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My name is Andrew Wilper. I am a practicing primary care physician (PCP) and researcher. In addition, I have substantial experience in medical education and care for the underserved. I am grateful to have been asked by Senator Sanders about my insights into the lack of health insurance in the United States and its effect on access to health care and health outcomes. I have also been asked to share my thinking on practical solutions to the primary medical care workforce shortage. I have divided my testimony into two parts. First I will address the evidence that lack of health insurance impedes access to health care and degrades health outcomes. Second, I will discuss the primary care physician shortage in the U.S. and strategies to increase the number of primary care physicians.

I) The Effect of Lack of Health Insurance on Access to Care and Health Outcomes in the U.S.

For decades, researchers have demonstrated the ill effects of the lack of health insurance on access to medical care. This body of literature is enormous, and the signal is clear; lack of insurance is definitively associated with decreased access to medical care and poorer health for those without such access. The Institute of Medicine (IOM) summarized these findings and their implications in a six-volume series in the early part of this century, identifying three mechanisms by which insurance improves health: 1. Getting care when needed, 2. Having a regular source of care, and 3.Continuity of coverage.[1-6] Research by myself and others has built on this work. The evidence continues to paint a clear and unambiguous picture. Lack of health insurance is associated with worse health status, decreased likelihood of having a usual source of medical care, and death.[7-,10] In a 2009 article, we updated an older estimate produced by the IOM, linking 44,789 deaths in 2005 with lack of insurance, more than were estimated to die that year as a result of renal failure. Contrary to the popular notion that most uninsured are young and healthy, we found that roughly one-third of the uninsured had a chronic medical condition that would require medical care, and that the uninsured are more likely to suffer undiagnosed, and therefore untreated, chronic illness.[8,11] The uninsured are more likely to go without needed care than the insured, and to be admitted to hospital for illness that could be prevented.[12,13] The data also supports the notion that when previously uninsured individuals gain coverage through Medicare, their decline in health reverses.[14,15] The research is consistent: health insurance leads to significant benefits and is good for your health.

These findings are borne out in my clinical practice. I have cared for many patients who delayed care as a result of lack of insurance. Perhaps the most poignant case was Mr. A, who worked as a delivery man. He was also a diabetic. I cared for this gentleman while I was in my residency training in Portland, Oregon. He was admitted to the hospital for a hypertensive crisis, which is

usually the result of longstanding hypertension that has not been adequately treated. His blood pressure was so high that he bled into his eyes. The damage extended to his kidneys. We were able to stabilize and send him home with new medications. It turned out that his employer had dropped his coverage prior to our meeting in the hospital. As a result, he could no longer afford to go to his primary care doctor. He had been ordering his insulin from Canada, which would arrive by mail. He was using this without proper supplies or monitoring, and was without his blood pressure medications. This led to our meeting. Ultimately, his kidney function became so compromised that he needed permanent dialysis. As you know, this is an extremely expensive treatment, costing approximately $80K per year. What I find so shocking about this story, is that as a society we were willing to pay for his dialysis treatments through the Medicare End Stage Renal Disease program, but were not able to treat his chronic conditions that likely would have allowed us to avoid dialysis in the first place. This case drove home the fact that even routine treatments are out of reach for people who are uninsured. Mr. A. was not simply the victim of bad luck, nor was he an outlier. His situation was a result of policies that have left millions of Americans without insurance and access to medical care.

II) Primary Care in the United States

Background

Good evidence supports the myriad benefits of a robust primary care workforce. Within the U.S., states with larger proportions of specialists actually have lower quality care.[16] Others have demonstrated that increased proportions of PCPs are associated with significant decreases in health care costs.[17] Primary care is also linked to lower all-cause mortality, infant mortality, fewer low birth weight babies, improved self-reported health, decreased costs, and decreased racial disparities.[18] Studies suggest an association between the availability of primary care and decreased emergency department (ED) use. Many patients using the ED report that they would be willing to use another source of care were one available. Nevertheless, we have not seen systematic changes to alleviate the shortage of PCPs in the U.S. This is in spite of widespread calls for reform. Indeed, in 2006 the American College of Physicians predicted that without comprehensive reform by Congress and Centers for Medicare and Medicaid Services (CMS), primary care, the backbone of the U.S. Health care system, may collapse.[19]

The proportion of U.S. physicians practicing in primary care is low compared to other industrialized nations. The Kaiser Family Foundation estimates a total of 834,000 practicing physicians in the U.S. in 2012.[20] The proportion of physicians practicing in primary care in the U.S. is approximately 40%, with the remaining 60% practicing in sub-specialties. This specialist-dominated distribution has been linked to the high costs and poor health outcomes in the U.S. This misdistribution occurs in the context of what many describe as a physician shortage. The Association of American Medical Colleges (AAMC), American College of Physicians, and the Council on Graduate Medical Education all estimate current shortages in the tens of thousands, and predict that these will continue to grow.[21-23]

Medical School

Numerous strategies exist to increase the number of medical students entering primary care. These include educational debt reduction, changes in federal funding streams to emphasize primary care, and increased funding to the National Health Services Corps. In addition, direct support for Community Health Centers participating in teaching medical students would support our nation's most vulnerable populations while training future PCPs.

