

# MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES: IMPROVING ACCESS TO CARE

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## HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED ELEVENTH CONGRESS FIRST SESSION

MARCH 24, 2009

**Serial No. 111-20**



Printed for the use of the Committee on Energy and Commerce  
*energycommerce.house.gov*

U.S. GOVERNMENT PRINTING OFFICE

67-817

WASHINGTON : 2012

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For sale by the Superintendent of Documents, U.S. Government Printing Office  
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## **MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES: IMPROVING ACCESS TO CARE**

**TUESDAY, MARCH 24, 2009**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON ENERGY AND COMMERCE,  
*Washington, DC.*

The subcommittee met, pursuant to call, at 10:10 a.m., in Room 2322 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Pallone, Dingell, Gordon, Eshoo, Green, DeGette, Capps, Schakowsky, Baldwin, Weiner, Harman, Gonzalez, Barrow, Christensen, Castor, Sarbanes, Murphy of Connecticut, Space, Sutton, Braley, Waxman (ex officio), Deal, Whitfield, Shimkus, Blunt, Rogers, Myrick, Murphy of Pennsylvania, Burgess, Blackburn, Gingrey, and Barton (ex officio).

Staff present: Karen Nelson, Deputy Staff Director for Health; Karen Lightfoot, Communications Director; Jack Ebeler, Senior Advisor on Health Policy; Stephen Cha, Professional Staff Member; Tim Gronniger, Professional Staff Member; Purvee Kempf, Counsel; Anne Morris, Legislative Analyst; Virgil Miller, Legislative Assistant; Camille Sealy, Detailee; Miriam Edelman, Special Assistant; Lindsay Vidal, Special Assistant; Alvin Banks, Special Assistant; Allison Corr, Special Assistant; Brandon Clark, Minority Professional Staff; Marie Fishpaw, Minority Professional Staff; Clay Alspach, Minority Counsel; Melissa Bartlett, Minority Counsel; and Chad Grant, Minority Legislative Analyst.

### **OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. The hearing is called to order.

Today the subcommittee is meeting for the third hearing in the "Making Health Care Work for American Families" series. In the previous hearings, we heard from the leading experts in health care that our delivery system is dangerously disconnected and that providing universal coverage means and affordable and quality health plans for all. Today we will explore the next step. Simply providing universal coverage will not guarantee that everyone will have access to the necessary care. We must also eliminate the inequities and disparities in health care, properly support and train our health care workforce and make prevention a national priority.

As a Nation, we have made tremendous strides in improving the health of all Americans. However, as numerous reports have highlighted, there remain significant inequalities with respect to both access to health care and the quality of care provided among different ethnic groups in this country. For example, the mortality rate due to heart disease and cancer is higher among populations including African-Americans, Asian-Americans and Pacific Islanders. The rate of new AIDS cases is three times higher among Hispanics than among Caucasians. I personally am also very concerned about the health disparities for American Indians and Alaska Natives. The mortality rate among Indian infants is 150 percent higher than for Caucasian infants, and Indians are nearly three times as likely to be diagnosed with diabetes. These disparities are not limited, however, to ethnic and racial divides but are consistently also found between genders, geographic area and among different income groups. For example, there are significantly more access-to-care obstacles for rural populations than there are for urban populations, and the 2002 Institute of Medicine report found that these disparities persisted even when factors such as insurance coverage and income level remained constant.

One of the contributing problems in my mind is the current state of the health care workforce. Study after study has proven the importance of primary care yet two-third of the U.S. physician workforce that practice as specialists and the number of young physicians entering primary care fields is declining. In addition to this, there are disparities in where these physicians are practicing. Metropolitan areas have two to five times as many physicians as rural areas and there is a shortage of physicians willing to practice in economically disadvantaged areas, both rural and urban.

Part of the solution, in my mind, is to strengthen our existing programs while at the same time exploring new avenues to reduce disparities and expand the workforce. As highlighted in a recent Commonwealth Fund report, Medicaid is vital in improving access to health care for low-income Americans. Title 7 and 8 of the Public Health Service Act are crucial programs to increase the primary care workforce and the National Health Service Corps is a very successful program to entice young medical professionals to practice in underserved neighborhoods. But we face many obstacles in ensuring access for all Americans. I am optimistic that in this Congress we will take action to ensure that all Americans have both coverage and access to care.

I want to welcome all of the witnesses today. I do want to say that certain members, not to take away from the others, but Ms. Christensen was very crucial in asking that we have this hearing today and address some of the disparity issues and certainly Ms. Capps, who is our vice chair, constantly making reference to the workforce and the need to address those workforce issues.

Mr. PALLONE. With that I will ask Mr. Deal to begin with an opening statement. Thank you.

**OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA**

Mr. DEAL. Thank you, Mr. Chairman. I want to also express appreciation to all the witnesses for being here today.

As we move forward in this series of hearings looking at what health care reform should encompass, I think there are some fundamentals that we all ought to keep in mind. I believe that some of the true issues in health care reform include transparency, efficiency and accountability in the health delivery system, and allowing a system to exist that involves a patient's right to choose.

This hearing, of course, is going to focus on access to health care services and various proposals aimed to overcome the obstacles to care. Unfortunately, too many Americans across the country do lack access to quality, affordable medical care. As we all know, there are a variety of reasons why this exists. Physical, geographical, cultural and financial influences all play a role in patient access to health care. While there are scores of obstacles to stand in the way of receiving it, effective reform such as cross-state purchasing of health insurance, association health plans, consumer-driven options that enhance quality and value, and similar options which build upon the doctor-patient relationship would make great strides forward in bridging the gap that exists under today's system.

There is a lot of talk in Washington that suggests that the most appropriate way to put our health care delivery system back on its course is to increase the role of government-run health care programs, particularly Medicare and Medicaid and SCHIP. I of course don't agree with that proposition. Patients receiving care through Medicaid oftentimes find it very difficult to find a physician who will accept their coverage due at least in part to abysmal reimbursement levels rendered for their services. Medicaid participants are frequently forced to travel great distances to receive access to needed care. In fact, just before the hearing today I had an opportunity to meet with a group of podiatric physicians from my district and they reiterated the challenges that their Medicaid patients face in finding a providing who will actually accept their coverage. In my rural district in north Georgia, this presents a significant challenge to many of my constituents and funneling even more individuals into government-run health care programs without addressing the heart of these programs does not reflect the reform that the American people are asking for.

Additionally, Congress should also consider other forms in the health care delivery system. I believe that any package we sent to the Floor should include a significant medical liability reform provision. Time and again we have repeated instances of frivolous lawsuits for medical liability cases being brought against health care providers as trial lawyers seek to exploit every opportunity to game the legal system and yield an oversized award. Unfortunately, we have seen as a result physicians continue to change the way they practice medicine, usually resulting in an onslaught of medically unwarranted diagnostic testing and referrals to other physicians solely for the protection of the provider, not the patient, under the practice of defensive medicine.

We are all aware of the significant and growing cost of health care. Unfortunately, with the understandably defensive nature of the health care delivery system in the United States, we can only expect these strains to multiply as the number of Americans receiving care grows. By empowering physicians with the ability to pro-

vide needed health care services without the burden of defensive medicine tactics, an estimated \$70 to \$126 billion per year could be saved, outcomes could be improved and utilization of our limited medical resources would be more effectively maximized. Rest assured, I value protection of patients' rights and efforts to reform the medical liability system should not be misconstrued as an effort to infringe upon those rights. If tragedy occurs, then certainly there should be redress for the individual who has been harmed.

I lost sight of the clock up there. There it is. I finally spotted it. I have run out of my time, so I am going to stop, but thank you all for being here today.

Mr. PALLONE. Thank you, Mr. Deal.

For an opening statement, the gentlewoman from California, Ms. Eshoo.

**OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. ESHOO. Good morning, Mr. Chairman, and thank you for the series of hearings that you are holding as we prepare legislation for health care for everyone in our country. I guess today can be called Doctors Day, so welcome to all the witnesses.

As a Nation we have innovative equipment, I think we have the most knowledgeable doctors, we have the widest array of medicines, but if millions of Americans don't have access to this, obviously something is very, very wrong, and it is worst for minorities and lower-income groups. In addition to the 47 million Americans who have no insurance whatsoever, there are millions more who are underinsured. Racial, ethnic, cultural, socioeconomic and geographical barriers exist in getting people the care they need and that is why it is critical for us to keep these factors in mind when addressing health care reform and I think that you are going to teach us a lot today.

I look forward to discussing how we can improve Medicaid and Medicare as well. There are parts of the country where two out of three doctors will not see Medicaid patients, in parts of my own district, and it is the heart of Silicone Valley so one might think that even though the Gallop Poll said that it is the most contented district in the country, we still have many gaps where no doctor will take new Medicare patients because they are reimbursed at rates far below their costs. The Geographic Price Cost Index, or the GPCI, has severely skewed doctor reimbursement rates so low in Santa Cruz County that many of my senior constituents have to travel an hour or more over a winding mountain road to see a doctor in another county. So this is just one example of how our health care system is broken and fails too many Americans.

I thank each one of you for being here today. I look forward to your testimony and most important of all, look forward to all of you working with us where in the year 2009, God willing, we will really reform the system once and for all.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Ms. Eshoo.

The gentleman from Illinois, Mr. Shimkus.

**OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS**

Mr. SHIMKUS. Thank you, Mr. Chairman.

When I started practicing medicine in the same location 30 years ago, my malpractice premium with the same insurer was \$10,000 a year. Today my premium is just shy of \$100,000 annually. Major malpractice reform with bipartisan support should be a starting point for our country's health care overhaul. Threat of litigation causes an inestimable amount of practice of defensive medicine. It will not take too many rate hikes for those of us providing obstetrical care in rural counties to say enough is enough and that we will not continue to provide high-risk services.

These days, malpractice insurance premiums are prohibitive. We have not been able to recruit new doctors in the area, particularly in surgical specialties, due to excessive premiums. Addressing medical liability reform and health care reform will free millions of doctors that can be directed toward improving care and access to care. It would also provide for a better distribution of physicians as recruitment and retention of physicians is greatly influenced by the medical liability environment of each State.

I have two additional letters, Mr. Chairman, and I ask unanimous consent that these be submitted for the record. They are from doctors in my district and health care providers, especially hospitals.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Without objection, so ordered. We thank the gentleman.

The gentleman from Texas, Mr. Green.

**OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman, for calling this hearing. In following my friend from Illinois, if we could handle medical malpractice, in Texas we wouldn't have 900,000 children and not covered by SCHIP because the State won't cover the match because we have one of the strong medical malpractice laws in the country and we still have a huge number of uninsured. I think we have to look at other issues.

I want to thank you for holding the hearing today on health insurance and access to care. Houston has the third largest Hispanic population in the country and I represent an area that is 65 percent Hispanic and medically underserved. In 2007, nearly half of the 47 million uninsured in the United States were minorities. Unfortunately, most minority populations have higher rates of diseases like diabetes, cervical cancer, HIV/AIDS and heart disease in our community. In fact, Mexican-Americans are twice as likely as Anglos to be diagnosed with diabetes. These diseases are mostly preventable but lack of access to care is still a barrier to the minority communities in part because of the many health problems in the Hispanic community.

As we know on this committee, access to quality primary and preventive care leads to a better quality of life and fewer health problems down the road. We will hear today that aside from barriers to primary care, we are facing a shortage of primary care phy-

sicians. This is troublesome because even if we reform our system, we may not have enough primary care physicians to serve all the patients who will be entering our health care system.

We are addressing the issue of health reform but as we move forward we have to reiterate that State and federal partnerships do not work if the State cannot come up with the federal match. Texas unfortunately has a long history in the SCHIP and Medicare program of not providing the matching funds much to the detriment of our residents. Health reform must be at a national level, and if we truly want to cover all Americans, although many States have their own wraparound programs, some of us do not and we can't leave those uninsured behind.

Again, I want to thank our witnesses today, and Mr. Chairman, I yield back my time.

Mr. PALLONE. Thank you, Mr. Green.

The gentleman from Texas, Mr. Burgess.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A  
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman. Thank you for holding this hearing. I feel like I am in a Chevy Chase movie, doctor, doctor, doctor, doctor and doctor, but, you know, reading through the testimony today, we are going to have an opportunity to touch on several important issues and they are issues that have been near and dear to my heart for a long time.

I do look forward to discussing the role of Medicare and Medicaid in providing care and the very serious issues we face in ensuring that our primary care workforce is able to meet the demands of the future and the role of health disparities among the various populations. Some very basic questions that we need to consider. How can we think of going forward until we have some solutions to the problems that we know exist within our public systems today and this hearing might very well serve as a checklist of what we know to be broken within those public systems. The federal programs, Medicare and Medicaid, that cover well over a third of our population, are headed for a budgetary collapse. We expect these programs to service the populations that they do now and in the very near future to serve even more, and the providers in the workforce face the threat of annual Medicare cuts, this year to be at 20 percent unless Congress acts before the end of December, and Medicaid reimbursements that are even worse, and to top it all off, the Association of American Medical Colleges reports that the physician shortage is expected to exceed 124,000 doctors by 2025.

I am encouraged to see attention being given to the physician workforce issues. I have been concerned about that for some time. In my home State of Texas, the number of doctors between 1995 and 2005 increased by 46 percent, nearly 5,000 doctors, but the State is still well below the national average. I believe that a good start for Congress is to enact legislation that this committee, this subcommittee approved, we approved in full committee that I introduced along with Congressman Gene Green, H.R. 914, the Physician Workforce Enhancement Act of 2009, to create additional residency training programs where historically none have operated in the past. We all know doctors are not very imaginative. We tend



to go into practice within 50 miles of where we do our training and this is a bill aimed at capitalizing upon that fact, but it is only one small step.

I also represent an area that has a significant minority population who suffers from a lack of direct access to medical services and obviously the health problems that result therefrom. But that is just it, Mr. Chairman. We need a lot of discussion before we proceed on the path of a comprehensive fix but we all know we need to proceed. Coverage does not always equal access. Coverage doesn't help the Medicare or Medicaid patient who cannot find a doctor willing to accept the program, or worse yet, a doctor who can no longer afford to keep their doors open because they have accepted what the government will pay. So simply burdening future generations is not the answer. It is up to us, it is up to this Congress.

I look forward to the testimony today and I will yield back the balance of my time.

Mr. PALLONE. Thank you.

The chairman of our full committee, Mr. Waxman.

**OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. WAXMAN. Thank you very much, Chairman Pallone, for holding this hearing.

We have already had two productive hearings in this series on health reform. At the first hearing the Institute of Medicine testified that health insurance coverage makes a big difference in personal health. For example, the health of uninsured middle-aged adults who have chronic conditions such as diabetes declines more rapidly than the health of insured adults with these conditions. Overall, uninsured adults are 25 percent more likely to die prematurely than adults with health insurance. The data are overwhelming. Health insurance improves access to care, which in turn improves personal health, while we also know that health insurance coverage does not necessarily guarantee access to needed care. Racial and ethnic minorities often don't get the care they need, even if they are insured. People living in rural areas of our Nation have some of the highest rates of chronic health problems like obesity but some of the lowest numbers of physicians and nurses to address these problems. Communities all over the country in urban and rural areas alike face growing shortages of primary care physicians and nurses. Coverage for all is essential but health insurance by itself won't solve these shortages. We will need additional measures to ensure that we have enough primary care physicians and nurses to meet the Nation's needs.

As the Institute of Medicine told us, many more low-income Americans would be uninsured today and at greater risk for poor health and premature death were it not for expansions in public programs like Medicaid and CHIP. Medicaid and CHIP are the Nation's insurers for low-income families and children and individuals with disabilities. However, just as Americans with private health insurance do not always have access to needed care, so those enrolled in Medicaid and CHIP may not always have access to the care they need. When our committee takes up health reform, we

will provide coverage for the uninsured. However, I also want to make sure that our legislation addresses the barriers to access that insurance coverage by itself can't fix. Today's hearing will help us craft solutions that will improve access to care for all regardless of race, ethnicity or geography.

I look forward to our witnesses' testimony. I yield back the balance of my time.

[The prepared statement of Mr. Waxman follows:]

**Opening Statement for Rep. Henry A. Waxman  
Chairman, Committee on Energy and Commerce  
Making Health Care Work for American Families:  
Improving Access to Care  
Subcommittee on Health  
March 24, 2009**

I want to thank Chairman Pallone for holding this hearing.

We have already had two productive hearings in this series on health reform.

At the first hearing, the Institute of Medicine testified that health insurance coverage makes a big difference in personal health.

For example, the health of uninsured, middle-aged adults who have chronic conditions such as diabetes declines more rapidly than the health of insured adults with these conditions.

Overall, uninsured adults are 25% more likely to die prematurely than adults with health insurance.

The data are overwhelming: health insurance improves access to care, which in turn improves personal health.

But we also know that health insurance coverage does not necessarily guarantee access to needed care.

Racial and ethnic minorities often don't get the care they need, even if they are insured.

People living in rural areas of our nation have some of the highest rates of chronic health problems like obesity — but some of the lowest numbers of physicians and nurses to address these problems.

Communities all over the country, in urban and rural areas alike, face growing shortages of primary care physicians and nurses.

Coverage for all is essential, but health insurance by itself won't solve these shortages. We will need additional measures to ensure that we have enough primary care physicians and nurses to meet the nation's needs.

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Today's hearing will help us craft solutions that will improve access to care for all, regardless of race, ethnicity, or geography.

I look forward to today's testimony.

Mr. PALLONE. Thank you, Chairman Waxman.  
The gentlewoman from Tennessee, Ms. Blackburn.

**OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE**

Ms. BLACKBURN. Thank you, Mr. Chairman. Welcome to our guests.

In order to truly reform the Nation's health care system, I am one of those that believes we have to focus on cost reduction, improved quality, increased access to all Americans. True medical liability reform is a critical component of the health reform debate. It is concerning to me that there has been little attention on how tort reform will affect access to care in the broader health care reform debate. The lack of liability reform hurts patients, hurts our constituents, impacts their ability to receive care due to enormous added costs incurred in the practice of defensive medicine which has driven trial lawyers looking to cash in on what they deem to be bad outcomes. Any attempt to make health care available to the underserved and uninsured will be doomed to failure if the legal costs of practicing medicine are not addressed.

With reimbursement issues added to the high cost of liability insurance, physicians who are often small business owners must weigh the risk of taking new patients, particularly the uninsured, if costs exceed reimbursement. A physician in my district recently told me without significant and real tort reform, no plan to control increasing health care costs will succeed. While it is healthy to consider the best practices for both patients and physicians, the debate must be resolved so the medical system can operate in a more effective fashion and be improved to consistently deliver high quality of care.

Mr. Chairman, I would like to ask unanimous consent that I enter some letters into the record from physicians in my district who have highlighted their concerns with the need for medical malpractice reform in the overall debate.

[The information was unavailable at the time of printing.]

Mr. PALLONE. Without objection, so ordered. I thank the gentlewoman.

Ms. BLACKBURN. I yield back.

Mr. PALLONE. The chairman emeritus, Mr. Dingell.

**OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN**

Mr. DINGELL. Thank you, Mr. Chairman, and I commend you for holding today's hearing on improving access to health care. This is a particularly timely topic since this is Cover the Uninsured Week. There are 46 million people in the United States who lack health insurance and some have estimated that without action, the number could reach 61 million by 2020.

It comes as no surprise that the uninsured have trouble accessing quality health care but access is a problem even for those with insurance coverage. The high cost of health care and lean insurance benefits have led more than 25 million people to be classified

as underinsured. These people are more likely to forego needed care because of costs. Furthermore, the Commonwealth Fund reports that in addition to gaps in insurance coverage, Americans lack timely access to care, meaning they are not able to see their doctors within 2 days of becoming sick.

As we move forward with comprehensive health care reform legislation, there are a few key issues that we must tackle with regarding to expanding access to care. First and most important, we must set a goal that our health care reform bill moves us toward universal coverage. That is why I support a provision that would require everyone to have health insurance. However, we must insure that care is affordable to everyone and I believe that is the only way we can have universal coverage and have it in a fair and proper way. Even if we require everyone to have health insurance, many Americans will still lack access to health care due to a shortage of primary care providers. Strong primary care systems have been shown to reduce costs and improve quality. However, of the 800,000 physicians in the United States, only 40 percent are primary care providers. By the year 2025, we will have a shortage of over 40,000 primary care doctors. Our health care payment systems have essentially subsidized specialty care.

As we construct new health care networks, one that I hope includes a public plan, nay, that must include a public plan, we must move from a fee-for-service payment structure to one that rewards quality and patient-centered primary care. We must consider incentives such as loan forgiveness, scholarships and other things to draw young medical students into the primary care field. Additionally, we must assess the need for nurses, nurse practitioners and physician assistants and we must then invest in a proper way of ensuring that that carries forward. These professionals serve on the front line of care and play a critical role in primary care and prevention.

We must address the persistent disparities in health care access and health outcomes for racial and ethnic groups. Numerous studies have shown that racial and ethnic minorities are consistently less likely to receive necessary care, even when controlling for other access-related factors. I believe, and I stress this, that health care is a right, not a privilege, and failure to address the root causes of these disparities is immoral.

Finally, if it were not for Medicare, Medicaid and CHIP, many people would be among the ranks of the uninsured and underinsured. These public programs service one-third of U.S. populations. Any comprehensive reform must ensure the viability of these programs.

I thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. PALLONE. Thank you, Chairman Dingell.

Next is our ranking member of the full committee, Mr. Barton.

**OPENING STATEMENT OF HON. JOE BARTON, A  
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BARTON. Thank you, Mr. Chairman. I appreciate you holding this hearing on issues related to improving access to care.



This is the third hearing, and as the witnesses will testify, improving access to health care involves many issues such as getting more people into the provider workforce, the role of public health programs and perceived health disparities. I am particularly interested in hearing about the role of medical liability reform as it relates to health care access, also about the role physicians can play to increase access points in their communities.

The current medical liability system in the United States affects the ability of patients to receive care when they need it. It is well documented that doctors are scaling back the care they provide or abandoning their practice altogether to avoid being sued. When you don't have providers, that can mean the difference between life and death for those patients who don't have a doctor.

My home State of Texas is a perfect example of how medical liability reform improves people's health care. In 2003, Texas voters approved a constitutional amendment that included a limit on non-economic damages while continuing to allow injured parties to be fully compensated for economic damages. Prior to that reform, skyrocketing insurance premiums were forcing doctors to flee the State, quit medicine or cut back on complex, lifesaving procedures. At the height of the crisis, Texas ranked 48th out of the 50 States in per capita physicians. In the years since the reform was passed, Texas has been transformed from a State in turmoil to a model. Doctors are coming back to Texas, patients are getting better care. More doctors mean improved access, especially for those Texans that are living in poor and medically underserved areas. I would urge this committee, Mr. Chairman, to take a serious look at liability reform as we move into the overall issue of health care reform.

I also believe that we should look at what is working in communities across this country to increase access to care. Last year we heard from a doctor in Louisiana whose community was ravaged by Hurricane Katrina. Hospitals were closed and residents were without access to needed medical services. Physicians in that community came together to run a physician-owned hospital that provided the quality of medical care the residents so sorely need. Now, I know it is not the popular conventional wisdom to suggest that people helping their community can make a difference without the bureaucrats in Washington telling them what to do but it is true. Who knows what happens when communities actually work together themselves and don't look to Washington for the solution. It is certainly not the Washington elite who have all the answers. We should applaud the people who have stepped up to the plate and expanded access to quality medicine in their own neighborhoods. This committee has a long history of being involved in the issue of physician-owned hospitals. These facilities have consistently demonstrated that they provide high-quality care for patients and achieve high patient satisfaction. Patients like receiving their care at these facilities. Physicians and nurses like working at these facilities and these facilities continue to top the charts in terms of health care quality. You don't have to take my word for it. Visit any physician-run hospital and you can see for yourself. I would extend an open invitation to anybody on this committee to come to my district and visit a number of physician-owned hospital facilities in my district if they don't have them in their own district.

When physicians have a stake in the system, they raise the standard of quality care to a level that patients then expect and demand from all providers. As we discuss access to care today, we need to keep this in mind. We should be expanding the number of providers, not limiting the number of providers.

Again, I appreciate you, Mr. Chairman, for holding this hearing. I have a letter from a doctor-owned hospital in my district, USMD, dated yesterday to myself by the chairman of the board that I would like to submit for the record if we could get unanimous consent.

