MASSACHUSETTS MEDICAL SOCIETY
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Testimony

"Health Care Workforce Shortages for the Future and Title VII Reauthorization"

Senate Health Education Welfare and Pensions Committee

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February 12, 2008

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Good Morning. I am Dr. Bruce Auerbach, President Elect of the Massachusetts Medical Society and Vice President and Chief of Emergency and Ambulatory Services at Sturdy Memorial Hospital in Attleboro, Massachusetts. It is my distinct pleasure to represent the Massachusetts Medical Society at today's hearing on the "Health Care Workforce Shortages for the Future" and reauthorization of Title VII of the Public Health Services Act. The Massachusetts Medical Society represents over 19, 000 physicians, students and residents and is dedicated to improving the health and welfare of the residents of the Commonwealth.

At the outset I want to emphasize the fundamental importance of the Title VII program and why we at the Massachusetts Medical Society believe these programs are imperative to achieve our overall goal of universal access to quality health care for all Americans. The Title VII program is one of only two federally funded programs specifically designed to increase the number of primary care physicians and providers, particularly in underserved areas. The importance of the primary care physician in the medical home is without dispute. There is strong evidence to demonstrate the effectiveness of physicians who provide first contact, comprehensive, longitudinal care, and coordination of care. Countries with strong primary care systems have lower health care costs than those with weaker primary care systems. In this nation we know that states with more primary care resources tend to mirror these lower costs and have better health care outcomes.

And yet at a time when health care reform is a priority on national and state agendas, and efforts to increase access to care are intensifying, we face burgeoning shortages of physicians, including primary care physicians. The American College of Physicians recently warned that "primary care the backbone of the nation's health care system is at grave risk of collapse." (Bodenheimer, "Primary Care- Will It Survive? NEJM August 31, 2006) *(Appendix i*) It is a fundamental truth - which we are learning the hard way in Massachusetts - comprehensive health care reform cannot work without appropriate access to primary care physicians and providers. In this context it is clear that the need for Title VII funds is perhaps even greater than when the program was originally conceived. When you consider that all the national studies have shown that the health care systems providing the best and lowest cost care to their populations are those with the most robust primary care systems, the imperative is clear.

My testimony today will focus on three areas: 1) outlining the primary care crisis in Massachusetts and our efforts to address this problem; 2) review the successes and history of Title VII programs and the impact on primary care, including community health centers and 3) share our recommendations for Title VII and related programs.

I. PRIMARY CARE CRISIS – MASSACHUSETTS PERSPECTIVE

For nearly a decade the Massachusetts Medical Society has systematically studied and documented changes in our physician workforce and medical practice environment. The need for this data was clear. While our physicians and patients reported increasing stresses to the system, others maintained that the Commonwealth suffered from an oversupply of physicians. To this end the Massachusetts Medical Society, in consultation with outside consultants, initiated two annual studies that profile changes in the medical practice environment and physician workforce.

The first of these two studies, the Physician Practice Environment Index report (*Appendix II)* was first published in 1997 and is a statistical indicator of nine selected factors that impact the delivery of patient care in Massachusetts and the United States. The indicators are as follows:

1. Applications to medical schools,
2. Percent of physicians over 55 years of age,
3. Median physician income levels,
4. Ratio of median housing prices to median physician income,

5. Mean number of hours spent on patient care activities,
6. Physician cost of doing business,
7. Number of visits per emergency department,
8. Change in average malpractice rates, and
9. Number of advertisements for physician employment in the *New England Journal of Medicine.*

This year's report published in April 2007 shows a decline in the Massachusetts medical practice environment for the 13th consecutive year. Further, the rate of deterioration in Massachusetts was 26% faster than in the United States as whole over the 14 year period from 1992 – 2006. This lengthy deterioration is one principle cause of accelerating physician shortages and reflects the growing imbalance between high costs of medical practice relative to a low rate of reimbursement in a state dominated by managed care. This economic imbalance is particularly harmful to primary care practices where revenues are historically proportionally much lower than costs.

