Proposals to restrict the number of first year residencies to not more than 10% above the total number of US medical school graduates raise important questions. This would allow for a sufficient number of training slots for US medical school graduates, provide some flexibility, and permit some limited opportunities for graduates of foreign medical schools. It would also dramatically reduce the future aggregate supply of physicians in the United States. On the other hand, such a policy would have serious adverse effects on institutions that are heavily reliant on international medical graduates (IMGs) to meet their service needs. The problem is that we use our training programs to fill service needs. so that any substantial change in the number of residency slots would have to be coupled with other means to provide services in these hospitals.

We strongly endorse the concept of requiring all payers to share in the cost of GME. Unfortunately, this is not the case today. However, we are not convinced that extending Medicare's GME payment methodology to all payers would be the most desirable mechanism. Any proposal for a national health care program must include a financing mechanism to assure that all payers pay their fair share of these educational costs and that costs are not shifted among payers.

A proposal worthy of further consideration is to assess all payers a certain percentage of their health care expenditures to be designated to a special fund for distribution among graduate medical education programs. This could help assure that all needed programs are adequately funded, while spreading the burden of financing more equitably.

Using Medicare payments to support only the number and mix of residents meeting public policy goals would be a powerful tool that could limit opportunities and force students into primary care. However, we also have serious concerns about such a coercive approach that would virtually dictate career choices. A better public policy would be to address the factors that deter physicians from voluntarily choosing primary care. A clear signal is needed that primary care services are valued by our society. To have a substantial effect on primary care, changes in GME funding will have to be coupled with payment and practice environment changes that make primary care attractive.

PRIMARY CARE IN UNDERSERVED AREAS

As the Administration and members of the Finance Committee well know, the financing of universal coverage alone will not solve the problems of health care delivery in rural and inner city areas. Individuals in both kinds of communities are faced with a shortage of accessible physicians and health care facilities. Solving this problem may be one of the more challenging issues in the health care reform debate.

The deficit in primary care services is especially acute. Federal government estimates show that it would take 4,440 primary care physicians to eliminate the current 2,000 Health Professions Shortage Areas. New York City Health Commissioner Dr. Margaret Hamburg reports that there are only 28 physicians who practice genuine primary care among nine low-income communities in New York City, one of the medically richest cities in the U.S.

Strategies to increase the overall number of primary care physicians alone will not solve the problems in rural and inner city areas. Fiscal, professional, and lifestyle incentives will be necessary to attract and retain health care professionals in underserved areas. Medical schools must do more: recruit applicants who are likely to choose these areas; recruit faculty who value and promote rural and inner city practices; and provide students with hands-on experience in clinics, physician offices and other environments in underserved areas. Funding for graduate medical education can be targeted to specifically enhance these approaches. Experiences in ambulatory settings need to occur early on, in medical school or even earlier.

The Federal government has a strong role to play in reversing the neglect of the existing health care infrastructure. Capital investment is needed in some areas for community-based facilities that deliver care in a safe, culturally sensitive environment. Financial incentives to encourage service in underserved areas must be augmented for the National Health Service Corps and other programs that elevate community-oriented medical practice and make it a financially feasible choice.

REIMBURSEMENT

The ever-growing income disparity between primary care physicians and other specialists must be substantially narrowed if current trends in specialty selection are to be reversed. It is difficult to assess the exact influence that income has on specialty choice over other factors such as medical school and practice environments, indebtedness, and prestige. Data does indicate, however, that the numbers who choose primary care specialties has decreased as the income disparity between generalists and specialists has increased.

The Administration has recognized through its budget proposals the need to protect primary care reimbursement from further erosion. We urge Congress to approach deficit reduction from this perspective. While moving in the right direction, we believe that bold steps must be taken soon within the Medicare program and in the President's health care reform proposal.