Mr. PALLONE. I am sorry. What is it that you want to submit?

Mr. BARTON. A letter from a physician-owned hospital in my district.

Mr. PALLONE. Without objection, so ordered.

[The information was unavailable at the time of printing.]

Mr. BARTON. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Barton.

Our full committee vice chair, Ms. DeGette.

**OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO**

Ms. DEGETTE. Thank you very much, Mr. Chairman. This is a very important hearing in health care access on all levels, and I am looking forward to hearing the testimony from our panel.

I wasn't going to talk about this but it appears to be in the talking points for my friends on the other side of the aisle so let me just mention that we did address the issue of medical malpractice reform and the concept of federalizing these traditionally State tort claims in the 109th Congress and we had a number of hearings in that Congress about this subject at which we took testimony, and frankly, there is absolutely no evidence that if we federalized these torts and we enacted caps on non-compensatory damages that that would help bring the cost of medical care down in any way.

I do think though that we need to address the issue of what is happening with doctors' insurance rates because doctors' insurance rates have consistently increased over the years, even in States like my State and Texas and other States where we have had caps on non-economic damages for some years, and I think we need to put all of this into the mix, but I think it is unfair to try to claim that we haven't addressed this, that we haven't looked at it or that medical malpractice rates are causing the terrible cost overruns that we have in our system.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentleman from Pennsylvania, Mr. Murphy.

**OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Mr. MURPHY of Pennsylvania. Thank you, Mr. Chairman, and thank you to all the doctors present here. We have enough to open up a sizable hospital, I guess. Who is minding the patients?

All of our concern is to improve access to care and I believe that has to include——

Mr. PALLONE. Is your microphone not working?

Mr. MURPHY of Pennsylvania. It was going off and on, sir. I don't know. Maybe someone on that side of the aisle is——

Mr. PALLONE. All right.

Mr. MURPHY of Pennsylvania. But don't do that to me, because I agree. Hold the clock there too.

Mr. PALLONE. We will try it. Go ahead.

Mr. MURPHY of Pennsylvania. Thank you, Mr. Chairman.

I am concerned about some of the inefficiencies that we put into the system itself which drive providers away, such as why aren't doctors more willing to be Medicaid and Medicare providers? Why are the rules we set forth a problem? Why does a person diagnosed with multiple sclerosis have to wait 2 years before they can be given medication? Why don't we pay for disease management of a diabetic but are willing to pay to have their legs amputated when they have complications? Why won't we pay an oncologist to do lab work on the day of chemotherapy if they are trying to determine if a patient can have the chemotherapy? There are so many questions that we have in this area that I think are barriers to access and I am hoping as part of the testimony we hear it will include how we can improve the health system the government runs through the Medicare, Medicaid and VA systems and learn to take down the barriers that stand in the way of access to care.

Thank you very much.

Mr. PALLONE. The gentlewoman from California, Ms. Capps.

**OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. CAPPS. Thank you, Mr. Pallone, and thank you to each of our witnesses today. We have a stellar panel here and thank you for coming.

This hearing is really central to our debate on how we are going to improve health care. If we can improve the way we care for the most marginalized in our society, then we can certainly improve the way we care for everyone. One of the barriers to access today is a lack of health professionals: nurses, physicians, dentists, a whole array of them. And contrary to what some of our colleagues on the other side have said about everyone supposedly being able to obtain health care at the emergency room, there aren't even enough health professionals to staff many emergency rooms 24/7 and 7 days a week. So as we talk about ways to improve access for everyone, let us talk about what else we can be doing to educate more health professionals and get them into the areas where they are needed most.

I look forward to the testimony. I yield back.

Mr. PALLONE. Thank you.

The gentleman from Michigan, Mr. Rogers.

**OPENING STATEMENT OF HON. MIKE ROGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN**

Mr. ROGERS. Thank you, Mr. Chairman, and thanks to the panelists.

Like you, I believe we must take action to provide more Americans with access to affordable, high-quality health insurance, but the details on how we get there are important. About 15 percent of Americans go without health insurance for some period of time every year. At the same time, 85 percent of Americans have health insurance, and for many of this 85 percent they have good coverage that provides for their families' needs. We must focus on the 15 percent. Who are they? How can we ensure that they have access to affordable insurance? In reality, a large portion of this group is young and goes without insurance by choice. A large part of this group is already eligible for government programs but not signed up. How should we address these issues?

In finding solutions to address the 15 percent problem, we must be careful not to destroy a system that does work for tens of millions of Americans. I am concerned that some proposals addressed today would do just that. Forcing millions of Americans who already have health insurance to accept fewer benefits, reduced access and higher costs is hardly a solution. I believe we can find solutions to provide universal access to health care, lower costs and better quality for all Americans. I believe we can strengthen critical safety net programs like Medicaid, Medicare and SCHIP but we must work together to achieve this goal.

Mr. Chairman, I look forward to working with you and the members of this committee on this important issue, and I yield back the remainder of my time.

Mr. PALLONE. Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

**OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN**

Ms. BALDWIN. Thank you, Mr. Chairman. It is notable that we are holding this hearing on ensuring access to care during Cover the Uninsured Week.

We are discussing two issues today that are very close to my heart, health disparities and primary care workforce shortages. On health disparities, the level of inequality in our health care system is a shocking injustice. Thanks to several of my colleagues, we have recently focused greater attention on racial and ethnic health disparities. I also want to draw attention to the fact that the lesbian, gay, bisexual and transgender community also experience significant health disparities. Most well known as an issue, of course, is HIV/AIDS but the LGBT community experiences other health care disparities as well. We are far less likely to have health insurance compared to our straight counterparts. LGBTQ youth are up to four times more likely to attempt suicide than their heterosexual peers and we also know that many delay care due to fear of discrimination, leading to higher mortality rates from heart disease and cancer. To address these disparities, I am developing legislation that I will offer later this year.

Let me quickly also express my strong concern about our existing and looming primary care shortages. To address one small aspect of this problem, I offer bipartisan legislation that would provide reimbursement for the costs of graduate degrees in nursing in exchange for a commitment to teach nursing for at least 4 years.

Without the worry of educational debt, nurses will be able to devote time to training the next generation of the frontline primary care workforce.

Thank you again, Mr. Chairman, and thank you to our witnesses today.

Mr. PALLONE. Thank you.

The gentleman from Kentucky, Mr. Whitfield.

**OPENING STATEMENT OF HON. ED WHITFIELD, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY**

Mr. WHITFIELD. Thank you, Mr. Chairman, and I want to thank the panel and particularly for listening to all of us this morning, and we have heard a lot of discussion today about liability insurance and whatever needs to be done to correct that problem, we may have differences of opinion about it but I think it is imperative that we focus on the fact that there is a problem.

Members of the Kentucky Medical Association left my office just a few days ago and they referred to the study in Massachusetts that showed that 83 percent of doctors practiced defensive medicine and almost 28 percent of the tests, procedures, referrals and consultations were ordered to avoid lawsuits. And then almost half of America's medical students in their third or fourth year of medical school have indicated the liability crisis was a factor in their choice of specialty, threatening America's future access to high-risk medical services such as a surgery and other specialties, so I think it is something we must focus on as we move forward on health care reform. Thank you.

Mr. PALLONE. Thank you.

The gentlewoman from the Virgin Islands, Ms. Christensen.

**OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS**

Ms. CHRISTENSEN. Thank you, Chairman Pallone, and thank you again for this series of hearings that continue to inform and guide us as we prepare to reform health care this year.

Today we are looking at access and several barriers to it. It is important to understand that while providing coverage is the linchpin of reform, it is not the only thing that must get done to ensure access. We must have more and more diverse providers at all levels. We need to stop the way malpractice is increasing costs and forcing doctors out of practice, and as you will always hear from me, we must eliminate disparities and ensure that the system we create assures equal access to quality care for every America.

I want to thank the panelists for the work that they have been doing to show us the way forward, and I look forward to your testimonies. I yield back.

Mr. PALLONE. Thank you.

The gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Thank you, Mr. Chairman. Before I waive my opening remarks, I want to ask unanimous consent to submit for the record a letter, Mr. Chairman, from the Georgia Mutual Insurance Company to the Medical Association of Georgia on the question of is tort reform working in the State of Georgia; the response,

most definitely. I ask unanimous consent to submit this letter for the record.

Mr. PALLONE. Thank you. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. If all of you could give me these letters so we can take a look at them, I would appreciate it, because I know I am always concerned that we are going to have too much for the record, but I think you only had a few in each case.

Mr. DEAL. Mr. Chairman.

Mr. PALLONE. Yes, Mr. Deal.

Mr. DEAL. In that regard, I would ask unanimous consent to include in the record the American Medical Association two-page statement on medical liability reform and also a two-page letter from Richard Scott on behalf of Conservatives for Patients' Rights. I would ask unanimous consent to include those in the record.

Mr. PALLONE. Without objection, so ordered. Thank you.

[The information was unavailable at the time of printing.]

Mr. PALLONE. Next is the gentlewoman from Florida, Ms. Castor.

**OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA**

Ms. CASTOR. Thank you, Mr. Chairman. First I want to say to the witnesses, I thought your written testimony was outstanding and very, very helpful as we proceed on our health care reform effort. I believe it shows that a consensus is building that broad-based, basic primary care reform, those simple visits to the doctors' offices and clinics will be central to providing affordable access to health care for all American families.

Dr. Mullan, your workforce analysis was particularly terrific, I thought, and your recommendations to improve primary care professionals very helpful along with Dr. Harris's recommendations for a national health care workforce policy. Thank you for highlighting the arbitrary and outdated caps on physician resident slots that is really harming high-growth States like mine, the State of Florida. You also had constructive recommendations on the primary care pipeline. I want to thank your organization for endorsing my bill, the Primary Care Incentive Act, that provides that tuition reimbursement for folks that go and work in community health centers and clinics and devote a number of years of community service. Dr. Lavizzo-Mourey, you also had some very creative solutions, also picked up on a lot of the workforce issues that Congresswoman Capps has taken the lead on in nursing, physician assistants, and I appreciate that. Dr. Smedley, your analysis and statistics were very eye-opening and just demonstrated how health care is really our civil rights struggle for our time. Thank you.

Mr. PALLONE. Thank you.

The gentlewoman from North Carolina, Ms. Myrick, who waives.

Mr. PALLONE. The gentleman from Connecticut, Mr. Murphy.

**OPENING STATEMENT OF HON. CHRISTOPHER S. MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT**

Mr. MURPHY of Connecticut. Thank you very much, Mr. Chairman. We are going to talk a lot over the course of the next few

months about making sure that people have insurance but I know today we are going to spend time on what should be our second priority, making sure that people that have insurance actually have access to care, and I would like to just share one particularly important story from Connecticut.

Last year in Tolland, Connecticut, in eastern Connecticut, about 190 dentists got together and decided to provide free care over the course of 2 days. The night before that clinic began, there were dramatic, torrential thunderstorms. Through the night, dozens of people lined up soaking overnight waiting for care the next morning, and their individual stories, which numbered 700 by the time that clinic was done, are shocking but unfortunately too common. There was a mother whose children insured through our State's SCHIP program, HUSKY, had been waiting 8 months to see a dentist for immediate care. There was a single woman who worked two jobs, had insurance but whose deductibles were so high she couldn't afford to see a dentist. And there were the unemployed workers there on COBRA whose employers never offered dental coverage in the first place.

This is just one story not original to Connecticut but they do illuminate a point. Just because you have health insurance doesn't mean that you get to see a doctor, doesn't mean you get to see a dentist. Health insurance without real access is little better than no insurance at all.

I thank the panel for being here and I look forward to your testimony today.

Mr. PALLONE. Thank you.

The gentleman from Ohio, Mr. Space.

**OPENING STATEMENT OF HON. ZACHARY T. SPACE, A  
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Mr. SPACE. Thank you, Mr. Chairman, for holding this important hearing, and specifically as it relates to rural health care disparities.

I had a chance to review some of the testimony for today and I couldn't help but be struck by some of the statistics highlight by Dr. Kitchell from Iowa in his testimony. Twenty percent of the Nation's population resides in rural areas yet 9 percent of our Nation's physicians reside in rural areas. Rural physicians see up to 30 percent more patients per physician. The cost of running a rural physician's practice is considerably higher than running an urban or suburban city physician practice, and the rural physicians' expenses, despite being greater, their Medicare reimbursements are far less. It is no wonder that some of the counties that I represent have one or two practicing physicians serving the entire county, requiring many of my constituents to drive long distances for basic care and that doesn't even cover the specialists. While the primary care focus is one that we need to be concerned with, it applies to other realms in the health care delivery field as well. Home health nurses, medical assistants and other professionals are in short supply.

One of the critical elements of this issue is the impact that it will have on our economy. Developing and training a workforce to meet the needs that are glaring in rural American right now will not

only enhance access to quality health care, it will provide an important avenue for economic opportunity in an area of the country that desperately needs it, so I would like to thank those who have come before the committee this morning and look forward to hearing all your testimony.

Mr. PALLONE. Thank you.

The gentleman from Iowa, Mr. Braley.

**OPENING STATEMENT OF HON. BRUCE L. BRALEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA**

Mr. BRALEY. Thank you, Chairman Pallone. I have been looking forward to this hearing because access to care is a primary care of mine and a primary concern of health care providers in Iowa and their patients.

Our current system has built-in equities which result in a lack of access to care for residents in many rural States like Iowa, as my colleague from Ohio has just pointed out. A glaring example of this is the Geographic Practice Cost Indexes, or GPCIs. These antiquated formulas ensure that some parts of the country receive drastically lower Medicare reimbursement rates than other parts and that has led to a critical shortage of doctors in some parts of our country. Despite the well-documented efficiency and quality of Iowa's health care system, Iowa health care providers still lose millions of dollars because they choose to care for Medicare patients. There is already a physician shortage in areas of Iowa and the existence of the GPCIs is a strong disincentive to those who often need it most, Medicare patients.

Last Congress I introduced the Medicare Equity and Accessibility Act, which addresses the GPCI problems. I am going to continue fighting for a solution to the GPCIs but in fact this is only a Band-Aid for a broader problem of disparity of care in rural areas. I look forward to hearing more about access to care in rural areas in today's hearing.

I also want to welcome my friend, Dr. Michael Kitchell, to the witness panel today. Dr. Kitchell is currently the president-elect of the Iowa Medical Society and someone I rely upon for sound advice on health care policy issues. He is also an expert on policies surrounding rural health care and I want to welcome him and look forward to his testimony. Thank you.

Mr. PALLONE. Thank you.

The gentlewoman from California, Ms. Harman.

**OPENING STATEMENT OF HON. JANE HARMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. HARMAN. Thank you, Mr. Chairman. There is obviously enormous expertise on the panel but there is expertise on this subcommittee too and I surely hope we will pull together and craft an excellent bill that addresses this important subject of access.

Access is tough for the insured and uninsured, especially in California where low reimbursement for Medicaid is pushing more and more doctors out of the program. In my district, we are lucky to have places like the Venice Family Clinic that provide free quality health care to low-income minority population that lacks private coverage. Eighty-one percent of the patients seen at the clinic are



minorities so the clinic places an emphasis on volunteer translator recruitment and medical tutorial programs. Remarkable volunteers are the arteries that keep the clinic going. My late father, a physician, devoted his time and passion to serving three generations of patients, like father, like daughter, and as a former VFC board member, I am a huge supporter of their work. As the Nation's largest free clinic, 24,000 patients last year, this is the only place for most of its patients to access care, helping them to avoid emergency room visits and other serious consequences. Unfortunately, many places in the country don't have Venice Family Clinics and that is a model that we should try to include as we draft the access part of the bill.

Thank you, Mr. Chairman.

Mr. PALLONE. The gentleman from Georgia, Mr. Barrow.

**OPENING STATEMENT OF HON. JOHN BARROW, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA**

Mr. BARROW. Thank you, Mr. Chairman.

When we talk about access to health care, we are talking about different things to different folks. In rural parts of the country, the problem is physical access. You got specialist doctors and nurses that don't want to practice in rural areas but you also have groups who live in those areas who are slower to seek care in the first place. You have a combination of an underserved community of high-risk patients. That is a bad combination. On the other hand, you have access problems that are financial in nature and we have different programs to try to make health care available to different groups of folks. We have Medicaid for the poor, we have Medicare for the elderly. We have programs like SCHIP for the kids and folks who make too much to qualify for Medicaid but not enough to get insurance on their own.

There is another group that is underserved for whom the cost of health care isn't altogether out of reach but it is just out of reach, and as a result it might as well be altogether unavailable and that is folks who can't afford to pay the price differential that the insurance industry charges them because of the size of the groups to lump them into. If you are in a smaller group, it costs you more to get that same health care package of benefits than it does for folks who are members of larger groups. The legislation I introduced in the last Congress, the SHOP Act, the Small Business Health Option Program Act, addresses this price disparity in ways that I think will make health insurance available to more folks who can afford to kick in for the cost of care they are drawing out rather than drawing out care at the emergency room without kicking in at all, so I hope we can explore ways and means of making health care more affordable for folks just by eliminating the price differential that folks have to pay for the same benefits package.

Thank you, Mr. Chairman. I yield back.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Gonzalez.

Mr. GONZALEZ. Waive opening. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

I think we have covered everybody here for opening statements, so we will now go to our panel. I know you have been waiting pa-

tiently and we appreciate that. I want to welcome everyone, and let me introduce you starting on my left here, and they are all doctors, every one. Dr. Brian Smedley, who is vice president and director of the Health Policy Institute, the Joint Center for Political and Economic Studies; Dr. Michael John Kitchell, who is president-elect of the Iowa Medical Society, the McFarland Clinic; Dr. Michael Sitorius, professor and chairman of the Department of Family Medicine at the University of Nebraska Medical Center; and from my home State of New Jersey, welcome, Dr. Lavizzo-Mourey, who is president and CEO of the Robert Wood Johnson Foundation. And then we have Dr. Fitzhugh Mullan, Murdock head professor of medicine and health policy and professor of pediatrics at the George Washington University; Dr. Jeffrey Harris, president of the American College of Physicians; Dr. James Bean, who is president of the American Association of Neurological Surgeons; and Dr. Diane Rowland, who is executive director of the Kaiser Commission on Medicaid and the Uninsured. Now, I am told that you don't actually have a timer down there so you won't know when the 5 minutes are up. The only thing more dangerous is when we don't have timers up here. But please try to stick to the 5 minutes if you can and of course the statements become part of the record, and we will start with Dr. Smedley.

**STATEMENTS OF BRIAN D. SMEDLEY, PH.D., VICE PRESIDENT AND DIRECTOR, HEALTH POLICY INSTITUTE, JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES; MICHAEL JOHN KITCHELL, M.D., PRESIDENT-ELECT OF IOWA MEDICAL SOCIETY, MCFARLAND CLINIC PC; MICHAEL A. SITORIUS, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF NEBRASKA MEDICAL CENTER; RISA LAVIZZO-MOUREY, M.D., M.B.A., PRESIDENT AND CEO, ROBERT WOOD JOHNSON FOUNDATION; FITZHUGH MULLAN, M.D., MURDOCK HEAD PROFESSOR OF MEDICINE AND HEALTH POLICY, PROFESSOR OF PEDIATRICS, THE GEORGE WASHINGTON UNIVERSITY; JEFFREY P. HARRIS, M.D., F.A.C.P., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS; JAMES R. BEAN, M.D., PRESIDENT, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS; AND DIANE ROWLAND, SC.D., EXECUTIVE DIRECTOR, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED**

**STATEMENT OF BRIAN D. SMEDLEY**

Mr. SMEDLEY. Thank you, Mr. Chairman. I appreciate the opportunity to provide testimony on racial and ethnic disparities and health care access and quality.

For nearly 40 years, the Joint Center for Political and Economic Studies has served as one of the Nation's premier think tanks on a broad range of public policy concerns for African-Americans and other communities of color. We therefore welcome the opportunity to comment on strategies for addressing health care disparities.

As the committee has pointed out, health care disparities are differences in access to and the quality of health care experienced by racial and ethnic minorities, immigrants, those who aren't proficient in English, those who live in rural communities and many others relative to more advantaged groups. Left unaddressed, these

disparities have the potential to unravel even the best efforts to contain health care costs and improve the overall quality of care. In addition, their persistence leaves U.S. health care systems poorly prepared to address the needs of some of the fastest growing segments of the population.

This morning I would like to briefly examine the causes and consequences of racial and ethnic health care disparities and offer some policy strategies for their elimination. As I hope to illustrate, these disparities are unjust and avoidable. I will therefore refer to them as inequities throughout the remainder of my testimony.

Health care inequities are not new. They are a persistent relic of segregation and historically inadequate health care for communities of color. Like access to other opportunities, health care for minorities suffered from government inattention for over 100 years after the end of the Civil War. Even less than 45 years ago, minorities routinely received inequitable care in segregated settings if care was received at all. Today health care is much more broadly available but the contemporary context remains shaped by this history.

I want to note at the outset that while health care access and quality disparities are unacceptable, they are not the most important factors that contribute to the widely divergent health status of America's racial and ethnic groups. Some groups, particularly African-Americans, American Indians and Alaska Natives and Native Hawaiians and Pacific Islands experience poor health relative to national averages from birth to death in the form of higher infant mortality, higher rates of disease and disability and shortened life expectancies. The large and growing body of public health research demonstrates that to address these problems, we must improve the social and economic contexts that shape health. As the World Health Organization's report on social determinates of health states, inequities in health and avoidable health inequalities arise because of the circumstances in which people grow, live, work and age and the systems put in place to deal with illness.

It is clear that many Americans, disproportionately racial and ethnic minorities, face health care access and quality inequities. Some of these inequities can be explained by socioeconomic factors while others cannot. The National Healthcare Disparities Report, which is prepared and released annually by the Agency for Health Care Research and Quality, has found that African-Americans, Hispanics, American Indians and Alaska Natives fare worse than whites on a preponderance of measures of health care access and quality. For example, the report finds that minorities are less likely to receive even routine evidence-based procedures and experience greater communication barriers.

Now, the NHDR provides a window to the health care experiences of a diverse patient population but it does not disentangle the influences of race, income and insurance on health care. A substantial body of evidence, as has been pointed out, demonstrates that racial and ethnic minorities receive a lower quality and intensity of health care than white patients even when they are insured at the same levels and present with the same types of health problems. Many factors contribute to these inequities and these often interact in complex ways. I would like to focus on an important un-

derlying factor in health care inequality and that is residential segregation. Racial and ethnic minorities are more likely than whites to live in segregated, high-poverty communities, communities that have historically suffered from a lack of health care investment. Institutions that serve communities of color are more likely to experience quality problems and have fewer resources for patient care than institutions serving non-minority communities. Just as an example, a recent study of African-American and white Medicare patients found that the risk of admission to high-mortality hospitals was 35 percent higher for blacks than for whites in communities with high levels of residential segregation. Racial and ethnic segregation and inequality therefore set the stage for inequitable health care in the United States.

To solve these problems, we must prioritize and invest in improving the health of communities that suffer from health care inequities. To make the largest gains, we should improve social and economic conditions for health. For example, the federal government should enforce provisions to address environmental justice in minority and low-income communities and should establish health empowerment zones in communities that disproportionately experience disparities in health status and health care. To improve health care access and quality for communities of color, the federal government should improve access to health care providers, as many on the committee have pointed out. We need to make special efforts to ensure that health care resources are better aligned with these communities' needs. We can do so by increasing the diversity of our health professional providers, supporting safety-net institutions, providing incentives for providers to serve in underserved communities, and addressing the geographic imbalance of health care resources like community health centers. We can also promote equal high-quality access to care by collecting and monitoring data on disparities and publicly reporting these data. We can also encourage the adoption of cultural and linguistic standards and encourage attention to disparities in quality improvement initiatives.

Mr. Chairman, my time is short and these are but a few of the many ideas that will be put forward today, and we look forward to working with you as you craft legislation to address these issues.