Graduate Medical Education

Graduate medical education (GME) has been the focus of many federally supported programs to increase the primary care work force. Funding for Title VII programs, which support training for PCPs, is continuously threatened by congressional cuts. Only the Title VII programs provide money directly to primary care training programs. Remarkably, for every Title VII dollar there are about $1,000 Medicare GME dollars, and these Medicare GME dollars push training efforts toward inpatient and subspecialty care. Medicare spending for GME is directed toward hospitals, which is heavily tilted toward hospital-based specialty care.[24] Medicare should direct funding to residency programs for education instead of directing it through hospitals. Medicare should also require assessments of community and regional physician work force for hospitals to qualify for GME funding. In effect, Medicare should begin requiring accountability in its subsidization of teaching hospitals. Remarkably, the federal government spends nearly $10 billion dollars annually to produces a physician workforce without a workforce plan. As part of his testimony before the House Energy and Commerce Subcommittee on Health, Dr. Fitzhugh Mullan called for "requir(ing) teaching hospitals to undertake community or regionally oriented analyses of physician workforce needs and make application for training positions based on a fiduciary responsibility to train a complement of residents that corresponds to agreed upon regional needs."[25] In its current form, GME is run by teaching hospitals to meet their own staffing needs, and graduates select their field of practice based on their personal interests. I have been personally told by a residency program director that his concern is the professional desires of his trainees, rather than population health needs. Given the annual income of certain physician types, Medicare could consider limiting or defunding training programs that do not meet population needs, or that could be reasonably funded via trainee loans given future income expectations.

Practice and Payment Reform

Payment reform is the most critical element of change needed to re-invigorate primary care. Remarkably, it is explicit federal government policy to direct oversized payment towards specialists and thereby skew workforce statistics. Efforts to reform the payment system in an effort to address the maldistribution of physicians by specialty have failed. The resource-based relative values scale has grossly distorted relative physician reimbursement since 1992. Now PCP compensation is 30% to 60% less than subspecialists.[24] Without payment reform, it is unlikely that efforts targeting medical students and residents will succeed in bolstering the primary care workforce. Indeed, the AAMC has declared that "education and training cannot overcome the intense market incentives that influence physician choices."[25] The income disparity could be addressed by increasing PCP reimbursement or by decreasing that of subspecialists.

A focal point for payment reform is a committee of the American Medical Association called the Relative Value Scale Update Committee, known as the RUC. This group of 31 doctors wields tremendous influence over physician pay in the U.S., with CMS following nearly all of its recommendations. One estimate has the RUC directing $54 billion in federal spending annually. Yet the group has no government oversight. This opaque group benchmarks reimbursement rates for physician services in the U.S. and does so in a way that favors surgeons and specialists. Only three seats on the committee are designated for primary care specialties.[26] Critics argue that RUC decisions are based on suspect data leading to systematic overstatement of time and work that favors surgery and subspecialty physicians.[27,28] The playwright George Bernard Shaw commented that "any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting of your leg, is enough to make one despair of political humanity."[29] We have gone a step beyond what Shaw feared by allowing physicians to set their own rates. At a minimum, the public deserves transparency in decision making from the RUC. Better yet, we should establish a process for rate setting that is not encumbered by conflicts of interest and does not favor narrow specialties.

Expanded patient access to PCP services could be achieved through strategies that reform current practice models. Expanded insurance via the Affordable Care Act will stress primary care supply. In the two years following health reform in Massachusetts, waits to see PCPs increased by 82%.[30] This has been linked to a mismatch between the supply and demand for primary care services. Policy efforts to implement the Patient Centered Medical Home will focus on risk adjusted capitated payments, non-traditional visits such as telephone and email care, in addition to delegating physician decision making to non-physician team members. This will require changes in our reimbursement system, workforce and the culture of medicine.

In summary, it is eminently clear that health insurance affords better patient outcomes, and that it been associated with decreased risk of mortality. Despite this, our current reform efforts in the Affordable Care Act will leave as many as 30 million uninsured. The physician pipeline recommendations above have been made for years by health policy and workforce experts. Nonetheless, efforts to increase the number of PCPs have been frustrated by the funding mechanisms for medical education in the U.S. This current system of funding is at best inefficient, meeting the needs of a narrow group of teaching hospitals and subspecialists. At its worst, the current GME funding stream acts as a principal driver for a workforce that meets the interests of physicians and hospitals rather than the health needs of the population. In addition, Medicare's grossly unequal fee payments to specialists and PCPs continues to discourage trainees from primary care careers. I have worked for over a decade in medical education as a student, resident, fellow, faculty member and residency program and hospital leader. My conviction is that publically sponsored training should be planned to meet the health care needs of our population rather than the staffing needs of hospitals or the lifestyle preferences of young doctors.

Thank you.

End Notes

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