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Chairman Baucus, Senator Grassley, and Members of the Committee:

Thank you for asking me to come before you today to discuss primary care workforce and payment issues as they pertain to health system reform. My comments are based on over 30 years of experience as a primary care physician, medical educator, professional society leader, and reformer. They are also informed by our first two years of experience with Massachusetts' landmark initiative to improve access to health insurance.

Contribution of Primary Care to Health System Effectiveness

Because we are all interested in achieving sustainable, affordable health system reform, let me start by briefly considering the contribution of primary care to the performance of health care systems. The available evidence overwhelmingly shows a strong relationship between access to comprehensive primary care and the effective functioning of health care delivery systems (1). When people have access to primary care, health care costs are lower, health status is better, and health disparities are fewer. The take-home message from the data: if we hope to improve our health care system we are going to need a strong primary care base.

Impact of a Dysfunctional Physician Payment System on Primary Care Practice and Workforce

Why then is there a serious and growing shortage of U.S. medical school graduates choosing careers in primary care (2) at the very time the nation's need is growing? The answers are multi-factorial (3) and include the well known factors of high levels of student indebtedness, low pay for primary care, lack of prestige, and heavy time demands. Less appreciated, but perhaps the most important of all is the current practice environment in primary care, characterized by high visit volume, rushed care, and inadequate time to do the job properly (4). This sorry state of affairs derives largely from a dysfunctional physician payment system, dominated by Medicare's RBRVS fee-for-service system. Although originally designed by my colleagues Hsiao and Braun at the Harvard School of Public Health to help rationalize reimbursement and correct imbalances in physician payment (5), RBRVS has been distorted in its application and now exacerbates these imbalances. Medicare's Physician Fee Schedule currently pays generously for performance of procedures and inadequately for evaluation and management (E&M) services, the basic doctoring that is the hallmark and bread and butter of primary care. Consequently, as a nation, we get exactly what we pay for: namely high volumes of expensive procedures, many of which are unnecessary or of questionable benefit (6), and too little doctoring. The result: we are first among industrialized nations in per capita health care spending and 25th to 35th in health outcomes (1).

Because all Medicare physician payment comes out of a single pot, the ever-increasing proportion of Medicare dollars that pay for expensive procedures reduces the fraction available to support basic doctoring. Faced with a worsening payment situation and rising expenses, primary care practices try to increase their revenue by ramping up visit volume, which is the basic unit of payment under RBRVS (partially adjusted for complexity). The net result is a practice environment driven by visit volume, leading to unhappy patients and demoralized primary care physicians, who find they do not have adequate time to meet their patients' needs (4). Instead of being able to diagnose and manage in the evidence-based, cost-effective, personalized manner we emphasize in their training, harried primary care physicians often find themselves doing little more than triaging, over-ordering elaborate diagnostic studies (to satisfy patients and keep from being sued), and making referrals – all of which drive up costs without necessarily adding value. Additionally, they are overburdened with administrative paper work and most cannot afford the multidisciplinary teams and modern information technology essential to operating a high performing practice (7). We have indeed relegated the "quarterbacks" of our health care system to serving as "gate keepers." No wonder our best and brightest young men and women in U.S. medical schools (who used to eagerly choose careers in primary care because they wanted to "make a difference") are shunning the field, and nonphysicians are proclaiming they can fulfill this watered-down primary care role, which is a shadow of its original conceptualization and implementation.

An inadequate primary care physician workforce threatens health system reform. In Massachusetts, our landmark health insurance initiative has dramatically reduced the roles of the uninsured (8) - an achievement we are all very proud of. However, because our primary care capacity is inadequate (8), the newly insured (as well as everyone else) are finding it increasingly difficult to find a primary care practice that will take them in. Consequently they are showing up in our emergency rooms in record numbers for nonemergency care, an expensive and inefficient outcome that threatens the financial viability of our initiative (10,11).

As the primary care practice environment worsens, a growing number of primary care physicians are going "concierge," markedly shrinking their practice panels and charging a retainer to the remainder who can pay the premium in return for guaranteed access and more personalized, less rushed care. Distressingly, many patients are now finding themselves "fired" by such practices and "medically homeless." The take home message: health reform in the absence of strengthening the primary care base is not likely to succeed.

Health System Reform Through Physician Payment Reform: Essentials of a Solution

Several principles and recommendations emerge for addressing the primary care workforce issues essential to achieving health system reform:

1. Fundamental reform of payment for primary care is essential to achieving health care reform in the United States and should be a priority for policy makers.
2. Physician payment should support desired outcomes, rather than discourage them; visit volume and piecemeal reimbursement need to be eliminated as the prime determinants of payment;

comprehensive or bundled payment might be a better means of encouraging the comprehensive, coordinated care desired (12).

3. Comprehensive or bundled payments should be risk-adjusted so there is no disincentive to care for the sick and needy, as there was under capitation.
4. The payment system should include incentives/bonuses for achieving desired outcomes in the areas of cost, quality, and patient experience; such incentives also require risk-adjustment.
5. Payment to practices should be sufficient to support the infrastructure needed to operate a high-performing practice, such as a multidisciplinary team and health information technology.
6. Although reform of physician payment probably needs to extend beyond primary care, starting with primary care makes sense, because of the field's central role in health system reform and its current crisis status.
7. Medicare should urgently support an intensive research effort to develop and field-test new models of primary care payment; the effort should extend well beyond RBRVS and could be incorporated into practice reform efforts such as those for the patient-centered medical home.
8. Student loan forgiveness may be a useful stop-gap measure for encouraging careers in primary care, but is unlikely to be a sufficient or durable measure in the absence of fundamental payment reform that improves the primary care practice environment.
9. Medicare should consider increasing support of undergraduate and graduate medical education for primary care, but should not mandate numbers or proportions of training positions.

Summary:

A strong primary care foundation is essential to the well functioning of a health care delivery system and to implementing meaningful, sustainable health care reform. A dysfunctional Medicare fee-for-service payment system lies at the heart of the current workforce crisis in primary care, because of its adverse effect on the practice environment. Incremental measures such as tweaking RBRVS and providing loan forgiveness are unlikely to suffice. Fundamental reform of payment for primary care is urgently needed, starting with rigorous field testing of new models that encourage and enable practice transformation. Medicare's central role in U.S. health care can help spur the necessary reform efforts. If we build a strong primary care system, I firmly believe we will have no problem recruiting a new generation of devoted, highly skilled young men and women committed to providing the robust primary care so urgently needed by our nation's citizens.

Thank you for the opportunity to share these thoughts with you.

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Boston, Massachusetts

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