[The prepared statement of Mr. Smedley follows:]

# Addressing Racial and Ethnic Health Care Disparities

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Testimony to the House Energy and  
Commerce Committee, Health Subcommittee

**Brian D. Smedley, Ph.D.**  
Health Policy Institute  
Joint Center for Political and Economic Studies

March 24, 2009

### **Addressing Racial and Ethnic Health Care Disparities: A Multi-Level Approach**

Brian D. Smedley, Ph.D.  
Director, Joint Center Health Policy Institute

Thank you, Mr. Chairman, for the opportunity to provide testimony on racial and ethnic disparities in healthcare access and quality. For nearly forty years, the Joint Center has served as one of the nation's premier think tanks on a broad range of public policy issues of concern to African Americans and other communities of color. We therefore welcome the opportunity comment on prospects for addressing health care disparities in the context of health reform legislation to be considered by Congress.

Health care disparities are differences in access to and the quality of health care experienced by racial and ethnic minorities, immigrants, those who aren't proficient in English, and others, relative to more advantaged groups. Left unaddressed, these disparities have the potential to unravel even the best efforts to contain health care costs and improve the overall quality of care. In addition, their persistence leaves U.S. health care systems poorly prepared to address the needs of some of the fastest-growing segments of the population. This testimony will examine the causes and consequences of health care disparities, and offer a policy framework for their elimination.

#### **Health Care Disparities: The U.S. Context**

Health care disparities are not new—they are a persistent relic of segregation and inadequate health care for communities of color. Like access to other opportunities, health care for minorities suffered from government inattention (and in some cases, explicit blessing of inequality) for over 100 years after the end of the Civil War. Even less than 40 years ago, minorities routinely received inequitable care in segregated settings, if care was received at all.<sup>1</sup> The nation's nascent civil rights laws had yet to make a significant dent in practices such as medical redlining and de facto segregation of health care facilities. Today, these problems are largely ameliorated, but the contemporary health care context remains shaped by this history. This section reviews evidence that disparities in health care persist. The next section attempts to disentangle the effects of race, place, and insurance status in contributing to health care disparities.

Access to high-quality health care is particularly important for communities of color because deep health status gaps persist among U.S. racial and ethnic groups. While the nation has made progress in lengthening and improving the quality of life, racial and ethnic health disparities begin early in the life span and exact a significant human and economic toll. For example:

- The prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States;<sup>2</sup>
- Among African Americans, the age-adjusted death rate for cancer is approximately 25 percent higher than for White Americans;<sup>3</sup>

- Although infant mortality decreased among all races during the 1980-2000 time period, the Black-White gap in infant mortality widened;<sup>4</sup>
- While the life expectancy gap between the African Americans and whites has narrowed slightly,<sup>5</sup> African Americans still can expect to live 6-10 fewer years than whites, and face higher rates of illness and mortality.<sup>6</sup>

In terms of lives, this gap is staggering: A recent analysis of 1991 to 2000 mortality data concluded that had mortality rates of African Americans been equivalent to that of whites in this time period, over 880,000 deaths would have been averted.<sup>7</sup>

Despite these health gaps, communities of color experience significant disparities relative to whites in both access to care and in the quality of care received. The National Healthcare Disparities Report (NHDR), prepared and released annually by the U.S. Agency for Healthcare Research and Quality, is an authoritative source for the documentation of access and quality gaps. Summarizing a range of measures of health care access, the report found that access for some groups, such as African Americans and American Indians, was worse than for whites in the preponderance of the study's measures. Latinos experienced the greatest access problems of all ethnic groups; they received equivalent care as whites in only 17% of the measures, while the remaining access measures were overwhelmingly poorer for Latinos (83%).<sup>8</sup> With regard to health care quality, minority groups again fared poorly relative to whites: African Americans and Latinos receive poorer quality care than whites on 73% and 77% of measures, respectively, and Asian Americans and American Indians received poorer care on 32% and 41% of measures, respectively. These growing access and quality gaps are not trivial. For example, from 1999 to 2004 the proportion of adults age 65 and over who received a pneumonia vaccine increased for Whites (from 52% to 59%) but decreased for Asians (from 41% to 35%), and from 2000 to 2003 colorectal cancer screening rates increased for whites while falling off sharply for American Indians and Alaska Natives.<sup>9</sup> These growing gaps are not unexpected given that the increase in the numbers of the uninsured has been more dramatic in communities of color than in non-minority communities.

The NHDR provides a window in to the health care experiences of a diverse patient population, but it does not disentangle the influences of race, income, and insurance on health care. A substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of health care than white patients, even when they are insured at the same levels, have similar incomes, and present with the same types of health problems.<sup>10</sup> Below are a few examples from the research literature:

- Insured African-American patients are less likely than insured whites to receive many potentially life-saving or life-extending procedures, particularly high-tech care, such as cardiac catheterization, bypass graft surgery,<sup>11</sup> or kidney transplantation.<sup>12</sup>
- Black cancer patients fail to get the same combinations of surgical and chemotherapy treatments that white patients with the same disease presentation receive.<sup>13</sup>
- African-American heart patients are less likely than white patients to receive diagnostic procedures, revascularization procedures, and thrombolytic therapy,

even when they have similar incomes, insurance, and other patient characteristics.<sup>14</sup>

- Even routine care suffers. Black and Latino patients are less likely than whites to receive aspirin upon discharge following a heart attack, to receive appropriate care for pneumonia, and to have pain – such as the kind resulting from broken bones – appropriately treated.<sup>15</sup>
- Minorities are more likely to receive undesirable treatment than whites, such as limb amputation for diabetes.<sup>16</sup>

Of these health care disparities, inequality in long-term care services is among the most troubling. Population trends show that people of color are the fastest-growing segments of the U.S. population. Racial and ethnic minorities are also burdened with a higher prevalence of chronic diseases. These realities require long-term care policies and funding streams that address the needs of minority patients, their families, and their communities.<sup>17</sup> Yet people of color requiring long-term care are less likely to be treated in such a system. Despite the increasing supply of nursing home beds and the emergence of assisted living facilities, African Americans are less likely than similarly-situated whites to be placed in a nursing home.<sup>18</sup> Studies also show that nursing home care remains largely separate and unequal. Most African American nursing home residents tended to be concentrated in a few predominantly African American facilities, whereas the vast majority of White nursing home residents live in predominantly White facilities. Facilities housing African Americans tend to admit individuals with mental retardation and difficulty in ambulating, and to have lower ratings of cleanliness/maintenance and lighting.<sup>19</sup> The nearly 15 percent of U.S. nursing homes that serve predominantly African American residents have fewer nurses, lower occupancy rates, and more health-related deficiencies. They are more likely to be terminated from the Medicaid/Medicare program, are disproportionately located in the poorest counties, and are more likely to serve Medicaid patients than are other facilities.<sup>20</sup> Other studies document a strong relationship between nursing home or long-term care facility racial concentration and quality. For example, controlling for individual, facility, and market characteristics, blacks were found to be admitted to nursing homes with 32% higher rates of deficiency (defined as evaluations of poor quality made by state surveyors under the federal nursing home certification regulation).<sup>21</sup>

### **What Are the Factors that Contribute to Health Care Disparities?**

Many of the same problems associated with racial and ethnic inequality in education, employment, housing, and criminal justice are implicated in health care disparities. One of the most pressing fundamental causes of these disparities is residential segregation. Racial and ethnic minorities are more likely to live in segregated, high-poverty communities, communities that have historically suffered from a lack of health care investment. The result too often is that the geographic distribution of health care resources within and across communities results in racially disparate health care: institutions that serve communities of color are more likely to experience quality problems and have fewer resources for patient care than institutions serving non-minority communities.



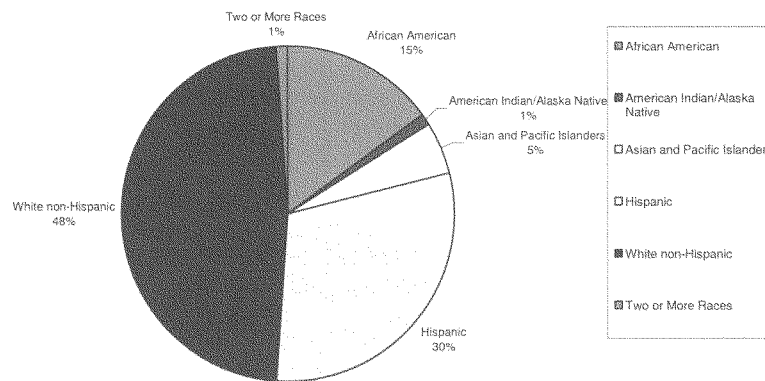
Racial and ethnic segregation and inequality therefore “sets the stage” for inequitable health care in the United States. But many other causal factors – such as policies and practices of health care systems, the legal and regulatory context in which they operate, and the behavior of people who work in them – are also involved.<sup>22</sup> Some of these causal factors include 1) differences in insurance coverage and sources of coverage, 2) the inequitable distribution of health care resources, and 3) aspects of the clinical encounter, including cultural and linguistic barriers in health care systems and the interaction of patients and providers. These examples are explored in greater detail below.

#### **Sources of Insurance Coverage**

In its landmark series on the causes and consequences of uninsurance, the Institute of Medicine concluded that the availability and quality of health care in the United States suffers when large segments of the population lack health insurance.<sup>23</sup> Racial and ethnic minority and immigrant communities are disproportionately uninsured (see Figure 1), making them especially vulnerable to health crises.<sup>24</sup> For example:

- While about 21 percent of white Americans were uninsured at any point in 2002, communities of color were more likely to be uninsured at any point (including 28 percent of African Americans, 44 percent of Hispanic Americans, 24 percent of Asian Americans and Pacific Islanders, and 33 percent of American Indians and Alaska Natives), and are more likely to be dependant upon public sources of health insurance.<sup>25</sup>
- While Hispanic children constitute less than one-fifth of children in the United States, they represent over one-third of uninsured children.<sup>26</sup> And among children in fair or poor health who lack insurance (nearly 570,000 children in 2002), over two-thirds are Hispanic.<sup>27</sup>
- More than 11 million immigrants were uninsured in 2003, contributing to one-quarter of the U.S. uninsured.<sup>28</sup> Between 1998 and 2003 immigrants accounted for 86 percent of the growth in the uninsured population.<sup>29</sup>
- Foreign-born people are 2.5 times more likely than the native-born to lack health insurance, a gap that remains unchanged since 1993.<sup>30</sup>

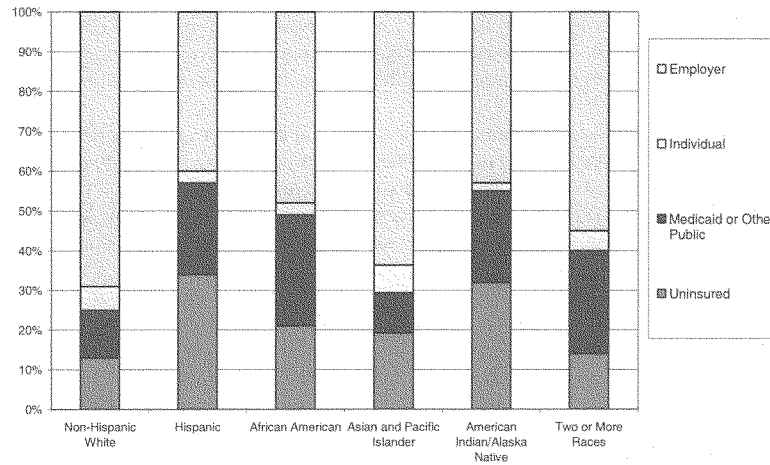
**Figure 1: Nonelderly Uninsured by Race/Ethnicity, 2005**  
Source: Kaiser Family Foundation, 2007



The crisis of health insurance disproportionately hurts low-income families and communities of color in no small part because health insurance in the United States remains linked to employment. Higher-paying jobs tend to offer more comprehensive health benefit packages, while lower-paying jobs – jobs disproportionately occupied by people of color – tend to offer only limited health benefits, if offered at all, that are often accompanied by high cost-sharing arrangements with employees. Moreover, as noted above, racial and ethnic minorities are disproportionately dependent on public insurance sources, such as Medicaid (see Figure 2). While Medicaid has been vital for expanding access to health insurance, its limited benefit package and low reimbursement rates have a dampening effect on health care access and quality among its beneficiaries.

**Figure 2: Health Insurance Coverage of the Nonelderly by Race/Ethnicity, 2005**

Source: Kaiser Family Foundation, 2007

**The Distribution of Health Care Resources**

These economic pressures can sustain a form of “medical apartheid”—that is, separate and unequal care for low-income and minority patients.<sup>31</sup> For example, physicians who serve predominantly racial and ethnic minority patients are less likely to possess board certification, and have greater difficulties accessing high-quality specialists, diagnostic imaging, and non-emergency admission of their patients to the hospital than physicians who serve predominantly non-minority patients.<sup>32</sup> A recent study over 300,000 patients treated at 123 hospitals across the country found that minorities were disproportionately likely to receive care in lower-quality hospitals, a problem that explained the largest share of disparities.<sup>33</sup> The geographic mal-distribution of services likely contributes to the problem. For example, a study of the availability of pain medication revealed that only one in four pharmacies located in predominantly non-white neighborhoods carried adequate supplies, compared to 72% of pharmacies in predominantly white neighborhoods.<sup>34</sup> Nearly one in five Latinas (18%) and one in ten African-American women reported not seeking needed health care in the last year due to transportation problems, compared to 5% of white women.<sup>35</sup> These problems are the by-product of residential segregation and economic pressures that reward the concentration of services in outer suburbs and wealthier communities, and create disincentives for practice in urban centers.<sup>36</sup>

**Regular Source of Health Care**

Having a regular source of health care – a local physician, clinic, or health center that patients can consider their “medical home” – is important, particularly for individuals who face or are at risk for chronic illness. When patients are able to see a health care

provider consistently, they are better able to build trusting relationships, ask questions, and give and receive information. Patients who lack a regular source of health care often report miscommunication, misdiagnoses, and greater frustration about their ability to receive needed care.<sup>37</sup> The uninsured and underinsured, many racial and ethnic minorities, people who are not proficient in English, those who live in rural communities, and those who have low incomes are more likely to report not having a regular source of health care.<sup>38</sup> Yet the regular-source-of-health-care gap among racial/ethnic and income groups is growing:

- African Americans, Hispanics, and the poor and near poor (of all racial and ethnic groups) are more likely than white non-poor groups to face barriers to having a regular source of health care. These gaps have increased since 2000. Over 42 percent of Hispanic poor and 37 percent of Hispanic non-poor people lacked a regular source of health care in 2001 and 2002, an increase of more than 30 percent and 18 percent, respectively, since 1995 and 1996.<sup>39</sup>
- During this same period, the percentage of poor and near-poor African Americans and whites without a regular source of health care went largely unchanged. But these groups were up to 75 percent more likely than non-poor African Americans and whites to lack a regular source of health care in 2001 and 2002.<sup>40</sup>
- The percentage of Hispanics from all income groups who lacked a regular source of health care increased between 1993 and 2002, despite a 15 percent decline over the same period in the ranks of white poor individuals who lacked a regular source of health care.<sup>41</sup>
- African American and Hispanic patients are nearly twice as likely as whites to report having a “non-mainstream” usual source of care (e.g., a hospital-based provider, rather than a private physician).<sup>42</sup>

### **Language Barriers**

More than 46 million people in the United States speak a language other than English. Of those, more than 35 million speak English “well” or “very well,” but over 10 million speak the language “not well” or “not at all.”<sup>43</sup> Individuals with limited English proficiency are less likely than those with strong English language skills to have a regular source of primary care or to receive preventive care. Moreover, they tend to be less satisfied with the care they receive, are more likely to report overall problems with care, and may be at increased risk of experiencing medical errors.<sup>44</sup> The quality of their health care therefore depends on the ability of medical professionals to effectively communicate. But many health care organizations do not provide adequate interpretation services:

- Nearly half of Latinos who are primary speakers of Spanish report having difficulty communicating with doctors or other health care providers because of language barriers.<sup>45</sup>
- Over one in five non-English speaking patients avoid seeking medical help altogether because of language barriers.<sup>46</sup>

### **The Clinical Encounter**

Aspects of the clinical encounter – the interaction between patients, their providers, and the health systems in which care is delivered – can play a powerful role in contributing to

health care inequality. Patients and providers bring a range of expectations, preferences, and biases to the clinical encounter that can be expressed both directly and indirectly. For example, at least part of the disparity results from biases and stereotypes that health care providers may carry about racial and ethnic minorities. Experimental studies confirm that physicians can hold a host of negative beliefs about minority patients. They are presumed to be more likely to abuse drugs or alcohol and to be less educated. They aren't expected to comply with physicians' instructions, to want an active lifestyle or to participate in rehabilitation if prescribed. Doctors are likely to consider white patients more "pleasant" and "rational" than Black patients, and to prefer white patients as "the kind of person I could see myself being friends with." These kinds of stereotypes and biases are often unconscious, the IOM reported, but nonetheless can influence physicians' decisions regarding when and what treatments to offer.<sup>47</sup>

More recent research confirms that implicit biases (that is, unconscious biases that may reflect racial socialization) influence medical professionals' decision-making. For example, Green and colleagues assessed the relationship between implicit biases (as measured by a widely-accepted computer-based test of the speed with which individuals make associations between people and concepts) and physicians' decisions regarding the use of thrombolysis (i.e., clot-busting medications) among hypothetical patients in the midst of a heart attack. While physicians reported no explicit preference for white versus black patients or differences in perceived cooperativeness, scores on implicit association tests revealed a preference favoring white Americans and implicit stereotypes of black Americans as less cooperative with medical procedures, and less cooperative generally. More importantly, physicians' level of pro-white implicit bias significantly predicted their likelihood of treating white patients and not treating black patients with thrombolysis. That is, physicians who harbored the highest level of implicit racial bias were less likely to treat black heart attack patients with a potentially life-saving treatment.<sup>48</sup>

Many of the problems identified above can be addressed by improving the racial and ethnic diversity of the health professional workforce.

### Eliminating Health Care Inequality

Health care disparities are a complex problem rooted in systemic racial and ethnic inequality and are embedded in multiple institutions. Their elimination will require a long-term commitment and investment to address multiple problems, involving many public and private stakeholders.

Table 1 presents a framework for policy steps that can be adopted by federal, state, and local governments to improve access to and equalize the quality of health care for all, with particular attention to the needs of communities of color. These include strategies to:

1. **Expand Access to Health Insurance.** The most important step toward eliminating racial and ethnic health care disparities is to achieve universal health

insurance coverage. Benefits should be comprehensive, and should include services that many communities of color need to access appropriate care, such as interpretation services.

2. **Improve Access to and the Diversity of Health Care Providers.** Even if the United States achieved universal health insurance coverage, because of residential segregation and the dearth of health care providers and resources in communities of color, special efforts must be made to ensure that health care resources are better aligned with these communities' needs.
3. **Promote Equal High Health Care Access and Quality.** As the studies noted above demonstrate, health insurance coverage by itself is insufficient to ensure that communities of color have access to and receive high quality health care. Several policies offer mechanisms to elevate and promote equitable care for all.
4. **Empower Patients and Communities.** To ensure that health care meets their needs, patients and communities should be empowered to participate in treatment decisions and to inform policies regarding the distribution of health care resources at the community level.

**Table 1. Achieving Health Care Equity: A Policy Framework**

<b>Expand Access to Health Insurance</b>	<b>Improve Access to Providers and Services</b>	<b>Promote Equal High Health Care Access and Quality</b>	<b>Empower Patients and Communities</b>
Strive for Universal Insurance Coverage	Increase Provider Diversity	Collect and Monitor Data on Disparities	Promote Patient Education and Health Literacy
Promote Fair Sharing of Costs	Support Safety Net Institutions	Publicly Report Data	Promote the Use of Lay Health Navigators
Promote Comprehensive Benefits	Provide Incentives to Providers for the Underserved	Adopt Cultural and Linguistic Standards	Promote Community-Based Health Care Planning
Target and Evaluate Outreach Efforts to Underserved	Address Geographic Imbalance of Health Care Resources	Encourage Attention to Disparities in Quality Improvement	Strengthen Community Benefits Obligations

### **Expand Access to Health Insurance**

High rates of uninsurance and underinsurance among for people of color are the foremost problems to solve to eliminate health care inequality. The United States is the last modern, industrialized nation to adopt a universal health care program. Health insurance coverage is primarily provided by employers, but as benefit costs rise employers are declining to offer coverage or are purchasing plans that require greater employer cost sharing. These economic pressures contribute to growing inequality in insurance coverage. Health insurance coverage is increasingly unequal, disproportionately hurting those who need health care the most—particularly racial and ethnic minorities, children,

and lower-income women and their families. For example, less than half of low-wage workers have employer-provided health insurance from their own employer or a family member's employer, and female low-wage workers are half as likely as male low-wage workers to receive health insurance from their employer.<sup>49</sup>

*Strive for Universal Insurance Coverage.* Health care access inequality must be tackled by state and federal efforts to develop a universally accessible, comprehensive, and equitable healthcare system. The most cost-effective way to achieve this goal is by pooling risk as broadly as possible in a common, comprehensive health insurance system—a national, single-payer health insurance plan. Such an approach allows patients to choose their health care provider, and insures that the delivery of care remains in public and private systems while allocating health care resources more fairly. For example, by allowing employers and individuals to buy into a public health insurance plan, policymakers can take significant steps toward improving health care efficiency and lowering costs. Medicare is more efficient than private plans because of its low administrative costs (about 2%, a figure seven times lower than most estimates of administrative costs in private health plans). And because Medicare is a federal program, subject to the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, ethnicity, language status, and other factors, it contains mechanisms of accountability that can be expanded and enhanced to ensure that any instances of discriminatory health care are thoroughly investigated and prosecuted.

*Promote Fair Sharing of Costs.* Many health care expansion proposals weigh new cost-sharing arrangements that are intended to make costs more transparent and promote cost-conscious consumer behavior. But several studies demonstrate that low-income communities are less likely to access health care as out-of-pocket costs rise.<sup>50</sup> Equitable cost-sharing takes into account and attempts to minimize the disproportionate impact that cost-sharing arrangements can have on health care access and utilization among currently underserved groups. These include public subsidies for those with low incomes to purchase health insurance, sliding fee scales for premiums, co-payments, and out-of-pocket costs, and efforts to study and respond to potential unintended effects of cost-sharing on utilization.

*Promote Comprehensive Benefits.* As noted above, many in communities of color require services such professional interpretation and translation. In addition, because these communities are less likely to access other needed services, such as dental and mental health services, comprehensive benefit packages should cover these services. Equalizing access to the same kinds of health care products and services regardless of insurance source will also help to reduce “fragmentation” of the health insurance market. A potentially significant source of racial and ethnic health care disparities among insured populations lies in the fact that minorities are likely to be disproportionately enrolled in “lower-tier” health insurance plans. Such plans tend to limit services, offer fewer covered benefits, and have relative small provider networks. These limits can harm access to quality care.<sup>51</sup> Given that several states are examining strategies to expand health insurance coverage, it is important that these coverage expansion proposals to

improve access to the same health care products and services, regardless of coverage source.

*Target and Evaluate Outreach Efforts to the Underserved.* Racial and ethnic minorities and immigrants are underrepresented, relative to eligibility rates, in public health insurance programs. States that have achieved greater success in increasing minority participation in public programs have developed and sustained aggressive outreach programs and have taken steps to improve and streamline enrollment, with particular attention to the needs of cultural and language-minority groups. Moreover, because state health insurance expansions may not reach communities of color equally, states should consistently evaluate outreach to and enrollment of underserved groups in public health insurance programs. Measurement of public insurance take-up rates in low-income communities and communities of color is an important step to ensure that health care expansion efforts reach underserved groups. States that regularly conduct such evaluations can be expected to see improved coverage rates among eligible populations.

#### **Improve Access to Health Care Providers and Services**

Universal health insurance coverage is an important step toward improving the geographic distribution of health care providers and resources, but federal, state and local governments must take steps to improve underserved patients' access to providers. Several jurisdictions have adopted strategies that improve community-level access to providers and services with particular attention to the needs of communities of color.