Substantial revision of the Medicare fee schedule would signal that Congress and the Administration are committed to improvements in primary care. Congress should enact an accelerated schedule for the adoption of resource-based practice costs. The 1997 start date contained in the President's budget proposal is unacceptable. HCFA and PPRC should be required to expedite Data collection for implementation not later than 1995. The recalculation of the practice and malpractice costs to reflect actual overhead is the single most important change that could be made to help the practitioner in the short-term.

In addition to this immediate correction, we urge you to provide statutory authority for substantially increasing the relative work values for evaluation and management services under Medicare. Increases in relative work values could be phased-in over several years but should begin immediately. We recognize that the profession would have to assume greater responsibility for monitoring and controlling the volume and utilization of health care services.

Several across-the-board proposals have been advanced to achieve federal deficit reduction and achieve short-term cost controls throughout the health care system, both public and private. We are greatly concerned that fee freezes, both system-wide or limited to Medicare, have the potential to drive primary care physicians out of practice. Across-the-board approaches, while seemingly equitable, in fact have disproportionately negative impact on the primary care physician. Refined approaches to cost control must be used in both private and public payment, otherwise current inequities will be locked in between primary care and procedures.

Without substantial improvements for evaluation and management services, the current RBRVS cannot be applied to other payment systems. Especially at the Medicare conversion factor, the use of the RBRVS-based fee schedule would be nothing less than devastating to primary care physicians. In his April 1, 1993 *New England*

Journal of Medicine article, Dr. William Hsiao provided compelling evidence that primary care services are seriously undercompensated. If all payers had paid according to the 1992 Medicare Fee Schedule, pediatricians would have earned average annual incomes of $35,000, family physicians $40,000, and general internists $44,000. But incomes for the high-end surgical specialties would still be quadruple and higher than those of the primary care specialties. Dr. Hsiao concludes that "the monetary-conversion factor established for Medicare is too low . . ." and that, "If all payers reimbursed physicians at this level, the United States could not maintain a supply of highly competent physicians."

REGULATORY AND ADMINISTRATIVE BURDENS

One of the most frequently cited causes of physician discontent is the ever-increasing time and effort required to comply with governmental regulations and administrative paperwork. Claims processing remains inefficient. Legitimate claims, such as a claim for an office visit on the same day the patient is admitted to the hospital, are denied—often without adequate explanation. Claims for concurrent care, when more than one doctor in the same specialty bills for services, are routinely denied when concurrent care is medically appropriate. Payments for nursing home visits and consultations are typically denied for patients requiring acute care when the physician has already seen the patient for a routine visit within prescribed time periods. Current payments fail to reimburse physicians for time spent managing and coordinating care for patients in nursing homes, hospices, and home health care.

There is inadequate communication regarding coding and reimbursement changes. Payment denial letters are often sent to beneficiaries without first contacting the physician. Down-coding of physician claims is often arbitrary. A uniform billing form, including an uniform electronic form, is needed that would apply to Medicare as well as other payers. However, Medicare's efforts to encourage electronic billing have resulted in a policy that rejects so-called "non-standard" claims such as the pre-printed "superbill" forms typically used by primary care physicians in small and solo practices that do not have computerized billing systems.

Medical necessity and quality assurance reviews are often excessive and inappropriate. Pre-admission certification requirements are time-consuming and unduly intrusive. Retrospective medical necessity reviews are cumbersome and onerous. Post-payment audits are disruptive and can result in serious cash flow hardships as physicians are forced to pay substantial sums within 30 days that later, during the appeals process, are found to have been justified.

Physicians resent demands to justify medical decision-making to non-physician reviewers and object to second-guessing of their decisions by physician reviewers who are not experts in the specialty being questioned. Physicians also resent cumbersome, time-consuming, duplicative, and punitive peer review organization (PRO) processes that rely on case-by-case reviews rather than profiling of physician practices and educational efforts to improve the quality of patient care.