The second report, The Massachusetts Medical Society Physician Workforce Study *(Appendix III)* was developed with the input of prominent labor economists and chronicles changes in physicians supply. In addition to ongoing shortages in several specialties, the 2007 Workforce Report shows severe to critical to shortages in primary care for the second year in a row. The impact of shortages in primary care physicians is of great concern given the unique role primary care physicians serve in managing individual patient care.

Among its findings, the study found that in 2006, 53 percent of patients were able to see primary care physicians within a week of contacting the physicians. In 2007, however, that rate dropped to 42%. Moreover, 17 percent of survey respondents with a serious, but not life threatening medical problem say the wait for a doctors appointment was a problem in 2007, an increase of 7% from 2006. Hospitals and physician practices report increasing delays in their ability to recruit or retain primary care providers. In my own community, where I am on the Board of the large multispecialty group practice, the time to recruit primary care physicians has doubled and tripled in the last 5 years. The impact on of the shortages on patients and physicians ability to provide quality care is multifold. In addition to significantly longer waiting times, physicians are forced to see many more patients in less time.

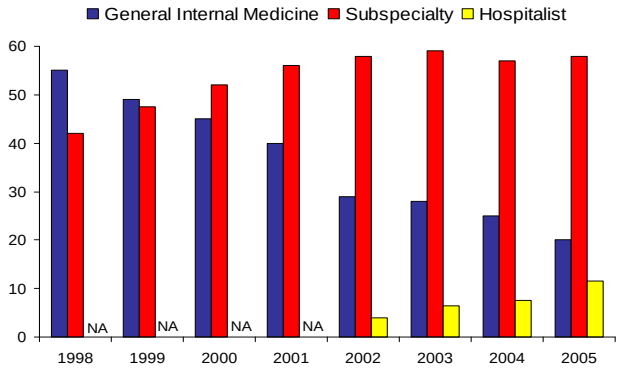
The Massachusetts Medical Society workforce study concluded "The task before those concerned about workface issues is to educate policymakers about how changes in the physician workforce will affect cost, access and quality and impress upon them that serious efforts to promote quality of care and reduce costs will not be effective unless qualified physicians are there to provide care." Taking heed of this statement is more important than ever as Massachusetts implements universal health care and attempts to provide affordable insurance to hundreds of thousands of previously uninsured residents.

These numbers are reflected nationally. The 2006 American of Academy of Family Physicians Workforce study reports that in 2005 there were 31.2 family physicians per 100,000 people in the US. The study found that meeting the nation's anticipated need for primary care in 2020 will require a workforce of 139,531 family physicians, or a ratio of 41.6 family physicians per 100,000 people. To achieve the 2020 target, the AAFP concluded that 3,725 family physicians will need to be produced annually by ACGME-accredited family medicine residencies and 714 annually by AOA-accredited family medicine residencies. As such, the typical ACGME-accredited family medicine residency would need to expand from an average of 21.7 residents to 24 residents.

Portending worse shortages for the future, the AAMC reported the number of family medicine residency positions available in the 2007 Match (2,603) continued to decline this year-100 fewer positions available than in 2006, and more than 500 fewer than were available in the 2000 Match. As the following charts dramatically illustrate, the escalating trend with resident's choices over the past 8 years has been away from primary care.

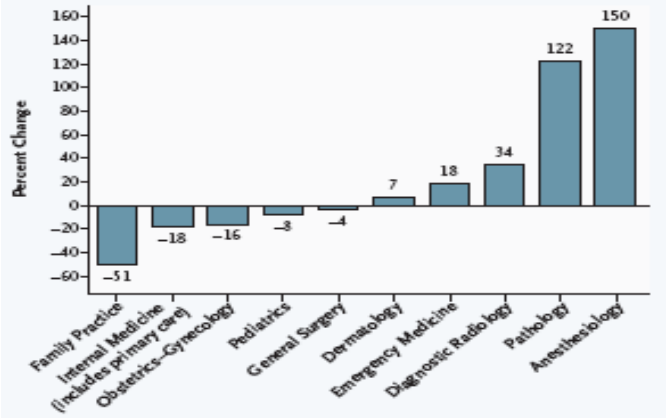
Primary Care Is Losing Ground

Proportions of Third-year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists



Shifting Career Choices: Winners And Losers

Percent Change between 1998 and 2006 of US Medical School Graduates Filling Residency Positions in Various Subspecialities



Data from the National Resident Matching Program. *N Engl J Med* 355:9; www.nejm.org; August 31, 2006

It is important to underscore that the impact of shortages in primary care physicians is exacerbated in terms of their impact on community health centers. Like most health care providers, Massachusetts' community health centers are facing staffing shortages of primary care physicians and non-clinical staff. The Massachusetts League of Community Health Centers estimates that a total of 100 physicians will be required in the current year to meet the needs of existing patients as well as newly insured patients seeking care at community health centers under health care reform. That number is expected to be the same in each of the next two years. At the national level a 2006 JAMA Article, Shortages of Medical Personnel at Community Health Centers, concluded that while primary care physicians constituted 89 percent of physicians working in Community Health Centers, there were 428 vacant funded full time equivalent for family physicians and 376 vacant FTEs for registered nurses. There were vacancies for 13.3% of family

physicians positions, 20.8% of obstetrician's gynecologist's positions and 22.6% for psychiatrists. Of particular note, the study concluded that physician recruitment in CHS was heavily dependent on National Health Service Corps scholarships, loan repayment programs and international medical gradates with J-1 visa waivers.

While a number of factors contribute to the primary care shortages, most agree that rising medical student debt is particularly formidable to those interested in practicing primary care. The AAMC reports that in 2006 medical school graduates owed on average about $130,000, with estimates for Massachusetts medical schools estimated to be about 10% higher. This figure is expected to increase as both private and public institutions face increasing costs in all areas, and accordingly, must raise tuitions. Median tuition and fees for the school year ending in 2004 increased 5.7% at private schools over the previous year, and 17.7% at public institutions. The burden of medical school debt, coupled with undergraduate debt, compounded by interest rates is a significant detriment to primary care where predicted revenues are 30% lower than the mean.

The Massachusetts Medical Society is working on a number of initiatives to address the primary care shortage and to better understand factors influencing medical student's decision as to career choice. The previously referenced NEJM article also noted that it is generally believed that lifestyle concerns also play a role, as primary care physicians often experience heavy loads of after hours call with little or no reimbursement. Furthermore it notes that primary care physicians typically receive less reimbursement both in terms of resources and prestige when compared to specialists. On the global level, it is clear that reimbursement reform for primary care physicians will be necessary to allow for financial stability for these practices. In addition to increasing reimbursement, payment methodology should reflect the nature and value of primary care practices which are based on cognitive skills, longitudinal management and prevention.

At the state level, the Massachusetts Medical Society is currently surveying medical students to determine the factors which most influence their decision in choosing a specialty or primary care. The Massachusetts Medical Society is also working closely with the State Commission on Workforce, Secretary of Heath and Human Services Bigby, and Mayor of the City of Boston Thomas Menino on various task forces and commission to develop recommendations to address the primary care problems. The Massachusetts Medical Society supports legislation that was recently reported out of Committee (House Bill 4514) which will provide loan forgiveness for physicians choosing to practice primary care. The Medical Society has proposed amendments which are referenced in my attached testimony (Appendix III). Internally the Medical Society has convened several internal workgroups to focus on physician's shortages, primary care shortages and medical student debt relief.