*Improve Provider Diversity.* State and federal governments must also take steps to strengthen the health professions' ability to serve the nation's increasingly diverse population. By the middle of this century, nearly half of all who live in the United States will be members of racial or ethnic minority groups, and four states – California, Hawaii, New Mexico, and Texas – are already "majority minority." Racial and ethnic minority patients are more likely than majority-group patients to experience cultural and linguistic barriers when attempting to get the health care they need, and often express greater satisfaction when they receive care from a provider of the same background.<sup>52</sup> In addition, several studies demonstrate that racial and ethnic minority health care providers are more likely to express interest in and work in medically underserved communities.<sup>53</sup> To help health care systems to address the needs of an increasingly diverse patient population, state and federal governments should take steps to increase the racial and ethnic diversity of health care providers by reducing or eliminating financial barriers to health professions education for low-income students, strengthening magnet science programs in urban high schools, and, consistent with the U.S. Supreme Court's ruling in the 2004 *Gutter v. Bollinger* decision, supporting the consideration of applicants' race or ethnicity as one of many relevant factors in higher education admissions decisions.

*Support Safety Net Institutions.* People of color and low-income individuals are more likely to access health care in safety net institutions, such as public hospitals and community health centers. In many cases, these institutions face financial vulnerability because of low Medicaid reimbursement rates and/or the costs of providing uncompensated care to uninsured individuals. These institutions may fare better in states



where near-universal health insurance coverage proposals are enacted and where health insurance expansions are realized, but they will likely to continue to face financial vulnerability until truly universal coverage is achieved. States vary widely, however, in their support for safety net institutions. California, for example, has assumed much of the cost of hospital indigent care, Maryland and Massachusetts have established statewide uncompensated care funds, but many other states fail to assist institutions that serve low-income and uninsured populations.

*Provide Incentives to Providers for the Underserved.* Creating and/or enhancing incentives – such as education loan repayment or debt forgiveness – to encourage health care professionals to establish practices in underserved communities can be an important strategy to balance the distribution of health care providers, particularly primary care providers. Low-income and minority communities often have the most pressing need for health care services, but they are served by a dwindling number of providers and institutions that lack resources to expand and improve services. State and federal governments have attempted to address this imbalance by providing incentives, such as funds for graduate medical education programs that focus on underserved populations, tuition reimbursement and loan forgiveness programs that require service in health professional shortage areas.<sup>54</sup>

*Address Geographic Imbalance of Health Care Resources.* State and local governments are increasingly returning to Certificate of Need (CoN) assessments as a tool to reduce geographic disparities and reduce the “fragmentation” of the health insurance market. Historically, the purpose of the CoN process has been to control health care costs and ensure that capital and technology investments in the health care industry reflect community needs. In most states that employ CoN, the process has required hospitals or other health care institutions that seek to establish or expand services to submit proposals so that state boards can evaluate projects to eliminate unnecessary duplication of services and ensure that investments strategically address health care needs. But the process has met significant resistance and criticism for its failure as a cost-containment measure. The CoN process, however, has great potential to encourage a better distribution of health care resources, reflect community and statewide need. States should re-evaluate, and in some cases reinvent CoN through new policies that ensure accountability for the use of public funds.<sup>55</sup>

### **Promote Equal High Health Care Access and Quality**

As the studies noted above demonstrate, universal health insurance coverage by itself is insufficient to ensure that communities of color have access to and receive high quality health care. Federal, state and local governments are increasingly examining mechanisms to promote “equality of health care quality.” These strategies have the potential to improve the accountability of health care systems to patients and employers, and reduce health care costs and improve quality for all patients by encouraging greater use of evidence-based guidelines and by rewarding the provision of cost-effective primary care.

*Collect and Monitor Data on Disparities.* State and federal contracts and policies are increasingly requiring all public and private health systems to collect data on patients' race, ethnicity, gender, primary language, and educational level, and to monitor for inequality in access to needed services and in the quality of care received. Currently, federal and state data collection efforts with regard to health care disparities are uneven. Some states require recipients of state funding (e.g., Medicaid managed care organizations) to collect and report health care access and quality data by patient demographic factors, but many others fail to utilize their leverage as regulators, payers, and plan purchasers to encourage all health systems to collect and report data using consistent standards. And given that federal and some states non-discrimination laws apply to health care settings and require diligence to enforce, federal and state requirements to collect and report standardized data are an important benchmark for efforts to reduce health care inequality.

*Publicly Report Data.* Publicly reporting health care access and quality disparities at the institutional (e.g., hospital or health clinic) level is important to ensure that the public and policymakers are aware of when and where health care inequality occurs. Once state and federal governments have obtained health care access and quality data by patient demographic data, this information should be publicly reported at the smallest possible level (e.g., hospitals and health centers), to promote greater public accountability, to allow consumers to make more informed decisions about where to seek care, and to assist efforts to monitor disparities and take appropriate action to investigate potential violations of law.

*Adopt Cultural and Linguistic Standards.* To ensure truly accessible health care, health care systems must also be responsive to patients' cultural and linguistic needs. State and federal policies can expand access for disparity populations by promoting cultural and linguistic competence in health care settings, and diversity among health care professionals. The federal Cultural and Linguistic Access Standards (CLAS) identify over a dozen benchmarks that have been widely accepted and increasingly adopted by health systems and providers. And despite the fact that federally-funded health care organizations are mandated to meet four of the standards, few states have taken steps to encourage more widespread adoption of the guidelines and recommended standards. Such programs improve the cultural competence of health systems and increase the likelihood that patients of color will access and be satisfied with the health care they receive. In addition, some jurisdictions are requiring cultural competency training for all health care professionals as a condition of licensure. As of 2005, for example, New Jersey required that all physicians practicing in the state must attain minimal cultural competency training as a condition of licensure.

*Encourage Attention to Disparities in Quality Improvement.* State and local jurisdictions are also increasingly extending financial incentives to health systems that adhere to evidence-based clinical guidelines as a means of promoting the highest standards of health care for all patients. Health care quality improvement efforts, such as pay-for-performance or performance measurement, are gaining increasing attention. But they can unintentionally deepen health care access and quality gaps. Because underserved

communities are typically sicker and face greater barriers to treatment compliance, performance measurement can inadvertently dampen provider enthusiasm for treating low-income communities or communities of color. Quality improvement efforts should take into account the challenges and needs of underserved communities and reward efforts that reduce disparities and improve patient outcomes relative to baseline measures. Some quality improvement measures adjust for patient case mix or emphasize disparities reduction efforts, to avoid unfairly penalizing providers while holding them and health systems accountable for improvements in health outcomes.

### **Empower Patients and Communities**

Too often in American health care, patients are expected to make sound health care decisions and advocate for their needs absent the knowledge and power necessary to do so. Such an approach can be particularly problematic for communities of color, who face lower levels of health literacy and who often – because of historical and cultural reasons – feel less empowered to aggressively advocate for their health care needs than more socially and educationally advantaged groups. Moreover, governments have the power to lessen the impact of a market-driven health care industry has tended to overlook the needs of low-income communities and communities of color in favor of wealthier communities that promise lower financial risks and greater financial reward. State and federal governments should give all communities the power to make recommendations and weigh in on decisions regarding health care policies that affect them.

*Promote Patient Education and Health Literacy.* Several jurisdictions are developing and assessing the efficacy of patient education programs, such as health literacy and navigation programs, and are replicating effective strategies. Patient education programs commonly seek to help patients understand how to best access health care services and participate fully in treatment plans. Successful programs are well-researched and are tailored to the need of underserved communities. Such efforts to empower patients can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. Patient education programs are most effective when designed in partnership with target populations and when language, culture, and other concerns faced by communities of color are fully addressed.

*Promote the Use of Lay Health Navigators.* Health departments can support the training of and reimbursement for community health workers, sometimes also known as “lay health navigators” or *promotores*, who can serve as a liaison between health care institutions and their patients. Community health workers are trained members of medically underserved communities who work to improve community health outcomes. Several community health workers models train individuals to teach disease prevention, conduct simple assessments of health problems, and help their neighbors access appropriate health and human resources. In health care contexts, they serve as a liaison between patients and health systems. Community health worker models are rapidly spreading, as research and practice indicates that such services can improve patients’ ability to access care and understand how to manage illness. State and federal

governments can stimulate these programs by providing grants, seed funding, or other resources to help stimulate their promulgation.

*Promote Community-Based Health Care Planning.* States can promote and/or (in most cases) reinvigorate community health planning, in which members of the community identify their needs and assist policymakers in planning, implementing, and evaluating the effectiveness of public health care systems. Community health planning has a long history, but its promise as a tool to reduce health care disparities has yet to be fully realized. Community health planning seeks to strengthen communities to play a greater role in their own health, actively involving residents in the planning, evaluation, and implementation of health activities in their communities. The 1974 National Health Planning Law sought to create and support a network of community Health Services Agencies (HSAs), but a lack of funding and effective mechanisms for community input to shape health policy has led to a decline of HSA power and influence. Some states, such as New York, are examining strategies to reinvigorate HSAs and to include disparities reduction efforts as part of the mission of these planning agencies.

*Strengthen Community Benefits Obligations.* Non-profit and tax-exempt health care institutions attain their special status as a result of contributions they make to the broader public good. By far, most tax-exempt institutions allocate their charitable resources to the costs of care (particularly emergency room services) for the uninsured. But policymakers are increasingly seeking a more in-depth understanding of the potential charitable contributions of non-profit hospitals and health systems. These can include comprehensive approaches such as strategies to encourage healthy behaviors and improve social and physical conditions in communities. If successful, these efforts meet both the community's and the hospital's goals of improving health status and reducing the demand for high cost emergency room and inpatient care. Such strategies centralize the importance of improving community health, empower community members to voice concerns, and increase non-profits' public accountability for their tax-exempt status.<sup>56</sup>

### **Social and Community-Level Influences on Health Disparities**

The policy strategies outlined above are directed at improving the ability of health care systems to respond to the needs of communities of color. As discussed, however, improving the health status of many racial and ethnic minority groups will require policy strategies focused outside of the health care arena. These include efforts to improve housing and community living conditions, improve food resources and nutrition options, improve conditions for exercise and recreation, and ultimately, to reduce economic and educational gaps. These social and community-level strategies – along with examples of state and local efforts to implement them – are discussed in Text Box 2.

**Text Box 2 - Addressing Social and Community-Level Determinants of Health**

Social and economic inequality among racial and ethnic groups and other marginalized populations is the most significant underlying factor behind most health status inequality. Racial and ethnic discrimination and segregation perpetuate and deepen these gaps. Health care, therefore, cannot eliminate health status gaps between population groups. Federal efforts should look to a broad range of social and economic policy when crafting strategies to improve and equalize health status for all, and state health agencies should play a leadership role in coordinating these efforts. And states can play a large role in providing incentives for effort to improve health conditions in a community and more effectively punish acts that weaken community health conditions. These include efforts to:

- Improve the coordination of relevant state and federal agencies that should address determinants of health inequality (e.g., in education, housing, employment, criminal justice). Governments that seek to reduce racial and ethnic social and economic gaps are inherently engaging in health equity work. Almost all aspects of federal, state, and local policy in education, transportation, housing, commerce, and criminal justice influence the health of residents, and can have a disproportionate impact on marginalized communities. Governments that have taken steps to coordinate the work of agencies that impact health disparities are likely to reduce duplication of effort, increase efficiency, and more effectively address health outcome disparities.
- Create incentives for better food resources and options in underserved communities (e.g., grocery chains, “farmers’ markets”). Several local jurisdictions have established public-private partnerships to bring supermarkets to underserved areas. For example, the city of Rochester, New York, which experienced an 80 percent decline in grocery stores in the 1970s and 1980s, used public resources (the Federal Enterprise Community Zone program, the Community Development Block Grant program, and other sources) to attract a major supermarket chain to open stores in the city.<sup>1</sup> More recently, Pennsylvania awarded a \$500,000 grant to help establish a supermarket in the Yorktown section of Philadelphia, part of a broader initiative to support the development of supermarkets and other food retailers in urban and rural communities that lack adequate access to supermarkets.<sup>1</sup> State and federal governments can make similar investments.
- Develop community-level interventions for health behavior promotion (e.g., smoking cessation, exercise). Federal and state programs to promote healthy behaviors are increasingly recognizing the need to target community-level risk factors and strengths that affect individual health behavior. Such programs are often vital for low-income communities and communities of color, which have fewer community resources for exercise (e.g., safe public parks and recreation centers), effective nutrition, and reduction of individual health risks (e.g., low-income urban communities have more public advertisement of tobacco products and greater availability of alcohol). State and federal agencies can exert legal and regulatory authority to reduce community-level health risk and promote healthy behavior.
- Address environmental racism (e.g., by aggressive monitoring and enforcement of environmental degradation laws). Racial and ethnic minority communities are disproportionately hurt by the presence of toxic waste dumps, and industrial and occupational hazards. Through legal and regulatory strategies, state and federal agencies can reduce environmental health risks and monitor whether and how communities are affected by governmental or commercial activity.

### Conclusion

Health care access and quality is more often compromised for racial and ethnic minorities than for whites, for those who don't speak English well relative to those who are English-proficient, and for immigrants relative to U.S. natives. These disparities have a long history in the United States and are both a symptom of broader structural inequality and a mechanism by which disadvantage persists. Moreover, they carry a significant human and economic toll; the Institute of Medicine estimates that 18,000 people die prematurely each year because they lack health insurance, and that the annual cost to the nation of the poorer health and shortened life spans attributable to uninsurance is between \$65 and \$130 billion.<sup>57</sup> Because people of color are disproportionately among the uninsured, these numbers carry a greater burden in minority communities.

Encouragingly, policymakers are increasingly focused on eliminating these disparities. A range of policy strategies are available to federal, state, and local governments, but it is important to recognize that no single policy – such as expanding access to health insurance – will fully address health care inequality. Health care disparities are complex and are rooted in many causal factors that span across a range of levels – including institutional, governmental, and individual levels. It is therefore important to identify, implement, and evaluate multi-level strategies addressing health care financing, systems, and workforce development. Such strategies should operate together to improve health care access and quality for vulnerable populations. The strategies identified here are only a first step toward creating a more equitable health care system for all.

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<sup>2</sup> U.S. Department of Health and Human Services, National Center for Health Statistics. 2007. *Health, United States, 2006*. Washington, DC: U.S. Department of Health and Human Services.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Harper S, Lynch J, Burris S, and Smith GD. Trends in the Black-White life expectancy gap in the United States, 1983-2003. *Journal of the American Medical Association*, 297(11):1224-1232.

<sup>6</sup> U.S. Department of Health and Human Services, 2007.

<sup>7</sup> Woolf SH, Johnson RE, Fryer GE, Rust G, and Satcher D. 2004. The health impact of resolving racial disparities: An analysis of US mortality data. *American Journal of Public Health*, 94(12): 2078-2081.

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<sup>9</sup> *National Healthcare Disparities Report, 2006*. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm>, accessed June 28, 2007.

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- <sup>21</sup> Grabowski DC. The admission of blacks to high-deficiency nursing homes. *Medical Care*, 2004, 42(5):456-64.
- <sup>22</sup> Ibid.
- <sup>23</sup> Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: National Academy Press, 2003.
- <sup>24</sup> People of color comprise only about 30% of the U.S. population, but over half of the nation's uninsured are racial and ethnic minorities. See U.S. Department of Health and Human Services, 2007.
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- <sup>26</sup> Robert Wood Johnson Foundation, *Going Without: America's Uninsured Children*, [www.rwjf.org](http://www.rwjf.org) (August 2005).
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Mr. PALLONE. Thank you, Dr. Smedley.  
Dr. Kitchell.

**STATEMENT OF MICHAEL JOHN KITCHELL**

Dr. KITCHELL. Thank you, Chairman Pallone, Ranking Member Deal and Congressman Braley for inviting me. I practice neurology in a 167-member physician-owned multi-specialty clinic in central Iowa. We have offices in 21 different sites in rural Iowa and we have about 1 million patient visits per year.

Maintaining access in rural America is difficult because of physician shortages, long distances to travel and fewer services that are available. You will hear other speakers today that will talk about the shortage of physicians in certain specialties, for example, internal medicine. In Iowa, we actually have 3.7 times fewer internal medicine physicians as the State of Massachusetts, and you aren't aware, Massachusetts has recently declared a critical shortage of 12 different specialties including internal medicine. So if those shortages in Massachusetts are critical when we have 3.7 times fewer internists, I would say we are just about comatose.

The medical economic survey has actually shown that rural physicians practice expenses are higher in their survey. They are higher than inner city, suburban and urban physicians. The main reasons for practice expenses being higher in rural areas is the number of patients that we see. When you have half as many physicians in rural areas, you have to see a few more patients.

Rural physicians are paid less by Medicare for our work despite the fact that we work longer hours. Medicare pays rural physicians less for practice expenses despite the fact that Medicare has never done a survey of the actual practice expense differences for physicians in rural areas. This has been going on for 17 years. Medicare pays us less for e-prescribing. You know, I looked for a geographic discount on electronic prescribing equipment and I couldn't find any geographic discounts. I looked for geographic discounts on office equipment, computers and yes, even electronic medical records and, you know, I couldn't find a geographic discount on electronic medical records.

Medicare also pays us less for quality, and Congressman Braley has been kind enough to sponsor a bill to eliminate the devaluation of quality. Medicare pays quality for physicians at a lower rate in rural areas. I think that that devaluation of quality is the ultimate insult to rural physicians. Some rural Medicare fees are as low as one-third of what our private insurance payers are paying us. Some health care services are delivered at a loss in rural areas because Medicare pays so little. If Medicare expanded or if Medicare would cut their payments, obviously there will be more losses, more losses of dollars, more losses of service. You can't make up on volume when the cost of the service is greater than what you are paid.

Congressman Braley, Senator Grassley and Senator Harkin have all sponsored legislation to eliminate or at least reduce these geographic penalties. President Obama in October also has come out in support of geographic equity. I hope that you will also come out in support of geographic equity.

A lot of what is wrong in health care though is due to the physician payment system. This physician payment system is called the

resource-based relative value unit system, that is, our payment system pays for resource use. It should be no surprise then when we pay for resource use that we have the most expensive health care system in the world. When we pay for more expenses rather than pay for the most effective care, we are going to get more expensive care and we won't get as much cost-effective care.

We need to pay for value, not geography. We need to pay for things that matter to the patient. We need to pay for the right tests and treatment, not just more tests and treatment. Iowa is a good example of a high value in health care. It shows that high-quality health care doesn't have to be so expensive. The Commonwealth Fund has rated Iowa's health care system as number one in children's care and number two for care of adults. The Agency for Health Care Research on Quality, Dartmouth and other researchers have consistently shown that Iowa and Midwestern States take the lead in quality and cost-effective care. I testified 6 years ago at the Senate Finance Committee on the national health policy forum and I urged that Medicare pay for value, not volume. I urged that Medicare pay for quality, not quantity. Unfortunately, over the last 6 years there hasn't been much progress made in paying for value or paying physicians for quality. The Medicare payment system for quality is called Physician Quality Reporting Initiative, or PQRI. PQRI is definitely a failure. Only 8 percent of the Nation's physicians succeeded with this program. PQRI does not reward quality. It simply rewards reporting. The lowest quality physician in this country could report correctly on three quality measures that they never did any of those measures and they would get the bonus.

Mr. PALLONE. Doctor, I hate to interrupt but you are a minute over, so if you could wrap up?

Dr. KITCHELL. Medicare's Hospital Quality Rewards program is a success because it measures larger groups and systems. So what should Medicare do to reward quality and value for physicians? Another lesson that can be learned from Iowa is about coordinated care, teamwork and accountability. Quality measures should be based on teams, groups and systems. We need to encourage all physicians to be part of the system. Middlesex County, Connecticut, is a good example of independent physicians getting together, improving quality, improving value and being accountable. We need changes in the payment system for geographic equity to reduce cost and increase quality of value.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Kitchell follows:]

**Statement for the Record**

**Dr. Michael Kittell, McFarland Clinic, Ames, Iowa**  
**Hearing before the House Energy and Commerce Subcommittee on Health**  
**March 24, 2009**

**Rural Health Care: Challenges and Lessons**

Rural health care has both unique challenges as well as lessons that can assist in reforming government health care policies.

Thank you for inviting me to speak with you. I am President-elect of the Iowa Medical Society and a practicing neurologist at McFarland Clinic, a multi-specialty group in rural Iowa. We are physician-owned and an organized, integrated group of 167 physicians in 33 specialties. We have 21 office sites in central Iowa, with about one million patient visits per year. We have physicians on staff in eight hospitals throughout Iowa.

**Rural Health Care**

The health of many rural citizens is fragile, and rural access is even more fragile due to a number of issues that threaten our health care system.

Rural Americans are generally older and poorer than other areas of the country. Compared to urban areas, more rural citizens report fair or poor health. Almost one half of rural adults suffer from chronic diseases.

There are higher percentages of Medicare and Medicaid patients in rural areas. Medicare and Medicaid reimbursement of rural physicians is generally much lower than private insurance, resulting in severe stress on physician practices.

**Problems with Access**

Access to health care is a problem in rural areas largely due to physician shortages. Rural citizens make up over 20% of the nation's population, but only 9% of our nation's physicians reside in rural areas. With less than half the number of physicians per population, rural physicians are under far greater stress. Surveys by **Medical Economics** have shown rural physicians see up to 30% more patients per physician, and their hours of work are longer. The same survey showed rural physicians' practice expenses are \$250,000/yr. per physician compared to \$180,000/yr. for inner city physicians and \$210,000/yr. for urban physicians. So the data show that rural physician practice expenses are significantly *greater*, though Medicare reimburses us *less*.

Another complexity for physicians in rural America is the on-call effort. With half the number of physicians per capita, the days on call are more frequent. Lower

reimbursement and greater call burden makes physician recruitment nearly impossible, as physician recruitment is national in scope. For the last four years I've been on call every third night, and some of our physicians are on call every night or every other night.

At McFarland Clinic over the last ten years there has never been a time that we had fewer than 25 openings for physicians. Many times it has taken 4-6 years before we could fill a physician opening. Recruiting of physicians for rural areas will continue to get worse unless the payment system changes.

Physician shortages in rural areas are largely caused by Medicare payment policies that geographically penalize rural physicians. Geographic penalties (called the **Geographic Practice Cost Index** or GPCIs) continue to reduce access to physicians in rural areas and create extreme variations in utilization across the nation. Congressman Braley, Senator Grassley, and Senator Harkin have all sponsored legislation to reduce these geographic penalties, and **President Obama** has expressed his support for geographic equity.

### **Geographic Equity**

Geographic equity has been a major concern of rural physicians for many years. These geographic penalties (GPCIs) reduce fees for physicians because of where they live.

GPCIs reduce Medicare fees rural physicians are paid in three ways. One is by reducing the "work effort" portion of the fee. The work effort payment in rural areas is less than in urban areas. Only by enacting a 1.0 floor for the work GPCI in 2003 was this geographic penalty reduced, but there is still a differential of 8%.

Another GPCI adjustment is for physician office rent, which Medicare measures by proxy, using HUD data on local apartment rentals. CMS has used a proxy that bears little resemblance to the amount physicians actually spend on office rent. CMS has incorrectly given it far more weight than empirical evidence proves should be assigned, resulting in severe penalty to physicians in sparsely-populated states.

### **The Challenges**

Rural physicians have not only had their work and practice expenses geographically adjusted by Medicare, our quality and e-prescribing payments have also been **geographically devalued**. Our **quality** payments are 30-34% less than the highest areas of the country. **E-prescribing** payments are also geographically adjusted, despite identical costs for rural areas.

With the geographic devaluation of payments, rural physicians are left with little capital to invest in innovation and technology. For example, imaging equipment costs are the same throughout the country, yet the Medicare payment for the technical component of these procedures is almost half as much as in some urban areas. Medicare payment for certain services is actually lower in some areas than the cost of those services, and if further cuts occur, some services will be discontinued.

The challenge in rural America is to find ways to maintain and improve health care access despite shortages of physicians and services.

I hope Congress will agree with **President Obama**: there should be **geographic equity**.

#### **SGR Formula Cuts**

The Sustainable Growth Rate (**SGR**) formula has threatened nationwide cuts for physician Medicare payment for many years, and a 20-21% SGR cut in Medicare fee payments is a huge threat for access to care in rural areas. Many rural physicians would be forced out of business by cuts of that magnitude.

Medicare fee payment rates for some specialty physicians are currently 1/3 of what private insurance fees are paying for the same service. In Iowa private insurance companies are paying 40% to 300% (depending on the service and insurance company) **more** than Medicare for the same service. Clearly, cutting Medicare payments or expanding Medicare without increasing payment is a potential disaster in rural areas.