Finally, physicians are burdened by onerous regulations such as the Clinical Laboratory Improvement Act (CLIA) and the Occupational Safety and Health Act (OSHA). These regulations, while well-intended, involve costly and excessive requirements that add to the burden of operating a primary care office practice.

Detailed recommendations for addressing many of these administrative and regulatory burdens were provided in the May 1992 report of the Advisory Committee on Medicare-Physician Relationships, chaired by Dr. Nancy E. Gary, MACP. We strongly urge that the commendations of this report be implemented.

EXPANDED ROLES OF NON-PHYSICIANS

There will be greater reliance on integrated delivery systems in a reformed health care system. These networks will bring together physician and non-physician providers to deliver cost-effective, coordinated care. We encourage these trends, but lines of accountability will have to be clear. The efficiency of this kind of approach should produce savings essential to maintain universality and quality care.

A national policy on physician supply must fully consider issues relating to the roles and supply of non-physician providers such as nurse practitioners and physician assistants. A national workforce plan will be needed since changes in the numbers, roles, and distribution of non-physician providers will impact needs in the physician workforce and vice versa. The workforce must be carefully monitored to allow for mid-course corrections if the pace or direction of supply changes unexpectedly. Oversupply in either the physician or non-physician provider pools means individual dislocation and will add to the cost of the system.

To delineate the appropriate roles for non-physician providers in the delivery of primary care, there are a number of important issues to examine:

—how to maintain quality of care while meeting the increased demand in an expanded system. What services can be competently provided by which providers based on different levels of education and training? When is physician supervision and consultation required? How can comprehensive services be coordinated but still allow for flexibility in their delivery?

—how to provide primary care services in a cost-effective manner. How does one evaluate the true cost of providing primary care services by different providers in different settings? Salary level is, for example, only one variable among many to consider in the calculation of the cost of providing service. The cost of non-physician referrals to generalist or subspecialists could be substantial and should be fully evaluated.

CONCLUSION

Thank you for the opportunity to highlight a few of the issues involved in primary care and to provide our perspective. As I have indicated, the College and the ACP Task Force on Physician Supply are continuing to explore the ramifications of many of the proposed policy changes that are before this Subcommittee. We would welcome an opportunity to further share our findings with the Subcommittee as they are developed. I would be pleased to respond to any questions that you may have.

REPSONSES OF DR. NOLAN TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. The State of New York has had early experience with planning for the physician workforce through the creation of the New York Committee on Graduate Medical Education. What has been the impact of the Committee's work? How effective have the educational consortia that have been developed become? What lessons are there in New York's experience for our efforts at the national level?

Answer. In 1986, the State of New York formed a Council on Graduate Medical Education to meet the needs of the State for more Primary Care Physicians, and for a larger minority representation in residency training programs. As the Council has evolved over the years, it has presented to the State Health Department and legislature initiatives which are either funded or about to be enacted which mirror initiatives that have been suggested at the Federal level. These include:

(1) The formation of Consortia between a medical school and a group of affiliated hospitals to increase the percentage of residency positions in the primary care disciplines to 50%. Albany and New York Medical College have been approved by the state for their consortia, but Buffalo has been the only one funded. In addition, Buffalo has been made a Demonstration Project, funded by a percentage of IME dollars given by the consortial hospitals to the School. Approximately 1.2 million dollars in 1993, 1.7 million in 1994 and 2.2 million in 1995 will be used to fund grants for Primary Care Initiatives by the school and hospitals. Exciting and innovative projects have been funded, and are underway but it is clearly too early to evaluate the results.

(2) New York State has started a program of upweighting resident reimbursement to hospitals on a 1.5 FTE basis for primary care programs (as defined by Title VII grants), 1.0 FTE for categorical medicine and pediatrics and 0.9 FTE for all other specialties. The majority of the new dollars awarded for primary care programs are to be used by program directors for new faculty and support services. As a result, a number of traditional medicine and pediatric programs are changing their curricula to meet the Title VII criteria. In this regard the upweighting is having a desirable effect despite the fact that the primary care residents receive no increase in stipend as a result.