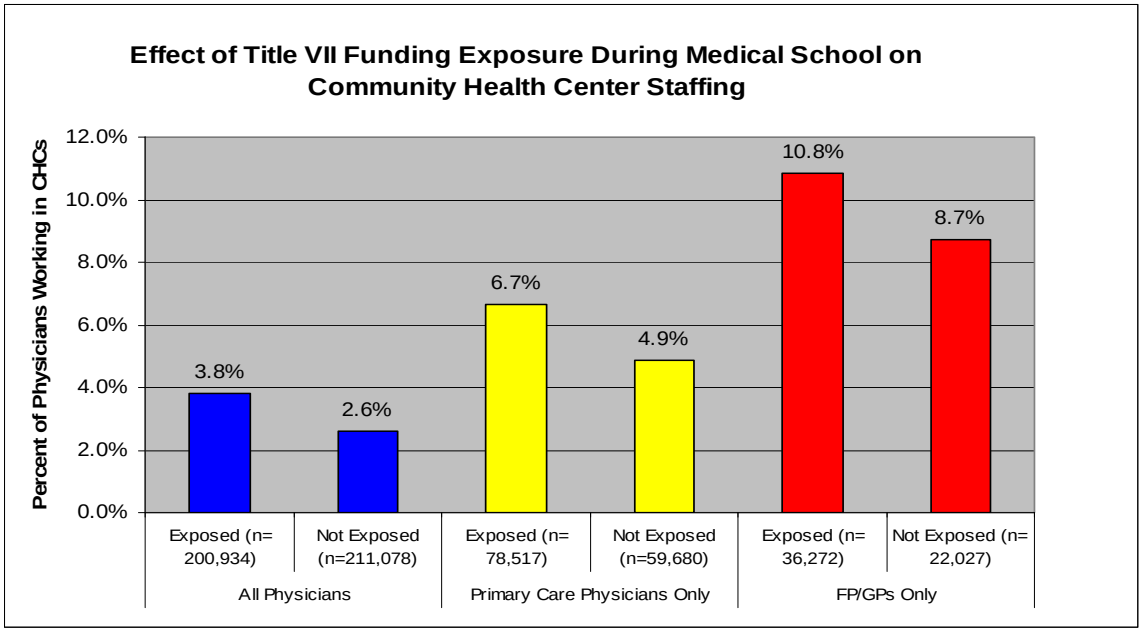
II. TITLE VII: HEALTH PROFESSIONS EDUCATION ASSISTANCE ACT

Since 1978, the Bureau of Health Professions, via Section 747 of Title VII, has been a critical source of support for medical education in primary care. In fact, given the absence of a Center for Primary Care at the NIH, relatively small and static funding at AHRQ, and ongoing decreases in Medicare GME reimbursement, Title VII is one of the only outside sources of funding to stimulate medical education, residency education, faculty development, and academic development in Primary Care. Title VII funds are often currently linked to training physicians to work in underserved communities. Several programs in Massachusetts are recognized as leaders in the training of medical students and residents within Federally-funded Community Health Centers – an important goal of Title VII programs. These include: 1) the Family Medicine Residency at Boston University Medical Center which utilizes Community Health Centers to train residents, 2) University of Massachusetts Medical School in Worcester which enjoys a national reputation for its development of education/service models within federally funded CHC's; and 3) the Greater Lawrence Family Health Center which is the only Community Health Center in the country that serves as the primary sponsor of a Family Medicine Residency Program.

Community Health Centers play a vital role in ensuring access to health care and are a priority for health care reform initiatives. There are 52 non-profit community health centers in Massachusetts which serve one out of nine (700,000) state residents. In 2006, these health centers provided more than 3 million outpatient visits. Massachusetts health centers care for patients of all ages and racial and ethnic backgrounds, and represent a major source of care for medically underserved women and children. Health center patients are disproportionately low-income, publicly insured or uninsured, and are at higher risk for contracting chronic and complex diseases. There are dozens of national studies which document the cost effectiveness and quality of care provided by community health centers.

While the federal government has made significant investments in the growth of Community Health Centers, as noted previously, it has not made a companion investment in the training of physicians who work in these health centers (Rosenblatt et. al., *Shortages of Medical Personnel at Community Health Centers*). There are significant data to show that Title VII funding has a direct impact on Community Health Center staffing. As the following chart details, medical schools and primary care residency programs funded by Title VII, Section 747 disproportionately serve as the medical education pipeline that produces physicians who go on to work in CHCs and participate in NHSC. This finding is particularly true among family physicians.