#### **Quality and Value: The Lessons**

Despite the long history of payment disparities, many rural areas of America have had high quality, cost-effective care. The Commonwealth Fund has rated the Iowa health care system as the highest in health care for children and second highest for adults. Iowa hospitals and physicians have been leaders in high quality care and cost-effective care. With our very efficient and high quality healthcare providers, we have the highest **value**. Unfortunately there have been problems with Medicare's program to reward physician quality and value.

If there are cuts in Medicare reimbursement for the efficient and cost effective areas unfortunately there could be a decline in services, access, and quality.

Our country needs a new payment system that is based not on use of resources or volume/intensity of services, but on **payment for the value** of the care delivered. The reformed payment system should hold physicians **accountable** for their quality and their cost-effective care.

The **American Medical Association** (AMA) has sponsored the Physician Consortium for Performance Improvement (PCPI or the **Consortium**), and the Consortium has taken the lead in developing measures to help improve **quality** in health care. To improve quality one must be able to measure it, and the AMA's Consortium has developed over 250 new quality improvement measures for physicians. The Consortium will continue to develop more measures that are helping to facilitate improvement as well as to measure and reward quality improvement.

Dartmouth research on variation in Medicare spending and quality of care has shown that there is a relationship between high quality and more efficient, cost-effective care. Unfortunately our current physician payment system rewards **more** tests and treatment

rather than the **right** tests and treatment. Physicians should be rewarded for keeping their patients healthy and out of the hospital. With the current payment system physicians who do a better job actually get paid **less**.

### **Paying for Quality**

The Medicare program called **Physician Quality Reporting Initiative (PQRI)** is a failed attempt to reward physician quality, as only 16% of our nation's physicians participated, and only 8% of the nation's physicians succeeded with PQRI. Some physician leaders have labeled the PQRI program a "disaster". PQRI has had many problems including poor feedback and methodological problems. Many high quality physicians who participated in PQRI failed to earn the bonus not because they were low quality but because the reporting was too complex and contorted. PQRI doesn't actually reward quality, it only rewards reporting. Even the **lowest** quality physician could report to PQRI that they **never** did any quality improvement, and they would be rewarded by this failed program.

In contrast to PQRI, the Medicare quality rewards program for hospitals has been successful in promoting better quality and team work in care process improvement. Though PQRI has been a failure so far, I am in complete support of programs by Medicare to promote and reward physician quality.

A better way to reward physician quality would be to measure and reward teams, groups and systems. Individual physician measures are typically inaccurate because of attribution problems, and patients often see multiple physicians.

The **Iowa Medical Society** has collaborated with the **Iowa Hospital Association** since 2006 in the **Iowa Healthcare Collaborative** to continually measure, report, and improve the quality of all health care providers in Iowa. This collaborative and team effort is a great example for our nation of how to improve quality in health care.

Iowa has also had a tradition of primary care physicians taking responsibility for the coordination of comprehensive and continual care for their patients in a **medical home** type of model. The concept of a medical home "team based care" for patients is something Iowa's primary care physicians understand and hope will become recognized and rewarded because it is of **value** to the patient.

### **Quality Work is Team Work**

Quality and patient safety initiatives have all used team, group, or system-based care. The emphasis in quality improvement is in **team work**, not **individual** physician or fragmented care.

Our health care system should do much more to promote and reward quality for **all** physicians and **all quality measures** in a group or system. Instead of picking out "bad apples" or "superstars" like the individually based PQRI reporting measures, we should

promote **team** and **system** improvements, raising the quality of care for the entire group or system, and benefiting more patients.

The current payment system needs reform. It does not reflect the expenses and work effort of rural physicians nor does it promote value. Changes are needed to bring about **geographic equity, reduce costs, and improve the quality and value** of our health care system. We hope our nation can learn about **the value of teamwork and accountability** from the high quality, highly efficient Iowa health care system.

Michael Kitchell, M.D. Box 3014 McFarland Clinic, Ames Iowa

Mr. PALLONE. Thank you.  
Dr. Sitorius.

**STATEMENT OF MICHAEL A. SITORIUS**

Dr. SITORIUS. I would like to thank you, Mr. Chairman, for conducting this subcommittee hearing on the accessibility of health care.

I am here to share information about the Bellevue Medical Center, which is currently under construction in Bellevue, Nebraska, a suburb of Omaha. The Bellevue Medical Center is an entirely different entity than anything we have seen across the country. It is going to be a full-service community hospital providing a wide array of services including emergency services 24 hours to one of the largest communities in the United States without an acute care hospital. It is majority owned by the largest public hospital system in the State. It is expected to open in April of 2010. This medical center illustrates how hospitals, doctors and communities come together to enhance the access of health care to populations in need. I believe the Bellevue Medical Center represents the best in American health care. When we open our doors next spring, we will be an example of a public hospital system, a group of committed and talented physicians, a supportive city government and a thriving and responsive business community that came together to make health care accessible to an underserved population.

Bellevue is the third largest city in Nebraska, it has about 45,000 residents, and it is home to Offutt Air Force Base and the United States Strategic Command. Approximately 10,000 active-duty military personnel, 20,000 dependents and 11,000 military retirees live in the Bellevue area, a very important asset to the Bellevue community. It may come as a surprise that Bellevue has not currently or has ever had a community hospital or emergency room in the city. The Offutt Air Force military hospital, Ehrling Bergguist, closed in 2005 as part of the Base Closure Realignment Commission. Though clinics remain at the Ehrling Bergguist Hospital, the remaining same-day surgery and evening urgent care clinics will be closing in the fall of 2009. As a family physician, I can see firsthand the need for a hospital in Bellevue. There are approximately 180,000 people in eastern Nebraska and western Iowa who would benefit from the hospital, and will, in 2010.

Currently, all the rescue squads in the Bellevue community leave that community for access to emergency care. Low-income individuals benefit from this full-service hospital as well. The UNMC Physician Group currently has a clinic in the Bellevue area which serves a significant low-income and Hispanic population which live in the near south Omaha area. This hospital will provide access to care that is currently not available to that population.

Furthermore, I have a unique vantage point on the medical needs in this area. As chair of the Department of Family Medicine, we have had an affiliated family medicine residency training program with the Air Force since 1992. Unfortunately, with the closure of that base hospital in 2005, it has made difficult some of the training opportunities for one-fifth of the Air Force family medicine residents in their training programs. It is then important that we combine that military training need with the needs of the popu-



lation to come up with the idea for the Bellevue Medical Center. The center is a creative solution to address the health care needs of the community of which it is serving. The Bellevue Medical Center is aligned with an academic medical center, the University of Nebraska Medical Center and the Nebraska Medical Center. Faculty physicians and community physicians meet community needs. When it opens in April of 2010, it will be a full-service hospital delivering adult care, pediatric care, labor and delivery, emergency care, inpatient and outpatient surgery and intensive care. This represents a collaborative model involving public, academic community physicians and community leaders. The Bellevue Medical Center will hold strongly to the values of the existing Nebraska Medical Center for its excellence, innovation and quality patient care. In addition, it will serve as an educational mission for the medical center. It will train 20 percent of the Air Force complement of family practice resident physicians and will allow training in two different locations, the tertiary care academic medical center and the community-based Bellevue Medical Center in 2010.

And in this time of economic downturn, this project also has created jobs. In addition to the hundreds of construction jobs already created, the Bellevue Medical Center will employ 600 FTEs when opened.

The Bellevue Medical Center has strong community support. In fact, the community is extremely engaged and led the effort to make this Bellevue Medical Center a reality. I believe the Bellevue Medical Center can serve as a health care model for other communities. The Nation's health care system needs to encourage innovation through partnerships, in our case, an academic medical center partnered with faculty physicians, community physicians and the community. I would encourage other academic medical centers to consider to replicate what the Nebraska Medical Center has done in the Bellevue community. Moreover, the Bellevue Medical Center is also a model as it relates to care of our military service members, their families and military retirees. It is our position that our military service members, their families and retirees deserve the best quality health care possible from a nearby community hospital. The Bellevue Medical Center will be able to provide that care. This center will also care for all of the benefits provided under the Tri-Care program. The Bellevue Medical Center will accept and look forward to working with the Tri-Care patients.

In conclusion, as Congress begins to tackle health care reform, access to health care must be a significant part of any solution. I am proud to say that the Bellevue Medical Center stands ready to be part of that solution to expanding access to health care. We are excited that your subcommittee has asked us to share our story with you this morning.

Thank you for your attention and interest and I would be happy to answer questions when we get to that point.

[The prepared statement of Dr. Sitorius follows:]

Testimony of

Michael A. Sitorius, M.D.

Waldbaum Professor of Family Practice

Professor and Chair - Department of Family Medicine

University of Nebraska Medical Center

Omaha, Nebraska

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Before the

U.S. House of Representatives

Energy and Commerce Subcommittee on Health

Hearing on

"Making Health Care Work for American Families:

Ensuring Affordable Coverage"

March 24, 2009

My name is Dr. Michael A. Sitorius. I am the Waldbaum Professor of Family Practice and Chair of the Department of Family Medicine at the University of Nebraska Medical Center (UNMC). I am testifying today as a representative of the Bellevue Medical Center and not as a representative of UNMC.

I would like to thank you, Mr. Chairman, for conducting this Subcommittee hearing on the accessibility to health care. I appreciate the opportunity to testify. I am here today to share information about the Bellevue Medical Center, which is currently under construction in Bellevue, Nebraska, a suburb of Omaha. The Bellevue Medical Center is an entirely different animal than anything we have seen across the country. It will be a full-service, community hospital, providing a wide array of services, including a full blown emergency room, to a very large segment of one of the largest -- if not the largest -- communities in the United States without an acute care hospital nearby. The Bellevue Medical Center, which is majority owned by the largest public hospital system in the State, is expected to open to patients in April of next year (2010).

The Bellevue Medical Center illustrates how hospitals and doctors can work together to enhance the access to health care for a population in need. In many ways, I believe the Bellevue Medical Center represents the best in American health care. When we open our doors next spring, we will be a shining example of how a public hospital system; a group of committed and talented physicians; a supportive city government; and a thriving and responsive business community can come together to make critical care accessible again to a large and underserved population.

In my remarks on expanding the access to health care, I will focus on the following subjects:

- Background on the city of Bellevue, Nebraska
- The need for a community hospital in Bellevue
- Description of the Bellevue Medical Center
- and the Bellevue Medical Center as a model for other hospitals.

#### **Background on the Bellevue, Nebraska.**

As way of background, Bellevue is the third largest city in the great state of Nebraska. According to the 2000 census, it has a population of more than 44,300 residents and is part of the Omaha-Council Bluffs metropolitan area. Bellevue is the home of the Offutt Air Force Base and the United States Strategic Command (USSTRATCOM). Approximately 10,000 active duty military personnel, 20,000 dependents of active duty military personnel and 11,000 military retirees live in the immediate Bellevue area. As these numbers illustrate, the military community is quite important to Bellevue and the surrounding area. Furthermore, Bellevue is located in Sarpy County which, according to the U.S Census Bureau, is the fastest growing county by population in Nebraska and Western Iowa.

#### **Need for a community hospital in Bellevue, Nebraska.**

It may come as a surprise to many that Bellevue does not currently have a community hospital or an emergency room in the city. As mentioned earlier, it is potentially the largest city in the United States without a full service hospital. To further illustrate the need for a community hospital, the Offutt Air Force Base military hospital, Ehrling Bergquist, closed in

2005. This Air Force hospital closed because of financial cuts related to the Base Closure Realignment Commission. There remains an Ehrling Bergquist Clinic on the Air Force Base which currently has limited outpatient services including same-day surgery and evening urgent care, but this clinic is also scheduled to close in the fall of this year (2009).

As a family practice physician, I see first hand the strong need for a hospital in Bellevue. There are approximately 180,000 people in Eastern Nebraska and Western Iowa who would benefit from a community hospital in the Bellevue area. This is a fairly large population which right now does not have access to healthcare close to home. These individuals need a full service community hospital with an emergency room near their homes.

Moreover, individuals of low and moderate income will definitely benefit from a community hospital in Bellevue. According to the 2000 census, the median income for a household in the city of Bellevue was approximately \$47,000, and the median income for a family was about \$54,000. About 4% of families and 6% of the population are below the poverty line, including 8% under age 18 and about 4% over age 65.

To further illustrate how low-income individuals could benefit from a full-service hospital, the UNMC physician group currently has a clinic in the Bellevue area. This clinic serves a significant low-income and/or Hispanic population which live in South Omaha. A full-service community hospital in Bellevue would provide important health care to this same population group.

Furthermore, I have a unique vantage point on the medical needs of the area as I am the chair of the Department of Family Medicine at the University of Nebraska Medical Center (UNMC). UNMC has a Family Medicine Residency Program that provides family medicine training for active duty U.S. Air Force physicians. This three year training program is for those physicians who are located at the 55th Medical Group on the Offutt Air Force Base. The UNMC Family Medicine Residency Program is one of only five Air Force family medicine programs in the nation. Unfortunately, the former training facility for these Air Force family physicians was Ehrling Bergquist Hospital which, as discussed earlier, closed in 2005.

As a result of this closure of Ehrling Bergquist, I became convinced that Bellevue needed a community hospital that could serve both the military and civilian populations as well as become established as a training facility for the Air Force family practice physicians. Thus, the idea of the Bellevue Medical Center was born.

#### **Description of the Bellevue Medical Center**

The Bellevue Medical Center is a creative solution to address the healthcare needs of the community it will serve. Our approach is unique and we believe the only one of its kind in the United States. The Bellevue Medical Center is aligned with an academic medical center (The Nebraska Medical Center), faculty physicians and community physicians.

The Bellevue Medical Center will be a full service hospital that is expected to provide the full scope of medical services beginning in April 2010. It will open with 100 private, inpatient beds providing general medical services, labor and delivery care, emergency care, inpatient and outpatient surgery, and intensive care. The facility will feature significant investments in medical technologies, diagnostic services, two cardiac catheterization labs, on-site inpatient and

outpatient pharmacy services, laboratory testing, and physician clinic space. There will also be a medical office building adjacent to the hospital which will house outpatient clinics. Future expansion of the facility will allow for an additional 100 beds.

The ownership structure of the Bellevue Medical Center is as follows:

- 60% share owned by a regional academic and trauma medical center, The Nebraska Medical Center;
- a 18% share owned by UNMC Physicians, a medical practice for UNMC faculty (which is a non-profit 501(c)(3) education affiliated institution);
- and a 22% share owned by Bellevue and local community physicians.

The Bellevue Medical Center will hold strongly to the values of The Nebraska Medical Center, known for its excellence, innovation and quality patient care. With The Nebraska Medical Center's quality movement in full speed, the hospital has seen steady improvements and efficiencies in numerous areas including customer service, delivery of care, patient and employee satisfaction, reduction of medical errors, lowering average lengths of stay and mortality. These developments are illustrated in the following two awards that The Nebraska Medical Center has received.

- The Nebraska Medical Center has been recognized four years in a row for providing "An Outstanding Inpatient Experience" by J.D. Power and Associates, a global market research firm. According to J.D. Power and Associates, only 20-percent of all hospitals in the United States even qualify for consideration.
- The Nebraska Medical Center has also received the esteemed Magnet designation for extraordinary nursing care. The achievement, as determined by the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program®, is widely viewed as the "gold standard" in the nursing profession.

The Bellevue Medical Center is also consistent with the educational mission of The Nebraska Medical Center. The Bellevue Medical Center will serve as a teaching hospital and training facility for 20% of the Air Force's compliment of family practice physicians. This will allow training in two different and separate locations.

- 1) An academic and trauma medical center, The Nebraska Medical Center
- 2) and a community hospital, the Bellevue Medical Center (beginning in 2010)

The Bellevue Medical Center is valuable because the community hospital setting more closely mirrors the facility where the Air Force residents will likely practice after completion of the training program. When the Bellevue Medical Center opens, it will train 8 new family practice residents a year. Because it is a three year program, 24 residents are in training at any given time.

In this time of an economic downturn, it is important to point out that health care can continue to be a job creator. It is possible to both expand access to health care and expand access to jobs. As of today, the exterior enclosure of the Bellevue Medical Center is expected to be done by the end of May. The dry walling of the Bellevue Medical Center is in progress along with accompanying electrical and plumbing work. As the status of this project indicates, the

project is providing important construction-related work. Furthermore, the Bellevue Medical Center will create 600 jobs in its first year and will grow as the hospital grows.

The Bellevue Medical Center has strong community support. In fact, the community is extremely engaged and has led the effort to help make the Bellevue Medical Center a reality. In particular, its community supporters include: the Bellevue and Sarpy Chambers of Commerce, the Bellevue City Leadership, and local law enforcement and fire departments.

#### **The Bellevue Medical Center as a model**

I believe that the Bellevue Medical Center can serve as a healthcare model for other communities. The nation's health care system needs to encourage innovation through partnerships. In our case, an academic medical center partnered with faculty physicians and community physicians. In many of the nation's urban areas, there are public or private academic medical centers. These institutions, in many cases, have the resources and service-oriented mission, to help provide care to those in greatest need. I would encourage academic medical centers to attempt to replicate what The Nebraska Medical Center has done. Whether it be in an urban or rural setting, The Nebraska Medical Center would be happy to provide any insight on our model to other medical schools and/or medical facilities to help tailor their outreach to a community in need.

Moreover, the Bellevue Medical Center is as also a model as it relates to the care of our military service members, their families and military retirees. The Bellevue Medical Center, when open, will serve approximately 41,000 military active duty personnel, their families and military retirees who live in the immediate Bellevue area. It is our position that our military service members, their families and military retirees deserve the best quality of health care possible from a nearby community hospital. Bellevue Medical Center will be able to provide this care.

Active military and retirees receive health benefits from what is called TRICARE. The Bellevue Medical Center will accept and looks forward to working with TRICARE patients. We also look forward to working with our Department of Veteran Affairs' hospital system and augmenting the excellent quality of care that they currently provide.

In conclusion, as Congress begins to tackle health care reform, access to healthcare must be a significant part of any solution. I am proud to say that the Bellevue Medical Center stands ready to be part of the solution of expanding the access to healthcare. Everybody seems to be excited that we are coming to Bellevue. And we are all excited that your Subcommittee has asked us to share our story with you all this morning.

Thank you very much for your attention and interest. I look forward to answering any questions that you may have.

Mr. PALLONE. Thank you, Doctor.  
Dr. Lavizzo-Mourey.

**STATEMENT OF RISA LAVIZZO-MOUREY**

Dr. LAVIZZO-MOUREY. Thank you, Chairman Pallone and Ranking Member Deal and members of the subcommittee for this opportunity to testify.

As has been mentioned, it is Cover the Uninsured Week and communities all across the country are calling for fixes to our broken health care system. Expanding coverage must be a priority as Congress considers opportunities for health reform, but this alone will not fix the problem. In my written testimony, I have touched on issues of health care disparities and non-financial barriers to health but I would like to focus my oral remarks on the role of nurses in ensuring the access to high-quality care and opportunities for addressing the shortage of nurses and nurse faculty.

If you have ever been hospitalized or had a loved one who was hospitalized, you know that nurses make a difference. Nurses' diligence keeps bad things from happening to patients. Their actions prevent medical errors and infections. They keep patients safe from falls and from the complications of extended bed rest. They also work in community settings to prevent disease, help patients manage their diseases better and avoid unnecessary hospitalizations. As Congresswoman Capps noted recently at the White House Forum for Health Reform, there is a projected shortage of 500,000 nurses by 2020. The nursing shortage results from a confluence of factors: A shortage of nurse faculty, too few nurses enrolling in nursing programs and turnover among experienced nurses. There is a vacancy rate of 7.6 percent among nursing faculty which results in far too many qualified students being turned away. Solving this problem will require action at the national level and a commitment of resources both public and private. The results of our grantees' and partners' work suggest that the following steps must be taken.

First, we need to increase the number of nurses with baccalaureate degrees to create a larger pool of nurses who will qualify to pursue faculty careers. Second, we need to increase financial assistance to enable more nurses to attend graduate school and obtain teaching qualifications. Third, encourage private sector to adopt evidence-based practices including the use of technology that will improve the retention of nurses in their clinical roles. And finally, we need to support research to demonstrate the nurse's role in improving the quality of patient care and improving outcomes. It is also essential that funding for workforce development not ebb and flow with yearly changes in appropriations to Title VIII programs.

I want to highlight a few specific promising programs and strategies that address the nursing shortage and the faculty shortage. First, at our foundation we found scholarships to support accelerated nursing degrees for students who already have a degree in a discipline other than nursing. These are typically students that are ineligible for federal aid programs, and I can tell you, these scholarship programs are hugely oversubscribed. Second, we are providing career development awards to outstanding junior faculty.

Third, there are many State partnerships of nurses, educators, consumers, business groups, government and philanthropy that are working together on practical creative solutions like using shared curriculum, online education, simulation centers for training, easing the transition from associate to baccalaureate programs and increasing the diversity of the nursing workforce. Taken together, these programs seem to increase the number of baccalaureate-prepared nurses, provide incentives and rewards for nursing faculty to educate the next generation of nurses, shorten the pipeline for providing nursing faculty and provide a new cadre of nursing leaders.

Now, as we consider the critical task of ensuring that the education system can graduate new nurses, we must also retain experienced nurses. We have a demonstration project called Transforming Care at the Bedside that shows hospitals can successfully retain nurses through organizational reforms that do not add costs. I know that my colleague, Dr. Mullan, will focus on the shortage of primary care physicians, but nurse practitioners are an effective, high-quality way to fill the gap in primary care, particularly as we think about access in rural and other underserved settings.

So in conclusion, as Congress addresses both the shortage of primary care physicians and the need to control spending, I encourage you think about opportunities to use nurse practitioners more widely and effectively.

Thank you for this opportunity to testify today and for your attention to these issues that reach beyond ensuring health care coverage and allow us to strive for comprehensive, meaningful reform.

[The prepared statement of Dr. Lavizzo-Mourey follows:]



**Testimony of Risa Lavizzo-Mourey, M.D., M.B.A.  
President and CEO, Robert Wood Johnson Foundation  
Before the Subcommittee on Health of the Committee on Energy and Commerce  
U.S. House of Representatives  
Making Health Care Work for American Families: Improving Access to Care  
March 24, 2009**

Chairman Pallone, Ranking Member Deal, and members of the subcommittee, thank you for this opportunity to testify about strategies for improving access to care for America's families.

I am Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation (RWJF), the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans. Today, we are in the middle of Cover the Uninsured Week, which the Robert Wood Johnson Foundation has supported since 2003, in cooperation with a diverse coalition of national partners and supporters. This week, communities across the country are organizing hundreds of events to raise awareness about the fact that too many Americans are living without health insurance, and to demand solutions. Our health care system is at the brink. We must reform it: make it better, cheaper and more inclusive. Inaction is not an option.

Assuring that everyone in America has stable, affordable health care coverage is central to our Foundation's mission, and expanding coverage must be a priority as the Congress considers opportunities for health reform this year. We know that going without health insurance has serious consequences, not only for the uninsured person's physical, mental and financial health, but also for the community. This subcommittee heard a couple of weeks ago from Jack Ebeler

about the new RWJF-supported Institute of Medicine report on the consequences of uninsurance.<sup>1</sup>

The report shows that insured adults in communities with high rates of uninsured residents are less likely to be satisfied with the quality of their care and their choice of health care providers. Clearly, when millions of Americans are uninsured, everyone is affected.

But expanding coverage alone will not be sufficient. Meaningful health reform must also include efforts to improve the quality, value and equality of care; address health care costs and spending; strengthen the public health system's capacity to protect our health; address the social determinants of health; and prevent disease and promote healthier lifestyles. I am delighted that the subcommittee is considering all of these important elements through this series of hearings on Making Health Care Work for American Families.

In our more than 35 years of work to improve health and health care, the Robert Wood Johnson Foundation has learned many lessons about making health care work, about what constitutes high-quality, patient-centered care, and about the factors that facilitate or impede meaningful access to care and services.

Critical to implementing these transformations are our nation's nurses. In my testimony today, I'll focus primarily on the critical role that nurses play in ensuring high-quality care and some of the challenges and opportunities for addressing the nation's shortage of nurses and nurse faculty.

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<sup>1</sup> IOM (Institute of Medicine). 2009. *America's Uninsured Crisis: Consequences for Health and Health Care*. Washington, DC: The National Academies Press. Available at <http://www.nap.edu/catalog/12511.html>.