It would be important at the Federal level if upweighting is enacted to insure that this increased DME funding not disappear into hospital operating funds, but that it be used to increase the attractiveness of the Primary Care Program.

(3) New York State will almost certainly enact this year a major Loan Forgiveness Program for medical students choosing primary care, both during their residency training and in the first few years of practice if they remain in New York State. The Federal government would do well to foster such a plan on a national basis.

It is premature to judge the effectiveness of the educational consortia in New York State at the present time. Certainly, in 1993 the match rate in New York State for Family Medicine, Internal Medicine, and Pediatrics hit an all-time low! Obviously, this is worrisome and speaks to the need for a National Com-

mission to allocate training positions until such time as incentives like those started in New York State can work.

Question No. 2. The interest among medical students in pursuing training in internal medicine has undergone a breathtaking decline over the last several years. We have heard about all the residency positions that have gone unfilled, and I understand that on any measure of quality some of the very best programs have gone begging for residents from time to time over the last few years. Yet we hope to use whatever means are at our disposal to expand the number residents being trained in this and other primary car fields. What has the profession done to reverse this trend, and what has been the track record so far? What can the federal government do to help (or to hinder this process)?

Answer. It is true that medical student interest in internal medicine has sharply declined since 1986 and continues to decline in 1993. Unfortunately, the largest erosion of interest has been in general internal medicine and not in the subspecialties of internal medicine. International medical graduates are now training in prestigious programs that only admitted U.S. medical graduates in the past. The decline in primary care internal medicine interest is only in part due to educational issues, but medical students perceive lifestyle and respect issues for the practicing internist in negative terms.

The profession has been working extensively on educational reform at the undergraduate and graduate level to make general internal medicine more attractive by moving an increased amount of training from the hospital to ambulatory sites. Additionally, the ACP and others are building a network of community-based internists to give a "real world" experience to both students and residents. The profession has been less successful in addressing the reimbursement issues for generalists, and the clearly perceived discrepancy in compensation for the procedural-oriented specialists. This income desparity is clearly an area that government could and should address.

Question No. 3. We understand that a significant proportion of specialist physicians' time is spent giving primary care, yet they provide these services at relatively higher costs. What are the factors that drive up the costs of this kind of primary care? Can these physicians—presumably the best trained of doctors—be trained to provide this care at lower cost? Would there not be some sense in paying specialists at lower rates for the care they give to their primary care patients?

Answer. We believe that subspecialty internists represent the largest (and perhaps only) pool of potential primary care providers for adults. All subspecialists are originally trained as generalists, and the majority still provide comprehensive general care for a proportion of their patients. To retrain this group to be more cost-effective providers is certainly feasible. The American College of Physicians which has long been the major source of continuing education for internists is interested in education programs designed to accomplish this educational goal.

Specialists who are providing primary care to their patients are already being paid at similar rates for these services as those by other primary care givers.

Question No. 4. How can the federal government develop the most effective partnership with the private agencies involved in medical education? If programs are to be cut shouldn't it be the medical community through organizations such as yours that decide which programs should go? Isn't that wiser than asking the government to do it? Yet I believe I detect some reluctance to take on this important task.

Answer. We strongly believe that reduction in training programs should be the responsibility of organized medicine working as majority members of a Workforce Commission. The Federated Council of Internal Medicine of which the ACP is a member has adopted a resolution calling for 50% of the output of residency programs be in general internal medicine, and that subspecialty positions be significantly reduced. I believe that such reduction can be achieved by a consensus of training programs based on a quality assessment and an overall supply determination. We are not reluctant to undertake this responsibility.

Question No. 5. How do you judge the quality of residency programs? Is it possible to judge them across a spectrum of quality or can only the ability to meet minimal standards be judged?