Effects of Title VII Funding Exposure on Community Health Center Staffing



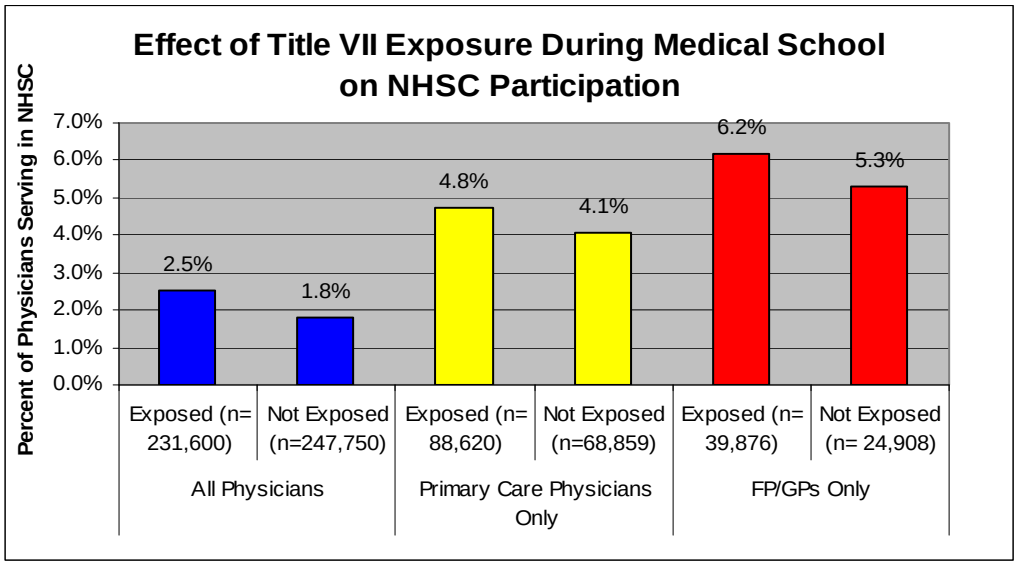
All are significant at $p<0.001$ for comparisons between exposed and non-exposed physicians, using chi square tests.

The authors of this study concluded that exposure to Title VII, Section 747, funds during medical school is strongly associated with subsequent work in community health centers. Almost 4,000 family physicians and general practitioners were exposed to Title VII funding during medical school and subsequently chose to work in a CHC. If these physicians had not been exposed to Title VII funds the authors anticipate over 750 fewer family physicians would have been working in a CHC in 2003. A recent JAMA article (Mar 1, 2006) shows currently 600 vacancies for family physicians in CHCs. Without Title VII dollars we would expect there to be twice as many vacancies. These are conservative estimates: data are from Medicare so pediatrics is underrepresented.

The same finding applied to the impact of Title VII funds during medical school on participation in the National Health Service Corps. This association is true for all physicians, but it is even stronger among primacy care physician, family physicians and general practitioners. As the following chart details, almost 2500 family

physicians were exposed to Title VII funding during medical school and subsequently participated in the National Health Service Corps. Without Title VII funding, it is expected that only 350 physicians who have served in the NHSC.

Effect of Title VII Funding Exposure on Participation in the National Health Service Corps



All are significant at $p<0.001$ for comparisons between exposed and non-exposed physicians, using chi square tests.

MASSACHUSETTS MODELS

As noted previously, several primary care training programs in Massachusetts receive Title VII funds. The successes of the Massachusetts programs in training family physicians who demonstrate a long term commitment to practicing in a community health setting are significant and dramatic. The impact of these programs coupled with the national data should dispel any debate as to the efficacy and import of Title VII funds.

University of Massachusetts Medical School (Worcester)

Learning contract: Since graduating its first class in 1974, the University of Massachusetts Medical School has maintained a Learning Contract that provides for partial tuition waivers for medical students who agree to (1) return to Massachusetts to practice a Primary Care specialty, or (2) return to Massachusetts to practice a specialty with a focus on providing care for vulnerable populations. Failure to do so triggers a payback.

Training in underserved communities produces physicians who practice in underserved communities: In 1976, UMass established the state's first Family Medicine training program, which graduated 454 Family Physicians through 2005, training in four tracks - a Community Health Center (Family Health Center of Worcester), a rural health center (Barre Family Health), an urban site (Hahnemann Family Health Center), and a small urban area (Fitchburg Family Practice). The results from the program are impressive.