**The Value of Nurses**

I hope none of you have ever had to be hospitalized or had a loved one hospitalized, but if you have, you know that it's the nurses who make the difference when it comes to high-quality, patient-centered care.

And the evidence supports that anecdotal experience: the Institute of Medicine report *Keeping Patients Safe: Transforming the Work Environment of Nurses* found that nurses, as the largest segment of the health care workforce and the professionals who spend the most time providing direct care to patients, are indispensable to patient safety and health care quality.

Indeed, the new data hospitals across the country are submitting to CMS on patient satisfaction show that nursing is the single most important factor in how patients rate their hospital experience and whether they would recommend their hospital to a family member or friend. Nurses' vigilance keeps bad things from happening to patients such as medication errors, patient falls, and pressure ulcers.

Nurses provide vital care and services not only in hospitals and in nursing homes, but in the community, as well. That's a key piece of ensuring access to meaningful care and services. We talk a lot about the importance of patient-centered care, and part of patient-centered care is meeting people where they are – sometimes literally. For example, schools present an important opportunity for increasing access to care for children and families. Fifty-six million children

attend an elementary or secondary school in the United States,<sup>2</sup> and schools offer a prime opportunity to reach kids where they spend most of their time. The Robert Wood Johnson Foundation has a long history of investing in school-based health centers, many of them nurse-led. Today, there are more than 1,500 school-based health centers across the country that provide critical health care, mental health and dental care services to vulnerable children and, in some cases, their families.

Nurses also play a vital role in ensuring that children get a healthy start in life through an innovative, proven, cost-effective program called the Nurse-Family Partnership. Supported by a range of public and private funding sources, including the Robert Wood Johnson Foundation, the program works in 28 states to pair young, low-income pregnant women and first-time mothers with nurses who provide home visits during pregnancy and through the child's second birthday. Nurses counsel their clients about the importance of prenatal care, proper diet and avoiding cigarettes, alcohol and illegal drugs and help parents develop skills and strategies for caring for their babies responsibly. In addition, they work with the moms to develop a vision for their own future, including plans to continue their education and find work.

The program has now served nearly 100,000 families. A 15-year study found that participants have positive outcomes in reducing child abuse and neglect, reducing behavior and intellectual problems among children, reducing arrests among children by age 15, and reducing emergency

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<sup>2</sup> Upcoming *Statistical Abstract of the United States: 2009*, Table 211. See <http://www.census.gov/compendia/statab/>

room visits for accidents and poisoning. A 2005 analysis by the RAND Corporation also found a \$5.70 return for every dollar invested in the program.<sup>3</sup>

### **The Nursing Shortage**

The value and importance of nurses is clear, but as we all know, our nation faces a critical shortage of nurses and nurse faculty. As Congresswoman Capps noted at the White House Forum on Health Reform earlier this month, there is a projected shortage of 500,000 nurses by 2020.<sup>4</sup>

Despite the growing need for new nurses, a survey from the American Academy of Colleges of Nursing shows that nursing schools turned away more than 40,000 qualified applicants to baccalaureate and graduate nursing programs in 2007. More than 70 percent of nursing schools responding to the survey pointed to faculty shortages as a reason for not accepting all qualified applicants into nursing programs. During this current academic year, there are 814 faculty vacancies at 449 nursing schools across the country, with most of those vacancies in doctoral-level positions<sup>5</sup>.

More recently, the situation has become even more dire, as state budget cuts force schools of nursing to suspend enrollment or cut faculty positions.

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<sup>3</sup> Karoly LA, Kilburn MR and Cannon JS. *Early Childhood Interventions: Proven Results, Future Promise*. Santa Monica, Calif.: RAND, 2005. Available online at [http://www.rand.org/pubs/monographs/2005/RAND\\_MG341.pdf](http://www.rand.org/pubs/monographs/2005/RAND_MG341.pdf)

<sup>4</sup> Buerhaus P., Staiger DO, Auerbach DI. *The Future of the Nursing Workforce in the United States: Data, Trends and Implications*. 2008.

<sup>5</sup> see <http://www.aacn.nche.edu/IDS/pdf/vacancy08.pdf>

As the job market tightens, many part-time nurses are increasing their hours to full-time, and retired nurses are re-entering the workforce to make up for a spouse's lost income. More than half of the nation's hospitals, according to a recent American Hospital Association survey, are making or at least considering layoffs. All of these effects of the economic downturn may create an artificially low demand for nurses, masking the prolonged, persistent shortage of nurses and nurse faculty. When the economy recovers, the impact of this temporary, apparent stabilization could further exacerbate the nurse shortage. There continue to be significant vacancies across health care and community health settings: in hospitals, in community health centers, in nursing homes and within home health agencies.

The last statistics I'll note on the problem are related to the demographics of the aging nursing workforce; by 2010, it's expected that 40 percent of the nursing workforce will be over the age of 50. The average age of a full professor of nursing, with a doctoral degree, is 59.1 years; the average age of nurse faculty retirement is 62.5 years.

#### **Promising Solutions to the Nurse Shortage**

The Robert Wood Johnson Foundation has supported research and programs that lead us to conclude that solving the nursing shortage is within our reach. Of course, we are not doing this alone, and we can't do it alone. We have many partners, and although we are committing significant resources to develop and evaluate models and approaches, solving this problem will require action at the national level and the commitment of significant resources.

As we work together to address the shortage of nurses and nurse faculty, the results of our grantees' and partners' work suggest the following steps be taken:

- First, increase the number of nurses with baccalaureate degrees to create a larger pool of nurses who qualify to pursue teaching careers in nursing.
- Second, increase graduate education financial assistance to enable more nurses to attend graduate school and obtain teaching qualifications.
- Third, encourage the private sector to adopt evidence-based best practices, including better use of technology, to improve the retention of nurses in clinical care roles.
- And finally, support research to gather the evidence of how nursing care links to high-quality patient care and outcomes.

I want to highlight more specifically a few promising programs and strategies for addressing the shortage of nurses and nurse faculty:

The Robert Wood Johnson Foundation has awarded more than 700 scholarships to students entering one-year post-baccalaureate nursing programs at 58 schools. These scholarships support accelerated nursing degrees for students who already have a degree in a discipline other than nursing, and who as non-first-time students typically are ineligible for federal aid programs.

A recent summit held by the Center to Champion Nursing in America included participants from 47 states and D.C. to discuss best practices to expand nursing education capacity. State partnerships of nurses, educators, consumers, business, government and local philanthropy are working collaboratively on a wide range of projects to improve nursing education. They're exploring practical and creative solutions like using shared curriculum, providing online education, and using simulation centers for training. They also are exploring opportunities to

improve students' transitions from Associate to Baccalaureate programs, and to increase the diversity of the nursing workforce.

I'm also pleased that the Robert Wood Johnson Foundation is supporting an innovative program in our home state of New Jersey to ensure that we have a well-prepared, diverse nursing faculty and workforce. In partnership with the New Jersey Chamber of Commerce, we are currently supporting two nursing collaboratives, one at the master's level and one at the Ph.D level, that will support the development, implementation and evaluation of new model curricula that prepare students for the nurse faculty role. In addition, we are currently providing career development awards to 15 outstanding junior nurse faculty across the country, through our national Nurse Faculty Scholars program, and will have another 15 scholars named this spring.

Finally, we've just launched a program that will support evaluations of models, programs and innovations that have demonstrated potential to increase enrollment and teaching capacity; improve nurse faculty work-life and satisfaction; and/or enhance nurse faculty recruitment and retention. Even as we and our partners experiment with creative ideas to address the problem, we want to be sure that we build the best evidence to understand which strategies will be most effective for expanding nursing education and attracting and retaining nurse faculty.

As we consider the critical task of fixing the pipeline issue – ensuring that the education system can graduate new nurses – we also must be attentive to the number of nurses who are reluctant to stay in their jobs.



A tracking survey of newly-licensed nurses by researchers at New York University and the University of Buffalo found that 13 percent of new nurses had changed jobs within one year, and more than a third said they felt ready to leave their jobs. Nurses also reported that it was not salary or even benefits that topped their list of the most important work characteristics; it was having the support, resources and ability to do the job well. Perhaps not surprisingly, then, the top reasons cited for leaving a nursing position were poor management and job-related stress.<sup>6</sup>

A vicious circle surrounds the nursing profession. Fewer people are entering nursing, which has led to a shortage. Because of the shortage, nurses who remain in hospital work must care for more patients under increasingly difficult working conditions. Because of these strained working conditions, more nurses leave the hospital workforce, thereby worsening the shortage and making recruitment of new nurses more difficult.

One program that has been successful in reducing turnover on medical/surgical units – an area of the hospital with generally high rates of turnover – is an initiative developed with the Institute for Healthcare Improvement, called Transforming Care at the Bedside, or TCAB.<sup>7</sup>

We know that medical/surgical nurses spend only about a third of their time delivering direct patient care—much of their time is spent filling out paperwork, tracking down medication or supplies, or doing other kinds of administrative tasks.

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<sup>6</sup> Kovner CT, et al., Newly licensed RNs' characteristics, work attitudes, and intentions to work, *American Journal of Nursing*, September 2007.

<sup>7</sup> See <http://www.rwjf.org/qualityequality/product.jsp?id=30051>

The idea behind TCAB is to identify, test and evaluate nurse-led innovations to improve nursing processes, which in turn can improve both nurses' satisfaction and the quality of care that patients receive.

It's as much about putting nurses in the driver's seat—identifying problems, brainstorming solutions, and having the authority to implement them—as about the innovations themselves. But some simple changes, like keeping supplies at the bedside rather than in a central storage area, or identifying patients at risk of falling by outfitting them with ruby-red socks, have on many units increased morale, increased the time that nurses are spending in direct patient care, reduced accidents and errors, and decreased nurse turnover.

Ultimately, a three-pronged strategy—to address the faculty shortage, increase the pipeline of new nurses, and retain experienced nurses—is what it will take to solve the nursing shortage.

**Primary Care Workforce**

In addition to the nursing shortage, we recognize that there is also a shortage of primary care physicians, with a predicted shortfall of as many as 40,000 primary care doctors by 2025. I know that one of the other panelists today will speak to the primary care workforce issue more broadly, but I want to say a few words about the role of the nurse practitioner as we think about access to care in underserved areas.

Nurse practitioners are the fastest-growing group of primary care professionals in the country, with more than 120,000 practicing nurse practitioners currently practicing, and close to 6,000 new nurse practitioners prepared each year.<sup>8</sup>

However, nurse practitioner graduations are no longer growing fast enough to meet escalating demand. Too few nurses can afford additional the training to become a nurse practitioner because of declining financial support for program development and inadequate student scholarships and loans. The tuition benefits hospitals have provided their nurse employees in the past to pursue nurse practitioner training are disappearing in the current economic downturn. Health reform will be seriously hampered if we do not support expansion of nurse practitioner training.

Nurse practitioners are able to prescribe medication, including controlled substances in most states, and nearly 40 percent have hospital admitting privileges. In 23 states, nurse practitioners can practice independently of physicians. In a randomized trial, the quality of patient care – both health outcomes and service utilization – were comparable between physicians and nurse practitioners.<sup>9</sup> It has long been established that using nurse practitioners also is cost-effective; including nurse practitioners in a physician practice can decrease the cost per patient visit by as much as a third.<sup>10</sup>

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<sup>8</sup> See <http://www.aanp.org/NR/rdonlyres/5C81057B-9C87-4C88-AD6D-6F78BDC55207/0/FAQsWhatisanNP31408.pdf>

<sup>9</sup> M.O.Munding et al., "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," *Journal of the American Medical Association* 283, no. 1 (2000): 59–68.

<sup>10</sup> Office of Technology Assessment (1981). *The Cost and Effectiveness of Nurse Practitioners*. Washington, D.C.: US. Government Printing Office.

Nurse practitioners are also essential to the nation's network of community health centers. More than one-third of ambulatory visits are now provided by non-physicians, including nurse practitioners. Nurse practitioners have staffed the recent largest expansion of community health centers since the Great Society Program; the centers now serve more than 16 million mostly underserved patients in more than 7,000 sites. The rapid growth of retail clinics to approximately 1,000 sites that provide 3 million ambulatory visits annually are staffed largely by nurse practitioners. The reforms in primary care, prevention and management of chronic illness being considered as part of health system reform will not be possible without thousands more nurse practitioners.

Yet barriers remain to using nurse practitioners as widely and as wisely as seems reasonable. Current Medicare rules allow nurse practitioners to certify people for admission to long-term care facilities, but not for home health or hospice care. As the Congress addresses both the shortage of primary care physicians and the need to control health care spending, I encourage you and your colleagues to think about opportunities to use nurse practitioners, who provide vital health care services in rural and other underserved areas, much more widely and more effectively.

**Disparities in Health Care**

Of course, it's not only in rural areas where disparities in access to health care exist. I was vice-chair of the Institute of Medicine committee that produced the 2002 *Unequal Treatment* report. We reviewed hundreds of research studies documenting gaps in care between black and Hispanic

and white patients, and it was sobering. We found that racial and ethnic disparities in care persisted, even when other factors such as health insurance and income level were equal.

An essential step is increasing the quality and availability of health care language services for patients with limited English proficiency. Poor communication can lead to devastating, even deadly consequences for patients. A study by the Joint Commission examined the difference in the impact that adverse events had on people with limited English proficiency, compared to English-speaking patients. Nearly half of the patients with limited English proficiency reporting adverse events experienced some degree of physical harm, compared with less than a third of English-speaking patients; the rate of permanent or severe harm or death was more than two-and-a-half times higher for patients with limited English proficiency.<sup>11</sup> Language can affect care quality and outcomes.

With nearly 20% of the nation's population speaking a language other than English at home, our health care system needs to do a better job of ensuring that all patients, regardless of the language they speak and understand, receive high-quality, culturally competent care. The patient-provider relationship is so essential to good health care, and when the two can't communicate, the quality of the interaction and the quality of care suffers.

I'll never forget a story that Dr. Glenn Flores from Wisconsin told me. In one of his studies, he taped and translated exams of 70 Spanish-speaking children in several Boston emergency departments and clinics. He found dozens of dangerous translation errors. In one instance, a

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<sup>11</sup> [http://www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving\\_health\\_literacy.pdf](http://www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving_health_literacy.pdf)

nurse ordered an oral antibiotic to clear up a 7-year-old's ear infection. The mother spoke no English—and a bystander pulled in to translate told her to pour the drug directly into the girl's ear. We don't all have to be doctors to know that pouring an oral antibiotic into a child's ear isn't going to cure the ear infection. What can we do to change this?

A Robert Wood Johnson Foundation program called Speaking Together helped hospitals demonstrate effective ways to help patients get the care they need by weaving language services into the fabric of clinical practice. That means making sure that all patients with limited English can communicate with their health care team through a bilingual provider or a trained medical interpreter. Even a few small changes can make a big difference: asking patients their preferred language; ensuring clinical staff know how to find an interpreter when they need one; or placing a sign over a child's bed to indicate that she doesn't speak English.

Patients who have access to trained medical interpreters when they need them – particularly at critical points in a health care encounter, like admission and discharge – are more likely to use preventive services and experience greater satisfaction with their care<sup>12</sup>.

What does it take to provide high-quality language services? Here's what the Speaking Together hospitals have learned<sup>13</sup>:

- **Language services should be included in every discussion about improving quality—** Communication is essential to quality; language services need to be included in improvement efforts in the organization.

<sup>12</sup> See Jacobs EA, Lauderdale DS, Meltzer D, et al. Impact of interpreter services on delivery of health care to limited English-proficient patients. *J Gen Intern Med* 2001 July;16(7): 468-74; Kuo D, Fagan MJ. Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. *J Gen Intern Med* 1999 Sep; 14(9): 647-50

<sup>13</sup> See [www.speakingtogether.org](http://www.speakingtogether.org)

- **Meaningful improvement is possible**—The *Speaking Together* hospitals demonstrated that quality improvement techniques can be applied to language services for the purposes of measuring and improving performance.
- **The power is in the data**—Hospitals can report data on language services performance and use this data to engage clinicians and leadership in making change in the organization.
- **Clinician involvement is key**—Clinicians are ultimately responsible for making sure that the language needs of their patients are met. Without clinician involvement, an organization cannot ensure that all patients are receiving quality care.
- **Language services cannot “go it alone”**—The language services department can work to improve the quality and accessibility of services, but it takes a multidisciplinary team to measure and improve the quality of language services delivery— including, but not limited to clinicians, frontline staff, registration and scheduling staff, quality improvement departments and senior leadership.
- **Investment is necessary to achieve quality**—Like many services in health care, some investment of time and financial resources is necessary to improve the quality of language services. Individuals responsible for allocating resources in an organization need to make a commitment to language services in order to improve overall quality of care.

### Improving Health Care Quality

The lessons and strategies from programs like TCAB and Speaking Together are now being integrated into the Robert Wood Johnson Foundation’s signature initiative to improve the quality of health care in the United States, called *Aligning Forces for Quality*. *Aligning Forces* aims to lift the overall quality of care in targeted communities and, at the same time, close racial and ethnic gaps. The initiative aligns the key players—those who give care, those who get care, and those who pay for care—within 14 geographic regions across the U.S., representing about 11 percent of the nation’s population. The 14 *Aligning Forces* community teams<sup>14</sup> have committed to collecting and publicly reporting on measures of health care quality (for example, the

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<sup>14</sup> The 14 Aligning Forces communities are: Cincinnati; Cleveland; Detroit; Humboldt County, Calif.; Kansas City, Mo.; Maine; Memphis; Minnesota; Seattle; South Central Pennsylvania; West Michigan; Western New York; Willamette Valley, Ore., and Wisconsin.

percentage of patients with diabetes who receive regular eye exams, or the percentage of patients who receive appropriate preventive screenings) by the end of 2009; they will also collect patient data by race and ethnicity.

Physicians and other health care providers want to provide the best possible care for their patients, and most think that they're performing well. Yet we know that Americans receive only about half of recommended treatment.<sup>15</sup> Collecting data about the gaps in care allows providers to understand where they're falling short, and to make improvements in those areas. Through Aligning Forces, we're not simply showing the providers their data and saying, "Hey, you're doing a terrible job; good luck with that." We and our grantees are providing assistance to help them do a better job, to apply the lessons learned over the years about what it takes to improve the quality of care for all patients and to close the gaps in care.

It's important that providers be part of the solution. Sometimes, the solutions are simple once you have the data and ask the right questions. For example, RWJF's Expecting Success program – another model that is being incorporated into the Aligning Forces work – supported 10 hospitals across the country in their efforts to improve cardiovascular care, with a particular emphasis on improving care for African-American and Latino patients.

We focused on this area because there is strong evidence of racial and ethnic gaps, both in care and outcomes, in treatment for heart disease. Heart disease is a leading killer of African

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<sup>15</sup> McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003;348:2635-2645.



Americans. And cardiac care is an area of medicine where the standards of care are well-established.

The hospitals generated and reviewed data that told them about the overall quality of care they were provided, as well as whether there were gaps between different racial and ethnic groups. And often times, just by asking the right questions, and just by virtue of collecting the data and paying attention, they were able to improve. Suddenly, some hospitals saw that there was a poor level of compliance with discharge instructions among Hispanic patients, just like Glenn Flores saw in his research. And it hit them like a ton of bricks: all of their written materials were in English.

These steps are seemingly so straightforward and simple: measure the quality of care delivered in each group, implement interventions designed to improve the quality of care for each group, and measure again. Through this process, the Expecting Success hospitals made impressive progress: at one hospital, counseling for smoking cessation jumped from 71 percent to 100 percent; at another, and heart attack patients receiving an angioplasty balloon within 90 minutes increased from 17 percent to 100 percent during the two years of the program. Across the 10 Expecting Success sites, the percentage of patients receiving all recommended care for heart failure improved 37 percent over two years.<sup>16</sup>

This notion of “Making Health Care Work for American Families” really is about putting the patient at the center of the relationship, ensuring that our health care system provides access to good care and preventive services for everyone in this country.

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<sup>16</sup> See <http://www.rwjf.org/files/research/expectingsuccessfinalreport.pdf>

Thank you for the opportunity to testify today, and for your attention to these issues that include but reach beyond ensuring health care coverage as we strive for comprehensive, meaningful health reform.

Mr. PALLONE. Thank you, Doctor.  
Dr. Mullan.

#### STATEMENT OF FITZHUGH MULLAN

Dr. MULLAN. Chairman Pallone, Ranking Member Deal, members of the committee, colleagues, thank you for the opportunity to testify today. I will be talking about the clinical workforce, largely physicians but not limited to physicians. I started as a physician in the National Health Service Corps. I served for a period as the director of the National Health Service Corps, and in recent years I have worked in scholarly pursuits trying to understand the dynamics and policies related to the health workforce. So I have practiced it, I have run it and now I am studying it, and I am here to share that with you as much as I can and very expeditiously.

Massachusetts has been cited as an example, and I will say to you, it is an example of my principal premise to you and that is that substantial reform and improvement in access and in health care in this country will not take place without substantial reform and improvement in the health workforce in this country, and the experience of Massachusetts has been when you provided expanded access, they did indeed come, and where they hit the first bump in the road was the absence of a good, strong primary care base, even in a State that is well endowed with physicians. So primary care is at the core of the reform of the health workforce.

A few words about the shape and size of the health workforce. I offer you this graphic as a way to conceptualize what I consider the three phases of the life cycle of a physician and that would be medical school, graduate medical education and practice. Clearly, practice is a 30- to 40-year proposition and the others presumably are somewhat shorter but all three have a character and a legislative component and I suggest you consider those in that regard and we will go through them in a moment with the particular legislative potentials of each of those. In general, we do have problems in primary care. We have a smaller base compared to many other countries in terms of how we approach it. We have an inverted pyramid with a small base and a large wobbly superstructure of people engaging in specialty and subspecialty clinical roles. More important than this are the trends in primary care which for a variety of reasons ranging from reimbursement to what is in, folks are not going into primary care. That is a huge problem for the future and one that can be addressed both by investments and financially but also by statements by public bodies such as the Congress that this is important.

Overall, my judgment would be in the somewhat contentious area of do we have enough doctors, I think we are in the right zone. We have a 30-year history now of increasing physician population ratio. We are at about 280 per 100,000. That puts us a little bit ahead of Canada and the United Kingdom, a little bit behind Germany and France. All these countries including ourselves are going to experience problems of aging population and I will address those in a moment.

Our major problem, however, is that they are poorly distributed. Physicians tend to be urban. They tend to be in well-to-do areas and they tend not to go where the most severe problems are. That

has continued to be a problem as we produce more doctors. They tend to continue to locate in similar areas. So we can make far better and more prudent use of our workforce if it was better distributed both in terms of geography and specialty, and we have two American inventions that are enormous assets in both what is happening now and what should and can happen in the future, and those, as referenced by Dr. Lavizzo-Mourey and others, are physician assistants and nurse practitioners, about 70,000 of the former, 100,000 of the latter. We invented them. Now the rest of the world is running to try to catch up but they have shown very effective use and they are effective not only in the primary care area but in the specialty area. A way to attenuate our need for more specialists is more collaborative work with non-physician clinicians including particularly nurse practitioner and physician assistants. We also have in place two very important programs that affect workforce and that is the Nation Health Service Corps as an incentive program and community health centers as a deployment mechanism to put folks to work. Those need to be invested in and continue to be recapitalized.

Now, let us quickly go through this continuum. In medical school we are seeing expansion. New medical schools are coming online. Old schools are expanding their capacity. This is good. We have in addition two very important programs that impact medical education. The first is Title VII in the jurisdiction of this committee. It is an old program. It could use reconceptualizing and certainly reinvigorating but it is where the federal government offers or can offer incentives to medical schools and medical students for different kinds of careers and there is a lot that can be said about that important area of investment. And of course, the National Health Service Corps, which happily is receiving more attention. There are about 3,500 people in the service in the field today. About half of those are physicians. You are talking 1,700 physicians, 800,000 physicians in America. This is a very, very small but important program. It needs to get on the map in a more major way.

Graduate medical education, a very important area, and primarily the jurisdiction of this committee because it is \$8 billion, \$8.5 billion in Medicare funds that fund the GME largely. It is a huge program without, as I have characterized it, a brain. It is formulaic. It is not currently available to help with workforce redistribution. A great deal could be done with that. A great deal of attention needs to be paid to that. Modest activities would include incentivizing community-based and ambulatory training. More major would be realigning Medicare GME with national workforce needs with a better, more formal allocation system.