Answer. I believe that the A.C.G.M.E., and the Residency Review Committee in Internal Medicine can indeed judge training programs by quality measures and not just minimal standards. As you know, an F.T.C. exemption will be necessary if such quality rankings are to occur.

Answer. No. 6. One of the strengths of the Canadian health care system has been its ability to control the size of the physician workforce. One feature is that the bodies which accredit training programs in Canada are the same as those that certify individual practitioners for their specialty. Is such a system really of benefit? Is it feasible to do this in the U.S.?

Answer. While having both the accrediting and certifying bodies in Canada under one organization has been effective there, I see no reason why having the two functions separate here should in any way impede control of the physician workforce. Certification is peripheral to workforce size, and empowering accreditation bodies to report quality rankings to a National Commission should achieve the desired results.

Question No. 7. I am a little concerned that you call capping the number of specialty slots a "coercive" method to induce people into primary care. Isn't that language a little strong? Of course we need to improve the practice environment—improve research into primary care and reimbursement too—but limiting the number of specialty slots hardly constitutes coercion. Would you like to comment?

Answer. I do not believe that capping the number of specialty slots is "coercive." While medical students may perceive it as such, they have never had free access to the specialty of their choice. Such selection has always been competitive in the sought-after disciplines. My own opinion is that capping is absolutely necessary at least in the short term if we are to rationalize our workforce needs. The ACP Task Force on Physician Supply will be recommending to the Board of Regents that the College support such a national allocation of resident slots, and the structure and process by which allocation be accomplished.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, thank you for holding today's hearing on the important issue of the primary care workforce. I would like to take this opportunity to commend your ongoing commitment to primary care issues. As an adequate supply of primary care providers is so closely linked to accessible health care in rural areas, I particularly appreciate your holding this hearing today.

Currently, in this country we have more physicians than we need to meet our health care needs. Ironically, thousands of smaller communities continue to face difficulties in obtaining the necessary providers to meet their health care needs. All of us can cite examples of communities in our states which are struggling to find health care providers or to keep the ones they have. In Arkansas alone, over 400,000 people living in 48 different rural communities lack adequate access to doctors.

The shortage of primary care health personnel is a particularly critical factor threatening the survival and effectiveness of rural health care services. Despite increased numbers of physicians, it continues to be difficult to impossible to train and attract family physicians, general internists and general pediatricians to medically underserved and remote rural areas.

Adding to this problem, a recent survey of rural physicians found that as many as 26 percent of these essential medical care providers were considering retirement or relocation within the next five years. That same survey showed that 111 rural counties had no practicing physician at all. In contrast, no metropolitan county lacked a physician. With this maldistribution, other health professionals such as nurse practitioners and physician assistants become even more important to the provision of care in these areas. However, in recent years, the proportion of nurse practitioners in rural areas has decreased. Evidence suggests a similar decrease of physician assistants in rural areas.

To address the maldistribution and shortage of rural primary health providers, I have introduced the "Rural Primary Care Act of 1993." This legislation will begin to address the maldistribution and shortage of rural health care personnel through the use of modest tax incentives. This type of approach will only work if there are primary care providers to recruit to work in rural areas. That is why I am especially pleased that today we are discussing ways to produce more generalists.

It is troubling to me that some Federal programs actually work as disincentives to providing primary care in rural areas. Efforts to produce primary care providers are up against a powerful trend towards high-tech, high-paying, medicine. The federal government, through Medicare, Medicaid, and other programs, spends billions of dollars each year training specialists in big-city hospitals. By supporting this style of medicine without insisting that a fair share of the residency positions go to primary care, the federal government, itself, is creating enormous disincentives to the practice of primary care.

As I learned from the experts who addressed an Aging Committee workshop on rural health last week, reforms in graduate medical education, including reforms in the number and types of residency slots available to medical school graduates, could increase the number of primary health care providers. I believe that any future reforms in medical education should be designed to result in an increase in primary

care residencies. This, in turn, should result in increased access to health care for residents of rural areas.