- 50% of graduates have remained to practice in Massachusetts; 65% practice in New England;
- 44% of graduates from the CHC track went on to practice at in a Health Professions Shortage Area (HPSA); and
- Graduates from the rural training site are more likely to practice in a rural area.

Recent approach: Establishment of an Office for Primary Care: In 2007, UMass Medical School and UMass Memorial Health Care established an Office for Primary Care. This office is charged with ensuring that the hospital system and the medical school will maintain a robust primary care network. Strategies include:

- Program development to stimulate student interest in primary care careers;
- Working with payers to Develop new models for primary care practice that enhance quality while improving both patient and physician satisfaction;
- Developing a longitudinal curriculum devoted to quality improvement in patient safety (funded through Title VII). This first-of-a-kind project will impact curricula across all four years of the medical school, the residency programs at the three primary care disciplines, and will provide training programs for primary care attendings, physicians, and faculty who interact with students and residents on a regular basis.

Greater Lawrence Family Health Center

Using Title VII funds, the Greater Lawrence Community Health Center teamed up with Lawrence General Hospital to sponsor the first community health center residency program in the country. At the time Lawrence was considered one the most underserved communities in the state with a severe shortage of primary care physicians. At that time the Community Health Center took care of about ten to twelve thousand patients out of community of 75,000. Using Title VII primary care funds, the Community Health Center partnered with Lawrence General Hospital for a unique residency program. As result of their partnership the Community Heath Center sees about 45,000 patients and is no longer considered an acutely underserved area. The infant mortality rate in Lawrence, once in the high teens, has now been dramatically reduced to single digits, even though the risk factors for infant mortality continue. In terms of workforce issues, about half of the physicians from the program have continued to work at the Community Health Center, while the other half have continued their work for the underserved in other areas. The success of program and the collaboration between the Hospital and Community Health Center was cited by then Secretary of HHS Donna Shalala as a national model.

Family Medicine Residency at Boston University Medical Center

The Family Medicine Residency at Boston University Medical was established in 1997 with funding from Title VII grants which have been critical to its success. By establishing and maintaining a strong link between the residency programs, hospital and community health canter, this program has significantly increased the number of family physicians who practice in the community health centers, while improving coordination and access to care between the hospital and centers. The BU program currently provides inpatient services for 12 of the 15 Health Net community centers with each attending providing care to about 40 to 50 patients at any one time. Their physicians provide inpatient services for about half of the ob-gyn and nursery where overall deliveries have increased from about 1600 to 28,000, mostly from community health center patients. In one center, these physicians also serve as hospitalists throughout the year, thus allowing the physicians to continue to care for their patients during their hospitalization. Although the acuity of these patients' illness is generally more severe, the length of stay for their patients is about 3.4 of day shorter. The advantage of this approach is significant - two thirds of the graduates who have trained in this program either practice in a community health center in Massachusetts or elsewhere. By linking the community health centers with the hospital, the program has arguably improved the quality of care provided while increasing the physician's satisfaction that care for their patients throughout the continuum. From a policy perspective it is significant, that these programs graduate family physicians that stay committed to primary care and choose to practice in needed areas.

III. RECOMMENDATIONS

As noted previously there are number of barriers to increasing the number of primary care physicians. These recommendations focus on efforts specific to Title VII and boarder policy areas.

1. REAUTHORIZE TITLE VII WITH SIGNIFICANT INCREASES.

Absent reauthorization in the past several years, Title VII programs have experienced a decrease in funding. For example, in FY 05 Massachusetts received $3,558,576 in Section 747 Primary Care Grants. In FY 06, funding was reduced by $1, 9992,863 for a total of $1,565,713. Given data to show the positive impact of these programs, and the growing shortage of primary care providers, we recommend that Congress reauthorize the Title VII programs with increases commensurate with the projected needs.