And finally in practice, a lot could be done if you train them and put them out. In an environment that devalues primary care, they will find other ways to do other things and charge the system in other ways. So practice has to be realigned. We need payment reform. We need practice organization reform, primary care medical homes, and finally, health information systems which happily are getting attention will make all providers, particularly primary care, this information much more effectively.

Finally, two ideas that I think need attention. One is, we function in an information-poor environment in terms of workforce planning. Data is not good. We need a national center for health workforce studies that would on a regular basis work on census issues, on analytic issues and on projection issues. And finally, a national health workforce commission, a deliberative body perhaps on the order of MedPAC that advises the Congress, the Administration and the American people on the issues of workforce, a very important, a very difficult, complex area. We need brains at work on that day in and day out with the sanction of the Congress that would help us think through these dilemmas.

So I thank you for your time. I would be happy to engage in discussion and participate with the committee as you consider reform in this area. Thank you, Mr. Chairman.

[The prepared statement of Dr. Mullan follows:]

**Testimony before the House Energy and Commerce  
Subcommittee on Health**

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**On**

**Health Care Workforce Issues and Access to Care:  
Assessing the Present and Preparing for the Future**

**March 24, 2009**

SUMMARY OF TESTIMONY FITZHUGH MULAN, M.D.  
BEFORE THE HOUSE ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH  
MARCH 24, 2009

- Improving access to health care in the United States will require modifications in the structure of the US physician workforce, the foremost of which will be the construction of a strong primary care delivery base.
- There are over 800,000 practicing physicians today or 280 physicians per 100,000 people. This represents a greater physician density than Canada (210) and the United Kingdom (250) but a density less than France (340) and Germany (350).
- The distribution of physicians in the U.S. heavily favors urban areas. Metropolitan areas have 2-5 times as many physicians as non-metropolitan areas. Economically disadvantaged areas have significant physician access problems.
- Two-thirds of the U.S. physician workforce practice as specialists. The number of young physicians indicating an interest in primary care is declining. Approximately 100,000 nurse practitioners (NPs) and 70,000 physician assistants (PAs) are practicing in the United States today. This represents an important asset for service delivery.
- Today's physician-to-population ratio is in the zone of adequacy and should be maintained with appropriate growth in the number of physicians trained to parallel growth in the population. Increased requirements for patient care due to the aging of the population or the inclusion of more Americans in a universal care plan should be met by more strategic distribution of physicians, both geographically and across the primary care – specialty spectrum, and the expanded use of physician assistants and nurse practitioners. The role of PAs and NPs should be in both the generalist and specialist sectors of the care delivery system.
- Medical schools – The current expansion of medical schools is welcome but Title VII legislation needs to be reinvigorated and up-funded to augment primary care training in medical schools.
- Graduate Medical Education – The current number of Medicare funded slots is sufficient to maintain workforce numbers. However, reforms need to be made in current legislation to prioritize and incentivize community-based and ambulatory training. Beyond that, serious consideration needs to be given to aligning Medicare GME with the workforce needs of the country. This would entail designing a new GME allocation system.
- Medical Practice – Primary care payment reform, support for new practice organizations such as primary care medical homes, and investment in health information technology are all important reforms that will help to promote a strong primary care practice base in the country.
- Data and leadership in the field of U.S. health workforce development is insufficient. A National Center for Health Workforce Studies and a National Health Workforce Commission would both be important assets at the federal level in managing health care workforce reform.

### **Introduction**

Thank you Mr. Chairman for this opportunity to testify today. During the 40 years since I graduated from medical school, I have been a member of the health care workforce of the United States working as a pediatrician; I have directed workforce programs such as the National Health Service Corps while serving as a member of the United States Public Health Service Commissioned Corps; and I have been a student of and commentator on U.S. workforce policy in my current role as a Professor of Health Policy at The George Washington University.

Therefore, it is with experience as a practitioner, administrator, and scholar that I come before you this morning.

Current health care access and the expansion of access to all Americans are necessarily reliant on both the number and make-up of the workforce available to provide care. In my remarks, I will briefly review the history, demographics, trends, and problems associated with the U.S. health professions workforce. I will focus on the physician workforce, which is large, at the center of the delivery system, and closely associated with the costs of the health care system. I will also talk about nurse practitioners and physician assistants who make major contributions to clinical care delivery in the country. Much of my commentary will reference the challenge of providing a strong and efficient base to the U.S. health care system – the sector of practice termed primary care. I will propose a number of areas in which legislative action would, in my judgment, support and augment the training and practice of primary care providers, thereby improving the availability, efficiency and effectiveness of the overall health delivery system.

### **Health Care Access and the Health Care Workforce**

Increasing health care access in the United States is necessarily dependent upon the current and future status of the health care workforce – in absolute numbers, specialty make-up, and geographic distribution. Health care reform in Massachusetts provides one instructive example of achieving health care reform without concurrently addressing the health care workforce. In 2006, Massachusetts enacted universal health care measures, increasing the number of insured by 340,000. However, within two years, reports of access problems due to an insufficiency of primary care providers emerged, causing the state legislature to scramble to enact primary care legislation.

In addition to the Massachusetts example, many organizations are indicating increasing concern over the primary care workforce. The National Association of Community Health Centers (NACHC) reports health centers currently have a shortage of over 1,800 primary care providers. Further, if health centers are to increase their services and access, they will need an additional 15,585 primary care providers to reach 30 million patients by 2015 or an additional 51,299 primary care providers to reach 69 million patients.<sup>1</sup>

Both the Massachusetts experience and the NACHC report remind us coverage does not equal access. In order to increase access, we must build a high quality, cost-effective, well distributed workforce.

### **The Demographics of the Workforce**

Today, there are over 800,000 practicing physicians in the United States. This number represents a steady increase over the last 50 years in both the number of physicians and the physician-to-population ratio (see Figure 1). The current density of physicians is 272 per 100,000. However, the distribution of physicians in the United States trends heavily towards urban and well-to-do areas. Less than 10% of physicians practice in rural areas while 20% of the country's population resides in these areas. Metropolitan areas have a primary care



physician-to-population ratio of 93 doctors per 100,000 people compared to 55 primary care doctors per 100,000 people in non-metropolitan areas. Specialists are even more concentrated, with greater than three times the density of specialists in metropolitan areas versus non-metropolitan areas.

American medicine is highly specialized. Currently, there are 142 Accreditation Council on Graduate Medical Education (ACGME) recognized specialties and combined subspecialties as well as multiple additional unrecognized subspecialties. Physicians reporting that they practice primarily as specialists comprise 63% of practitioners whereas those working in the primary care specialties (family medicine, general internal medicine and general pediatrics) comprise only 37% of doctors in practice. This figure is markedly different than it was 50 years ago when 50% of America's physicians were generalists. In Canada today, by contrast, 51% of physicians are currently family physicians and GPs.

The situation in primary care, however, is more problematic than the numbers might suggest. Hard work, low pay, and "lifestyle" expectations of medical graduates today have resulted in dramatic reductions in interest in primary care in U.S. medical graduates (see Figures 2 and 3). Between the mid-1990s and today, the number of training positions in family medicine has declined 20% and the percentage of the family medicine residency positions being selected by U.S. graduates has fallen from 72% to 44%. The majority of family medicine positions are now filled by international medical graduates.

A recent questionnaire of senior medical students considering careers in internal medicine showed that only 2% of them wanted to be general internists.<sup>2</sup> These trends have implications for the future – a future that will require more primary care services for our aging population. A recent study projects that we will be short approximately 40,000 primary care doctors in 15 years<sup>3</sup> – and that doesn't take into account the millions of Americans who will seek primary care when universal coverage is implemented.

#### **Physician Assistants and Nurse Practitioners**

The United States is a global pioneer in the creation of new categories of health professionals who contribute to the delivery of clinical services. Separate pilot programs in the 1960s introduced the world to the idea of the nurse practitioner (NP) and the physician assistant (PA). Since those early programs, both professions have grown enormously in size, stature and public acceptance. Approximately 125,000 nurse practitioners have been trained in the United States, the majority of whom are engaged in clinical practice. There are almost 70,000 certified physician assistants in the United States and more than 100 training programs.

Both of these professions are associated with primary care and practice in rural and underserved areas. About 25% of all nurse practitioners are located in non-metropolitan areas and an estimated 85% of them practice primary care. Physician assistants are active across the spectrum of medical specialties with more than one third of them working in primary care practices and approximately one fifth of them working in rural areas.

#### **The Career Lifecycle of a Physician**

Before considering questions of the sufficiency of the workforce or policy options to modify its direction, I would like to suggest a framework for considering physician careers. I call this the career lifecycle of a physician. It has three phases --- one of which is educational, one of which is transitional and the final one of which is vocational (see Figure 4). The phases are medical school, graduate medical education, and practice. The first two might be considered "pipeline phases" since they determine the quantity and nature of physicians prepared for practice. The final phase is the "payout" phase when the physicians are actually providing health care to the nation.

This framework allows us to consider capacity, cost and performance in three separate but interlinked longitudinal phases of the career path of physicians.

One further clarification is necessary to understand the dynamics of the physician lifecycle. The governing sector in the lifecycle is graduate medical education (GME). Contrary to popular belief, it is not medical schools that determine the ultimate size and specialty composition of the physician workforce of the country. Rather it is residency programs, taken as a whole, that serve as the final pathway into practice and largely govern the numbers and specialty distribution of the physicians in practice. In order to practice medicine in the United States, one needs a license from a state. All states require one to three years of residency in order to obtain a license. It is also important to recognize that a significant proportion of practicing physicians did not attend U.S. (allopathic) medical schools. Of the current first year residents, for instance, 64% graduated from U.S. allopathic (M.D.) medical schools, 7% from U.S. osteopathic (D.O.) medical schools, and 29% from medical schools abroad (International Medical Graduates or IMGs).<sup>4</sup> Almost all of these physicians will complete residency and enter practice in the United States. Thus, it is the size and specialty offerings of the aggregated residency programs of the country that really determine the future of the U.S. physician workforce.

### Sufficiency

As we examine the nation's health care system and as we consider options to increase coverage, fairness, quality, and affordability, we must wrestle with the question of how many physicians we need. This is a central question, not only because it involves the physician production process but also because it has important implications for training requirements for other health professionals (i.e. nurse practitioners and physician assistants.) It also has ramifications for prospective spending in a number of areas including hospital beds, diagnostic testing, medication usage and locations of practice.

Many policy scholars and analysts have written on this topic with strikingly different conclusions. Some have suggested that we are training too many physicians while others issue predictions that we are entering into a period of dramatic physician shortage. These projections are largely dependent on the assumptions made about the health care system of the future. If one assumes that the health care system will be highly coordinated with the well organized use of physician services, such as is the case in prepaid managed care plans like Kaiser Permanente, the case can be made that we might well have a surplus of physicians. If one assumes the continuation of a minimally organized, specialty dominated, predominantly fee-for-service system that is an extrapolation of today's circumstances, one can make the case for a perpetually escalating need for physicians. Both cases have been argued eloquently.

My view is that the density of physicians (the physician-to-population ratio) that we have at the moment is reasonable and the role of public policy (financing and regulation at the federal and state levels) should be to maintain a physician workforce of approximately the current size. This strategy should take into account projected growth in the size of the U.S. population (which is projected at 1% per year) so that the absolute number of physicians would grow in a modest but consistent fashion.

This strategy would be challenged by critics who would raise objections in the following areas:

1. The American population is aging, and by all measures, older citizens require more health care;
2. Physician practice patterns have changed and physicians don't work as many hours as they used to;
3. Technology is advancing and we will need more specialists to deliver the fruits of new technologies to the population;
4. Don't bet on better organization of the health care system.

These observations are all valid. A response to these concerns could certainly be placement of greatly increased numbers of physicians into practice --- whether from U.S. medical schools or from physicians trained abroad at

the expense of other nations. However, all evidence indicates this would be a very costly response since physicians are expensive to train and to compensate in practice. Additionally, excellent evidence shows an association of more physicians and, especially, more specialist physicians with higher health care costs. This is the case because more physicians and, particularly, more specialty physicians are associated with higher hospital utilization and increasingly costly patterns of practice. Importantly, this evidence also shows no benefit in care from this higher intensity of physician practice.

Reforming physician workforce policies in a way that promotes quality and constrains costs requires a different strategy. The essential elements of that strategy are three:

1. The revitalization of a primary care workforce that will be able to staff an organized system of national primary care delivery that needs to be created by reforms in the delivery system. Whether services are delivered in primary care medical homes, accountable care organizations (ACOs), prepaid group practices, or community health centers, the size and skills of the primary care workforce need to be robust;
2. The physician education pipeline needs to produce enhanced numbers of primary care physicians prepared to work in hard pressed inner city and economically challenged communities cities and rural areas as well as in economically comfortable urban and suburban settings;
3. To the degree that the clinical care workforce as a whole needs more providers to address the changing needs of the population, a strong strategy of support for nurse practitioners and physician assistants should be adopted. The increased use of PAs and NPs should not be limited to the primary care sector. Both professions have demonstrated excellent functionality as team members in all aspects of medical practice from the pediatric office to the operating room. Nurse practitioners and physician assistants are trained more quickly, at less expense than physicians, cost less in practice, and are not, on their own, drivers of ancillary clinical tests and services. Moreover, they represent a highly flexible workforce -- an important asset generally lacking in the physician workforce. In contrast, physicians (especially specialty physicians), invest enormous amounts of time, money and deferred income in establishing their capabilities and credentials. Training, retraining, and/or redirecting them is not easily done. Physician assistants and nurse practitioners are, comparatively speaking, "stem cells" and more able as individuals and as professions to focus on areas of emerging or urgent need. NPs and PAs provide a well-proven quality, clinical workforce that can interdigitate with all aspects of physician practice and whose pipeline can be turned up or down as needed to assist in addressing emerging or changing clinical needs.

No discussion of the physician workforce would be complete without reference to international medical graduates (IMGs) who constitute approximately 25% of physicians in practice and 29% of physicians in residency training. No American policy body --- certainly not the U.S. Congress --- has ever advocated that we "offshore" one quarter of our medical training or design a system in which our medical schools are only capable of training three-quarters of the physicians we need. Yet that is what we have done.

We can be proud that the appeal of our way of life and the prowess of our medical institutions that have made the United States a magnet for physicians from around the world for the last 50 years. Most have arrived under educational visas and, in overwhelming numbers, have remained in the United States following residency training. This has been an enormous gift to the United States. In steadily escalating numbers, these hard working, smart, and ambitious men and women from all over the world have staffed our health system. They have also allowed us to be casual in our medical education policy. There is no need for planning or precision nor, even, adequate funding for medical schools since large numbers of foreign graduates are always available to fill in the gaps in residency programs and in specialties that are out of favor with American graduates. Sixty percent of international medical graduates come from poor countries --- largely the Indian subcontinent, Africa

and the Caribbean. In many small countries the physician “brain drain” is the largest and most destabilizing aspect of their health sector. We are not the only country to rely on foreign trained physicians, of course. At one point, Nelson Mandela personally appealed to Tony Blair to stop “poaching” South Africa’s doctors. Recently, global attention has turned to the question of health system strengthening to fight AIDS and end poverty, and yet everywhere one turns the brain drain of doctors and nurses stands as an impediment to improved health in developing countries. Some have called it “reverse foreign aid.”

Heavy reliance on international medical graduates to fill residency positions and undergird the nation’s physician workforce is neither good domestic policy nor good foreign policy. Going forward, public policy makers and medical educators should work toward self sufficiency in medical education. This boils down to a single simple principle: U.S. medical schools should graduate approximately the number of students required to fill the first year residency positions offered in the country.

In that regard, the current initiation of new medical schools and expansion of class sizes at existing schools is a positive development. These new U.S. students will undoubtedly find residency positions upon graduation, decreasing our need to draw on the rest of the world to meet our medical needs. This will be an asset in our efforts to promote the U.S. as a good global citizen and also provide an overdue opportunity for more U.S. students to go to medical school in the U.S.

### **Reform in the Three Sectors of the Physician Workforce**

#### **Medical Schools**

The principal federal legislation impacting medical schools since 1963 has been the series of programs authorized under Title VII of the Public Health Service Act. From 1963 to 1976 the principal investments were designed to increase the number of medical schools and medical school graduates. Construction grants, capitation funds, and student loans were all used as stimuli for medical schools. The result was a more than a doubling of the nation’s annual medical school graduating class from approximately 7,500 students a year in 1960 to 16,000 students a year in 1980. This was an extraordinary achievement of public policy and medical education.

The problems with medical education, however, that concerned policy makers even in those early years went beyond absolute numbers. It was growingly clear that physicians were not equally distributed in the country nor were medical students reflective of the diversity of the population of the U.S. The term “primary care” was first used in the 1960s to focus on yet another problem with medical graduates - the increasing specialization of physicians such that many parts of the country had little access to generalist care.

The result was a new growing set of programs authorized under Title VII of the Public Health Service Act to promote community practice, rural practice, primary care, and opportunities for minorities and disadvantaged students. These included the Area Health Education programs, support for family medicine, general internal medicine, and general pediatrics, the Health Careers Opportunity Program and funding for physician assistants. During this same period, funding for nursing and, particularly, new nurse practitioner programs was similarly increased under Title VIII of the Public Health Service Act.

In the early 1970s, the funding for Title VII programs reached over \$2.5 billion (2009 dollars) (see Figure 3). In the mid-1970s, the consensus changed with the belief that we were training enough (some thought too many) physicians and Title VII authorizations and appropriations were throttled back. The Title VII programs have functioned in the very modest \$200 - 300 million/year range from that time until the present.

In the latter years of the Bush administration, serious efforts were made to eliminate all Title VII funding including support for primary care, minorities in medicine, rural placements and workforce tracking. During the same period, medical school revenues from NIH research funding have risen from \$2.4 billion in 1970 to \$16.3 billion in 2004 (all 2009 dollars), creating a robust culture of research at medical schools that dominates medical school finances, faculty values and school culture (see Figure 4).

Any serious proposal to reform medical practice in the United States must start with reinventing and reinvigorating Title VII funding to medical schools for the purpose of creating incentives and educational pathways that will select and train students for primary care, rural health, diversity, and social mission. Parallel support for nurse practitioners and physician assistants is important as well.

In the past, critics of Title VII have proposed high standards of measurement, asking “how do we know Title VII funds make a difference?” This is a difficult problem for programs with small funding streams that function within large institutions with many contrary incentives. Nonetheless, an impressive series of studies have shown that Title VII funds affect physician careers positively in regard to primary care, rural placement and minority opportunities. There are many ways in which Title VII could be augmented and strengthened. One of those would be an initiative which provides incentives for the creation of “teaching community health centers” – creating funded linkages between medical schools and Federally Qualified Health Centers (FQHCs) for the purpose of training. Another area in which Title VII needs strengthening is in the ability to collect important data and produce useful policy analyses on the workforce. A national center for workforce studies should be given serious consideration in augmenting Title VII authorities and funds.

Funding for the education of physician assistants and nurse practitioners should be continued and augmented to help provide the build-up of flexible clinicians for health reform.

While the National Health Service Corps (NHSC) it is not an educational program, it is a brilliant but underfunded asset available to redistribute health professionals – physicians, NPs, PAs and others. I say brilliant since it matches the needs of individual health science students/professionals with national needs for practitioners in underserved areas. The program has been “tested” since 1971 and works to the benefit of clinicians and communities. Many clinicians have remained in their assigned communities for long periods or full careers. At times, however, the NHSC has received criticism for not having as high “retention rates” as some would like. There are American communities that for reasons of geography or economy have never been able to retain physicians. To the degree that the NHSC can meet service needs with serial placements in these communities, the program is a success. The principal problem with the NHSC is its size. There are many more communities eager for NHSC help and many more clinicians interested in scholarships or loan repayment opportunities than can be met given the program’s budget. Major re-investment in the NHSC would do a great deal to increase access to health services in some of our poorest and most rural communities.

A word should also be said about Community Health Centers which are not teaching institutions but have a stellar record of providing learning sites and supervision for clinical students – often without recompense. Good data now shows that in many communities CHCs are struggling to find sufficient primary care providers to meet their staffing needs. Support through Title VII and Medicare GME for CHC based teaching activities will be essential to allow them to expand to meet the growing needs of the un- and underinsured populations of our country.

### **Graduate Medical Education**

Graduate medical education (GME) grew significantly through the 1980s and early 1990s and leveled off at about 100,000 residents and fellows a year in GME from the late 1990s to the early 2000s. In recent years there has been a small increase in the total number of residents and fellows. Residency programs are unevenly

distributed throughout the country, with history playing an important role. The locations of the earliest residency programs 100 years ago are the areas of the largest residency concentrations today including Boston, New York City, Philadelphia and Washington, D.C. In general, the resident physician-to-population ratio is highest in cities in the Northeast, lower in Southern and Western states, and lowest in rural areas.

The most important financial policy and educational instrument in graduate medical education is Medicare GME. While Medicare has paid for a portion of GME since its inception, the current system was established in 1983 as part of the prospective payment reforms of Medicare. The current system reimburses hospitals that train residents for two costs:

1. Direct costs (DGME) associated with residents, such as salaries, teaching time of faculty, administrative costs; and
2. Indirect costs (IME), which are intended to subsidize the higher cost of patient care in teaching hospitals related to both higher patient care acuity and the presence of residents in the hospital.

The calculation for direct and indirect payments is different, but both are based on the number of residents at a given teaching hospital and, as such, are a form of capitation payment - the more residents, the higher the payment. In 2006, direct GME payments totaled \$2.8 billion and indirect GME payments totaled \$5.8 billion, a total of \$8.6 billion. This total amount represents only 2% of Medicare's expenditures in 2006 and, perhaps, receives less public debate than it might. On the other hand, \$8.6 billion far and away the largest federal expenditure related to in any way to medical education.

As part of Medicare, these funds function as an entitlement and are allocated based on established formulas. Medicare legislation requires no community or regional physician needs assessment to qualify a hospital for GME payments, sets no targets for the number or type of resident physicians that a hospital trains and requires no accountability for the type or sufficiency of physicians in the hospital's city, county or state. Concerned with the cost of the program and its potential to escalate, Congress capped the number of federally funded residents in the Balanced Budget Act of 1997. In the last five years, the total number of residents in the country has grown slowly presumably due to the addition of "off-cap" residents and the selection of specialties with longer training periods.

While Medicare GME in its current form has provided a large and stable source of income for teaching hospitals that is understandably of enormous value to those important institutions, it is effectively a Federal payment without a deliverable - a subsidy. The resident compliment of any given hospital is determined by the staffing needs of that particular hospital with, presumably, the input of the chiefs of the clinical services. There is no requirement that the particular hospital or the medical school with which it is affiliated make any judgments about the workforce needs of their community, region or state. The result is that the annual graduates of the over 9,000 residency programs at nearly 1,100 teaching hospitals in the U.S. comprise the workforce of the country with no regard to specialty selection, practice location or regional needs.

Effectively, we are addressing the health care needs of the country with a physician staffing pattern based on hospital needs. This is a core problem for workforce reform. There are many ways in which Medicare GME could be reconceptualized and redirected. For the purpose of this testimony, let me suggest two levels of reform that might be considered. The first I will entitle "modest" and the second "major".

Modest reforms to current Medicare GME would entail modifications in the rules governing the use of GME funds. Currently, there are a variety of financial disincentives to offsite training. Hospitals stand to lose GME payments, both DGME and IME, for residents who spend time offsite (for instance in Community Health Centers, office-based practices, or local public health departments.) The sites, in turn, face either complicated negotiations to obtain GME pass-through funds or the prospect of training residents without receiving the benefit of GME financing.

There is much that could be done to make Medicare GME more user-friendly to primary care and community-oriented training. Reforms in this area would be helpful but would do little to change the basic problem of hospital staffing patterns dictating the nation's physician workforce.

A major reform would require reconstituting the current policy thinking that governs Medicare GME. Rather than seeing GME as a convenient vehicle for teaching hospital support, Medicare GME should be seen as the principal instrument to shape the physician workforce of the country. This perspective would require 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. This approach might also call for rebalancing regional and sectional allocations of GME funding and therefore physicians to provide a more balanced landscape of GME training.