However, reforms in medical education will not resolve all of the problems. Creating a solution to the rural health challenge will be much like assembling a large and complicated puzzle. But this puzzle doesn't come to us in a neat cardboard box with a picture on the top. We can't cheat when assembling our solution for rural health by looking at the puzzle picture to see where the pieces should go and what they should make. We must create the missing picture ourselves as we move forward to shape health care reform.

Reforms in undergraduate and graduate medical education are important pieces of this puzzle. So are the various types of economic incentives that we may need to produce, attract and retain primary health care providers. Special student loans and loan forgiveness plans for those who will practice primary care in rural areas could be pieces of this puzzle. Providing support and education for rural health personnel with video technology may be a piece. Drawing military doctors from closed military bases into civilian, rural health practice may be another piece of this puzzle. Adapting managed competition to meet the realities of rural health practice is another piece.

Coming up with solutions for our current rural health problems will be every bit as complicated as solving problems in our nation's large urban areas. It will require our dedication and our commitment to improving access to health care for all Americans to make health reform work for all communities.

Chairman Rockefeller, I commend you for holding this hearing today. I am pleased to be working with you and the other members of this committee on this important issue, and I look forward to hearing the testimony from our distinguished panel of witnesses.

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

I have called this hearing to address one of the fundamental issues facing our health care system today—the nature and distribution of America's health care workforce. Although the United States is the world's leader in high technology medicine, many Americans lack access to basic primary care and preventive health care services. This is due in large part to the fact that our health care workforce is now inadequate to this task, and all evidence points to the fact that this will only get much worse over the next several decades if no action is taken and taken soon. This Subcommittee held a hearing in July 1992 which outlined the scope of this problem, and today we will hear from a number of experts on potential solutions.

Primary care includes a broad array of public health, preventive, diagnostic, and therapeutic services. It is generally characterized by first-contact care, continuity of care, and coordination of health care services. Its orientation is toward the health needs of the whole patient and family as well as the health of the community in which the patient lives. Primary care services are provided by physicians—most often by general internists, general pediatricians, and family physicians—but also by nurse practitioners, physician assistants, and other so-called mid-level practitioners.

It has become clear that primary care providers are not only essential to ensuring adequate access to health care, they can often provide the relevant services for lower costs while maintaining the quality of care our citizens expect and indeed deserve. And as medicine becomes more complex, the role of the primary care provider in coordinating this care becomes all the more critical. This last fact has been increasingly recognized by highly organized systems of care such as health maintenance organizations which have been recruiting a tremendous portion of the graduates of primary care training programs in recent years. They have learned the value of primary care practitioners.

Yet despite the demand for more people trained in primary care, family physicians, general internists, and general pediatricians account for fewer than 30 percent of the practicing physicians in the United States. This compares to the 80 percent of U.S. physicians that practiced primary care in 1931 and the 50 to 75 percent of physicians in Germany, Canada, Japan, England, and Holland that are in primary care.

The problem is even worse in our inner cities and rural America. Many counties in my state of West Virginia have no primary care providers whatsoever, and across the country these areas have only one-third the number of people providing these necessary services compared to more affluent urban and suburban regions.

But don't expect these figures to change any time soon: Fewer than one-quarter of recent medical school graduates have expressed interest in primary care careers.

Even if by some action we were to begin *this year* to convince half of all graduating medical students to choose this kind of career, we would not achieve the more desirable 50:50 ratio of generalists to specialists until the year 2040!

It is not surprising that this complex problem has multiple underlying causes. Increasingly sophisticated technology dominates our health care system, and this is the very attractive domain of the medical specialists. This reaches its zenith in the teaching hospitals, also the site of most medical training. The academic health center has become the source of an incredible array of discoveries and innovations that have benefited society. However, primary care as an academic discipline has become a more and more difficult pursuit in our medical schools. Students often lack the needed role models to encourage them toward primary care.