2. IMPROVED METHODOLOGY TO DETERMINE NUMBER AND LOCATION OF PRACTICING PHYSICIANS

Surprisingly one of our biggest challenges continues to the creation of a national data base that records the number of practicing physicians in each state and location of their practice. It is our understanding that current federal data bases which are used for these designations count the number of physicians with medical licenses. These figures to do not accurately reflect those physicians who actively practice medicine on a full time basis and the true number of hours devoted to patient care. Thus in areas such as Massachusetts with a significant number of academicians and researchers, the data base is grossly misleading. An additional flaw is that the information may reflect a physicians homes address, as opposed to where he. /she practices medicine, further compounding the problem of accurately defining underserved areas. Reliable data bases will require better coordination with state and county medical societies to ensure accuracy and timeliness of the information.

While Medicare has created a number of shortage designations we believe eligible counties are not being recognized given the faulty data base. When the Medicare Modernization Act created new categories for physicians shortages, compared to number of Medicare beneficiaries, we were stunned that several counties in Massachusetts did not quality. One area was on the Cape, where the percentage of Medicare beneficiaries to physicians is very high and waiting times to see a physician were becoming legendary. In our experience, the national data base was seriously outdated and based on the licensed, as opposed to practicing physicians, in the area. It was only after several attempts and a great deal of grassroots work by the Massachusetts Department of Public Health and the local hospital – literally calling physicians to determine how many hours they practiced and where their office was located – did the region qualify for national shortage dollars. Our experience suggested this problem not unique.

3. NEW APPROACH TO DEFINING SHORTAGE AREAS

Given the growing shortages of primary care physicians across the board we would encourage a creative look at the definitions of shortage areas. Historic definitions have not kept pace with the increasing shortages in primary care physicians nationally. This being said, it is not our intent to disrupt or divert funding from those areas and programs which are historically considered heath professional shortages. These localities must continue to receive additional funds to address acute problems. However we do believe Congress should develop additional funding programs to help those areas which are also experiencing significant problems but have not qualified under historic definitions. While the concept of new dollars may seem irresponsible against soaring budget deficits, we would encourage you to consider the cost savings that will accrue from primary care.

4. MEDICAL STUDENT DEBT RELIEF AND OTHER FINANCIAL INCENTIVES FOR MEDICAL STUDENTS WHO PURSUE PRIMARY CARE

Given the significant burden of medical school debt, we recommend funding a demonstration project for a new type of grant program to forgive federally funded medical student loans. Eligible physicians who commit to practicing primary care in the demonstration grant states would have a portion of their federal loan forgiven. In order to encourage primary care physicians to practice in community health centers, consider forgiving a greater percentage or all of the debt for those who commit to practicing in a community health center.

The model differs from the current National Health Service Corps program in several respects. The demonstration project program would allocate funds to post medical school pre-residency physicians who have chosen to practice primary care in the demonstration grant state for a determined period of time. The NHSC focuses on medical students who, at times, have changed their preference for primary care during medical school. According to testimony presented at the state by the University of Massachusetts, "national data have consistently indicated that most physicians will establish their practice within 50 miles of where they complete their residency regardless of where they attended medical school. Furthermore, residents are nearer to the completion of their training, and so investments in individual residents will yield measurable results, in terms of the numbers of practicing primary care physicians much sooner than investments in incoming first year medical schools." In addition, this program would not be tied to current definitions of underserved areas. As noted previously the current federal definitions of shortage designation are extremely narrow thus preventing otherwise qualified counties from participating. The Medical Society is pursing a similar strategy at the state level suggesting that a federal state partnership for the grants might be advisable.

5. OVERALL PAYMENT REFORM

There is no question that ultimately Congress will need to address comprehensive payment reform for all physicians and health care providers. While not under the jurisdiction of this hearing, it is important to underscore that we believe the above recommendations will address temporarily acute problem areas in primary care. At a minimum reform for primary care physicians should focus on increased value for cognitive and preventive services, comprehensive longitudinal management of patients and proposals to incent quality and the medical home. While it would be impossible here to detail all the provisions necessary for such a systemic change, one thing is clear - without a sound financial model that incents quality care and a robust physician workforce, our efforts to improve access to health care and to reduce costs, will fail.

On behalf of the Massachusetts Medical Society I want to thank you for holding this hearing on an extremely important issue. We look forward to working closely with you on this and other health care issue facing our nation.