The federal government has been an accomplice in this trend. Despite the this committee's efforts in passing the new Medicare physician payment system, specialty medicine is still reimbursed well beyond primary care services. In addition, our government spends over $6 billion in support of graduate medical education, most often in a way which only serves to reward teaching hospitals for increasing the number of students being trained for highly specialized care. Finally, as the cost of education has risen, medical student debt has risen. This now averages over $50,000 at graduation, hardly what would encourage students to choose careers in the lower paying primary care disciplines.

Previous attempts to address this problem have largely failed. In the 1960s and 70s we assumed that if we trained more doctors there would be an inevitable diffusion into primary care and into our seriously under-served regions. The number of first year medical students increased from just over 8,000 in 1961 to almost 16,000 in 1990. At the same time the number of foreign medical graduates entering the U.S. exploded. Yet the proportion of primary care practitioners actually decreased. Other programs such as the support of training of nurse practitioners and the National Health Service Corps have not been able to fulfill their missions because of the substantial budget cuts these programs endured during the 1980s.

And now we are about to work together, all of us in this body, on both sides of the aisle, to address the serious need to reform our health care system. The President will present the Congress with his proposals for health care reform next month, and I expect a lively debate. Yet I believe that whatever form our health care system finally takes it is clear that there will only be increased demands for the kinds of primary care services we are discussing today

As my colleagues know I have been very concerned about this issue for several years. I am pleased that along with colleagues in the House we have been able to develop legislation that will be introduced later this month that will begin to address these fundamental problems of the health care workforce. Even if we do not pass health care reform this year—and let me say once again how absolutely essential I believe it is that we do pass it this year —we must begin to remedy the serious problems we will be hearing about today.

We have invited a number of experts to discuss with us potential solutions to these problems. Dr. John Eisenberg, the new chairman of the Physician Payment Review Commission is with us today, and I welcome him to the hearing and the commission. We will also hear from Dr. Marilyn Gaston, the Assistant Surgeon General and Director of the Federal Bureau of Primary Health Care, about the role of the National Health Service Corps. Dr. David Brown, the Dean of the School of Medicine at the University of Minnesota, will tell us about what medical schools can do to improve the number of primary care professionals they graduate. Dr. Roger Bulger will testify on behalf of the Association of Academic Health Centers and discuss their unique proposal to support primary care training. Dr. Wanda Huff, representing the International Coalition of Women Physicians, will talk with us about some of the concerns of minority physicians that are raised when discussing changes in graduate medical education that would hope to increase the number of primary care practitioners. I am happy that Dr. Allen Nelson will talk about the American Society of Internal Medicine's proposal to promote primary care. The American College of Physicians will be represented by Dr. Jim Nolan, an internist from Buffalo, NY. Leah Harrison, R.N. Assistant Director of the Child Protection Center at Montefiore Medical Center in New York, NY will testify on behalf of the National Association of Pediatric Nurse Associates and Practitioners addressing the role of nurse practitioners in delivering primary care services.

I have several specific questions which I would like them to address: We need to understand what our national policy should be concerning the health care workforce and what the role of the federal government should be in addressing these problems; how and if the support for graduate medical education under Medicare should be changed to achieve these national goals; how we will insure access to primary care services, especially for our most vulnerable populations; what the optimal role

would be for nurse practitioners and physician assistants in the new health care system and how federal policy should support this; and how we can be sure to do all this while continuing the efforts to recruit more students from under-represented minority backgrounds into health professions education. Finally, we must not undermine the ability of our health care system, especially the academic health centers, to provide the continuing innovation that has characterized the best parts of American health care.

We hope all these witnesses will help us craft practical solutions to these problems, to help ensure access to health care for those in need, and to help broaden access to careers in health care. I look forward to their testimony.

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