One problem with envisioning a system of this sort is that many teaching hospitals who are current recipients of GME funding are not large and do not have a large number of teaching programs. In fact, many larger hospitals have specific foci such as cancer or children or surgery that do not equip them to address regional needs. An answer to this problem is the formation of independent consortia of teaching institutions that would, when working together, represent training capacity that could address regional needs in a much more comprehensive fashion. A variant approach would be state based GME organizations that might (or might not) have a link to state government. In either case, the consortium would be able to represent regional needs and work with the Center for Medicare and Medicaid Services (CMS) on residency training targets and GME funding.

A consortium system would require the establishment of many new arrangements within the medical teaching sector. It might also mean that teaching hospitals would have to modify their complement of residency programs in ways that might not be popular with the chiefs of service or the hospital administration. Strong political objection would predictably be mounted against any such reform, but if this most crucial link in the construction of the physician workforce in the United States --- graduate medical education --- is to be modified to meet the needs of an efficient and effective health system in the future, changes will need to be made in the way the federal government does business with the teaching hospitals of the country.

### **Medical Practice**

Reincentivizing and redirecting primary care in the pipeline (medical schools and GME) will amount to little if parallel reforms are not achieved in support for primary care practice. Physicians are smart and ambitious enough that, if the current reimbursement inequities and structural disincentives to primary care practice remain in place, many will abandon primary care during their practice years despite excellent primary care education and support for primary care in their training years. The key areas in the practice environment that will help are practice reimbursement, practice organization, and health information technology.

Primary care physician average annual incomes are currently less than half those of their specialty colleagues. Given high medical school debt, late entry into an economically productive life and demands of the job, it is not hard to understand why primary care careers are severely disadvantaged in comparison to more lucrative specialty options that often have more controlled lifestyles. While physicians receive payment from many sources, the Medicare fee schedule is the primary determinant of physician reimbursement and is a candidate for major restructuring.

The organization of primary care practice is another area of major reform potential. The preponderance of primary care providers still work in solo practice or small groups. This minimizes the opportunity to develop a full service primary care team benefitting from new information technologies or relating in an effective way to specialty consultants. Larger team based practices with excellent information systems such as medical homes or

accountable care organization offer the promise of a new platform for health care delivery. Incentivizing and supporting these forms of practice stands to do a great deal to improve the overall health system, particularly promoting primary care, whose currency is patient well being over time linked to episodes of care provided by other practitioners. Health IT will organize and empower the primary care practitioner in ways that will make the practice of primary care much more effective. Investments in these areas are crucial.

#### **A National Center for Workforce Studies**

Underlying reform efforts in all three sectors of the physician workforce is the need for national level analyses and guidelines for workforce policies. Policy changes aimed at reforming the three sectors to address the health care needs of the nation can not be successful without clear workforce objectives, which require the ability to collect important data and produce useful policy analyses on the workforce. A national center for workforce studies should be given serious consideration.

#### **Conclusion**

In order to reform the delivery of health care in the United States in a way that is more effective and constrains costs, a number of changes need to be made in the workforce since the workforce is an essential governing component of the functionality, quality and cost of the system as a whole.

The number of physicians entering practice in the United States currently is in a zone of adequacy. Many of these physicians are trained abroad and measures should be taken to increase U.S. medical school output so as to decrease our dependence on foreign trained physicians. The training and use of nurse practitioners and physician assistants should be augmented to absorb increased demand in the system due to an aging population.

The current system is heavily balanced towards fragmented specialty care, making it inefficient and expensive. Moreover it is unevenly distributed, raising serious concerns of access and equity. Major investments in the pipeline at the medical school and GME level will be essential to rebalancing the system. At the GME level, in particular, where a large investment already exists, modifications need to be made in the system. In the practice sector, primary care is currently severely disadvantaged and reforms in payment systems and practice support will be needed to reincentivize and restructure the practice of primary care across the country.

It goes without saying that this is an important moment in the history of health care in the United States. The Congress has an unprecedented opportunity to lead in the reform of the system for the benefit of all Americans. I very much appreciate the opportunity to testify before you and I remain available to provide assistance in whatever way I can.

Thank you.

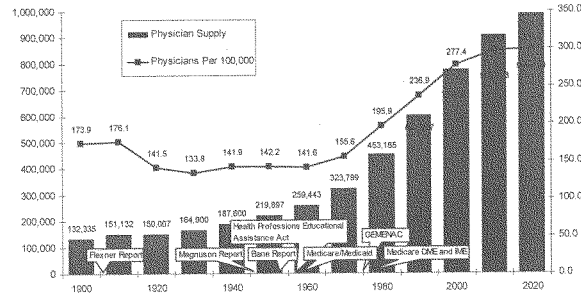


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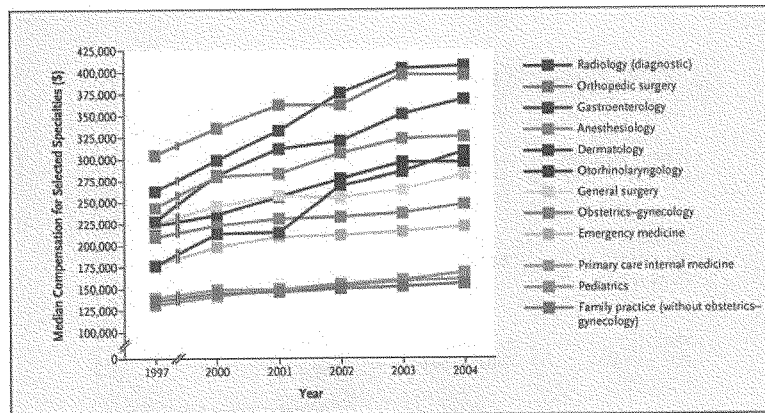
## FIGURES

Figure 1: Physician Supply 1900 Projected to 2020



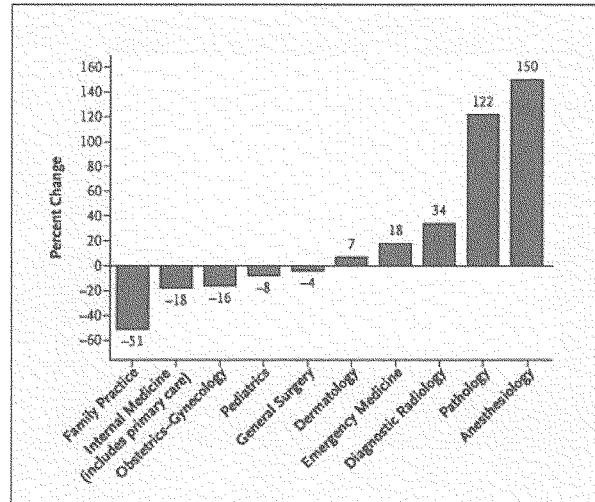
Sources: 1900, 1920: US Census occupations; 1910: Schofield (1964); 1930, 1940: Stewart WH (1960); 1950-2020 data provided by the Bureau of Health Professions.

Figure 2: Median Compensation for Selected Medical Specialties



Source: Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005. From: Woo: N Engl J Med, Volume 355(9), August 31, 2006:864-866.

**Figure 3: Percent Change between 1998 and 2006 in the Percentage of U.S. Medical School Graduates Filling Residency Positions in Various Specialties.**



Source: Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005. From: Woo: N Engl J Med, Volume 355(9), August 31, 2006, 864-866.

**Figure 4: Primary Care Workforce Reform**

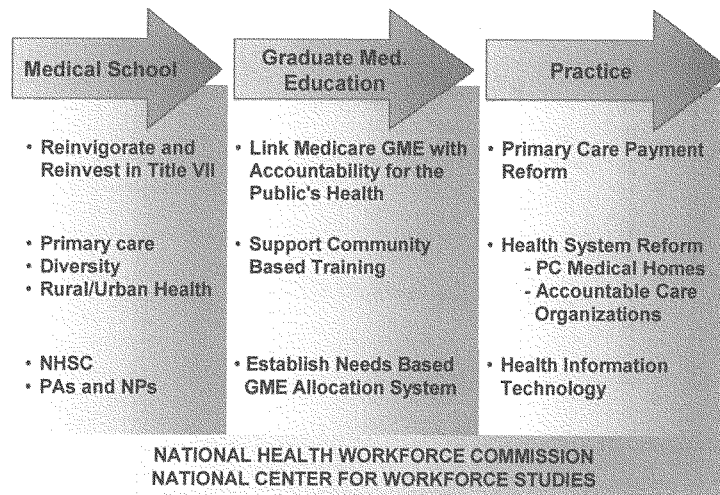
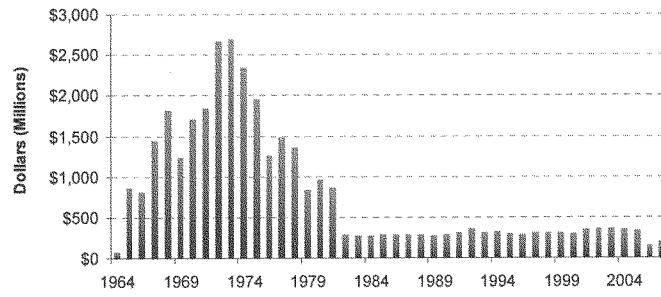
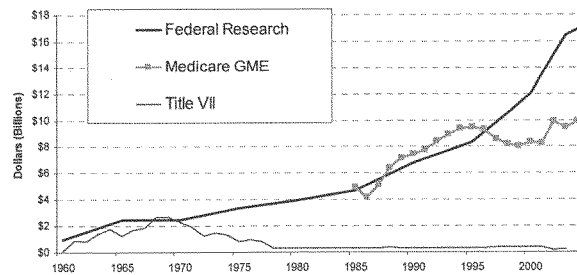


Figure 5: Title VII Funding, 2008 Dollars



Source: Health Resources and Services Administration

Figure 6: U.S. Medical School Revenue, 2008 Dollars



Source: AMMC Data Book, Centers for Medicare and Medicaid Services, Health Resources and Services Administration

Mr. PALLONE. Thank you, Dr. Mullan.  
Dr. Harris.

#### STATEMENT OF JEFFREY P. HARRIS

Dr. HARRIS. Thank you, Chairman Pallone and Ranking Member Deal, for allowing me to share the American College of Physicians' views on primary care workforce and how it affects access.

I am Jeff Harris, president of the ACP. Until recently, I practiced in a rural community with a population of 40,000 in Virginia. The office in which I practice focused on the delivery of primary care and nephrology. This year I have had the good fortune to be president of the American College of Physicians, representing 126,000 internal medicine physicians and medical students. The United States is experiencing a primary care shortage in this country, the likes of which we have not seen. The demand for primary care in the United States will grow exponentially as the Nation's supply of primary care dwindles.

The reasons behind this decline in the supply of primary care physicians are multifaceted and complex. They include the rapid rise in medical education debt, a decrease in income potential for primary care physicians, failed payment policies and increased burdens associated with the practice of primary care. Many regions of the country already are experiencing primary care shortages. The Institute of Medicine reports that it would take about 16,000 additional primary care physicians to meet the needs in currently underserved areas. Two recent studies found that the shortage of primary care physicians for adults will grow to over 40,000, even after taking into account the important contributions of nurses, nurse practitioners and physician assistants as part of the primary care team. Approximately 21 percent of physicians who were board certified in the 1990s have left internal medicine compared to 5 percent who have departed from internal medicine subspecialties.

Equally alarming is the fact that the pipeline of incoming primary care physicians is also drying up. In 2007, only 23 percent of third-year internal medicine residents intended to pursue careers in general internal medicine. This was down from 54 percent in 1998. Even more troubling, a recent survey found that only 2 percent of medical students plan to go into general internal medicine. ACP strongly supports the need to ensure all Americans have access to affordable health coverage. As more people are covered, though, the primary care workforce needs to grow to take on more patients. Primary care physicians are the first line of contact for individuals newly entering the health care system. If we do not increase the primary care workforce, it will become impossible in many communities for people who do not currently have a relationship with a primary care physician to find an internist, family physician or pediatrician who is taking new patients. In Massachusetts, where health insurance coverage was recently expanded and nearly 95 percent of the State's residents have coverage, the wait to see primary care physicians in Massachusetts has reportedly grown to as long as 100 days. Yet Massachusetts has a higher physician-to-patient ratio than most other States.

The cost of providing coverage to more than 46 million uninsured Americans will be much higher and the outcomes of care much

poorer without more primary care physicians. More than 100 studies referenced in the ACP's recent paper, *How is the Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care*, demonstrates that primary care is consistently associated with better outcomes and a lower cost of care. For instance, one study found that an increase of just one primary care physician per 10,000 population in a State was associated with a rise in the State's quality rank and a reduction in overall spending by \$684 per Medicare beneficiary.

The United States needs a comprehensive approach to ensure access to primary care. We should start with a national health care workforce process to set specific goals for educating and training a supply of health professionals including primary care to meet the Nation's health care needs. In the United States, the numbers and types of health care professionals being trained are largely determined by the availability of training programs, the number of applicants and inpatient service needs of academic medical centers. But institutional service needs are poor indicators of national health workforce requirements, particularly as patient care has continued to shift from inpatient to outpatient settings.

The Institution of Medicine has recommended "a comprehensive national strategy to assess and address current and projected gaps in the number, professional mix, geographical distribution and diversity" of the health care workforce. Secondly, we need to fund programs to cover the cost of medical education for students who agree to pursue careers in primary care and subsequently practice in areas of the Nation with greatest needs. Third, Medicare payment policies need to be reformed. The career choices of medical students and young physicians should be largely unaffected by considerations of differences in earnings expectations, yet Medicare payment policies systematically undervalue the comprehensive, longitudinal, preventive and coordinated care that is the hallmark of primary care. Currently the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties. Studies show that this compensation gap is among the most significant reasons for the growing shortage of primary care physicians. To eliminate this differential as a critical factor in medical student and resident choice of specialty, the average net compensation for primary care physicians would need to be raised by Medicare and other payers to be competitive with other specialties. We recommend that Congress institute a process that would result in such targeted annual increase in Medicare fee schedule payments to make primary care competitive with other specialties over a five-year period beginning next year. The funding for such payments should take into account primary care's contribution to reducing overall Medicare cost associated with preventable hospital, emergency room and intensive care visits, many of which are reimbursed under Medicare Part A. Although it may appear to some that our call to increase Medicare payments to primary care is self-serving, the fact is that almost half of the ACP's membership practices in subspecialties, not general internal medicine, yet they share our belief that having a sufficient primary care workforce is essential if patients are to have access to high-quality, effective and affordable care.

Finally, we need new payment models that align incentives for accountable, coordinated patient-centered care including continued expansion of the patient-centered medical home. The Commonwealth Fund's Commission on High-Performing Health Care Systems recently issued a report——

Mr. PALLONE. Dr. Harris, I didn't stop you because I was interested but you are 3 minutes over, so you have to wrap up.

Dr. HARRIS. I apologize.

Mr. PALLONE. That is all right.

Dr. HARRIS. One last paragraph. In conclusion, the United States faces a critical shortage of primary care physicians for adults. We believe that it is imperative for all Americans to be provided with access to affordable coverage. We also know that coverage alone will not ensure that patients have access to high-quality and affordable care if there are not primary care physicians available to meet those needs.

Thank you for your patience.

[The prepared statement of Dr. Harris follows:]

**Statement for the Record**

**American College of Physicians**

**Hearing before the House Energy & Commerce Health Subcommittee**

**“Making Health Care Work for American Families: Improving Access to Care”**

**March 24, 2009**

Thank you, Chairman Pallone and Ranking Member Deal, for allowing me to share the American College of Physicians (ACP’s) views on the primary care workforce and how it affects access to care.

I am Jeffrey P. Harris, MD, FACP, the President of the American College of Physicians, a general internist for three decades, who worked as a Clinical Associate Professor of Medicine at the University of Virginia School of Medicine. Until very recently, I practiced in a small, rural town in Virginia with a population of 40,000 people. I am pleased to be able to represent the College today at this hearing.

The American College of Physicians represents 126,000 internal medicine physicians and medical students. ACP is also the nation’s largest medical specialty society and its second largest physician membership organization.

We are experiencing a primary care shortage in this country, the likes of which we have not seen. The expected demand for primary care in the United States continues to grow exponentially while the nation’s supply of primary care physicians dwindles and interest by U.S. medical graduates in primary care specialties steadily declines. The reasons behind this decline in primary care physician supply are multi-faceted and complex. Key factors include the rapid rise in medical education debt, decreased income potential for primary care physicians, failed payment policies, and increased burdens associated with the practice of primary care.

A strong primary care infrastructure is an essential part of any high-functioning healthcare system. In this country, primary care physicians provide 52 percent of all ambulatory care visits, 80 percent of patient visits for hypertension, and 69 percent of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce.<sup>1 2</sup> Those numbers are compelling, considering the fact that primary care is known to improve health outcomes, increase quality, and reduce healthcare costs.

The hallmarks of primary care medicine include: first contact care, continuity of care, comprehensive care and coordinated care. The two specialties that provide the majority of adult primary care in the U. S. are family medicine and internal medicine. The training and care that family physicians and general internists provide are distinctly



different. Family physicians are trained to diagnose and treat a wide variety of ailments in patients from children to old age. Family physicians receive a broad range of training that includes internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and geriatrics.<sup>3</sup> General internists, on the other hand, provide long-term, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults, and the elderly. Internists receive in-depth training in the diagnosis and treatment of conditions affecting all organ systems. As documented below, the declining supply of general internal medicine physicians is of particular importance to Medicare beneficiaries' access to care. In 2007, internists provided 229,131,238 allowed services to Medicare patients compared to 130,120,289 for family physicians and 17,780,062 for general practitioners." (Source: CMS).

### **Primary Care Workforce: The Problem**

#### *The U.S. is Facing an Escalating Shortage of Primary Care Physicians*

There are many regions of the country that are currently experiencing shortages in primary care physicians. The Institute of Medicine (IOM) reports that it would take 16,261 additional primary care physicians to meet the need in currently underserved areas alone.

Demand for primary care physicians outpaces supply faster than any other specialty group. Specifically, the AAMC estimates that primary care accounts for 37 percent of the total projected shortage in 2025 – about 46,000 FTE primary care physicians.<sup>4</sup> These findings are consistent with recently published projections by researchers from the University of Missouri and the Health Resources Services Administration. The study also predicted that population growth and aging will increase family physicians' and general internists' workloads by 29 percent between 2005 and 2025.<sup>5</sup> Further, greater use of nurse practitioners (NPs) and physician assistants (PAs) are not expected to make enough of an impact on this shortfall.<sup>6</sup> Annual numbers of NP graduates fell from 8,200 in 1998 to 6,000 in 2005 and are projected to fall to 4,000 by 2015. In addition, only about 65 percent of NPs currently work in primary care settings. The number of PA graduates have remained stable at about 4,200 per year, but it is important to note that only one-third of PAs practice in primary care settings.<sup>7</sup>

ACP is particularly concerned about the adequacy of the supply of general internists who provide care in outpatient settings.

- General internists are leaving practice sooner than other physician specialties at the same time that fewer medical students and residents are choosing to make the practice of general internal medicine and primary care their central career goal. Approximately 21 percent of physicians who were board certified in the early 1990s have left internal medicine, compared to a 5 percent departure rate for internal medicine subspecialists.<sup>8</sup>

Equally alarming is the fact that the pipeline of incoming primary care physicians is also drying up, as medical students are drawn to more highly compensated specialties.

- In a survey of fourth-year medical students at eleven U.S. medical schools in the spring of 2007, 23.2 percent reported they were most likely to enter careers in internal medicine, including only 2.0 percent who reported that they were likely to enter careers in general internal medicine.<sup>9</sup> If this trend continues, a shortage of primary care physicians will likely develop more rapidly than many now anticipate.
- The number of third-year internal medicine residents choosing to pursue a career in an internal medicine subspecialty or other specialties has risen each year for the past eight years, while the percentage choosing careers in general internal medicine has steadily declined. In 2007, only 23 percent of third-year internal medicine residents intended to pursue careers in general internal medicine, down from 54 percent in 1998.<sup>10</sup>
- For each of the past two years, the number of U.S. medical students choosing internal medicine residencies has decreased by approximately 1 percent from the previous year. According to the 2009 National Resident Matching Program report, 2,632 U.S. seniors at medical schools enrolled in an internal medicine residency program -- down from 2,660 in 2008 and 2,680 in 2007. These numbers are particularly striking when compared with 3,884 U.S. medical school graduates who chose internal medicine residency programs in 1985,"said Steven E. Weinberger, MD, FACP, senior vice president for medical education and publishing, American College of Physicians (ACP), in response to the match results for 2009. "We are witnessing a generational shift from medical careers that specialize in preventive care, diagnostic evaluation, and long-term treatment of complex and chronic diseases, to specialties and subspecialties that provide specific procedures or a very limited focus of care."
- The 2009 match numbers include students who will ultimately specialize in general internal medicine and provide primary care, as well as those who will enter a subspecialty of internal medicine, such as cardiology or oncology. Currently, approximately 20 to 25 percent of internal medicine residents eventually choose to specialize in general internal medicine, compared with 54 percent in 1998. "This transition is happening at a time when America's aging population is increasing, and the demand for general internists and other primary care physicians will continue to grow at a much faster rate than the primary care physician supply," noted Dr. Weinberger.

*Without more Primary Care Physicians, Expanded Health Insurance Coverage Will Not Ensure Access to Care*

ACP strongly supports the need to provide all Americans with access to affordable health insurance coverage. We are committed to working with Congress and President Obama

to enact bipartisan legislation this year to achieve this goal, and would be please to share with the subcommittee ACP's specific recommendations on coverage.

We also know that health reforms to expand coverage will *fail* to improve outcomes and lower costs unless programs are created to reverse a growing shortage of primary care physicians:

- Persons who do not have access to health insurance coverage are less likely to have a physician as a regular source of care.<sup>11</sup> They are also less likely to comply with recommended treatments, to take their medications, and receive recommended preventive services. Accordingly, as more persons obtain health insurance coverage as a result of health care reform, they will appropriately seek to form a relationship with an internist, family physician, or pediatrician to serve as their regular source of care.
- Increases in the numbers of patients with chronic illnesses will accelerate the demand for primary care. According to *Health Affairs*, "In 2005, 133 million Americans were living with at least one chronic condition. In 2020, this number is expected to grow to 157 million ... Currently, most chronic illnesses care takes place in primary care physician practices ... Compared with specialist-only care, primary care offers high quality care at lower cost for patients with chronic conditions." The authors support the development of multidisciplinary teams in primary care and public health and recommend that the U.S. adopt the goal of "half of U.S. clinicians practice in primary care."<sup>12</sup>
- Most established primary care physicians are currently working at full capacity and will be unable to absorb the increased number of patient visits that will accompany coverage expansions. A rapid expansion of primary care capacity will accordingly be needed.

**Patients will experience reduced access to care if health care reform does not expand the primary care physician workforce capacity at the same time as coverage is expanded:**

- For the newly insured, there will be long wait times to get an appointment with a primary care physician, if they are able to find one at all.
- In a growing number of communities, it may become impossible for people who do not currently have a relationship with a primary care physician to find an internist, family physician or pediatrician who is taking new patients. Not because established primary care physicians do not want to accept the newly-insured into their practices, but because they have no time left in an already over-scheduled day to take on any additional patients.
- Patients of established primary care physicians who already are working at full capacity, but who still try to accept more of the newly insured into their practices,

will experience a reduction in the qualitative time their doctor is able to spend with them. Wait times for appointments will increase. Despite insurance coverage, without changes in the way care is provided, physicians may have to further decrease the time they currently spend with patients in order to try to accommodate increased demand for services – which could have a negative impact on quality, access, and timeliness. Primary care physician “burn out” is likely to increase because of physician dissatisfaction with not being able to spend enough time with their patients or being able to see them in a timely manner. Such burn outs will likely lead more primary care physicians to consider getting out of practice, which will then put further stress on remaining primary care physicians in their community.

- Massachusetts’ experience is a case in point of what can happen if coverage is expanded without expanding the primary care workforce. When health insurance coverage was recently expanded to nearly 95 percent of the state’s residents, some low income residents reported difficulty finding a physician or getting an appointment.<sup>13</sup> In fact, the wait to see primary care physicians in Massachusetts has reportedly grown to as long as 100 days.<sup>14</sup>
- The higher price tag associated with coverage expansions that do not concurrently address the need to rapidly expand primary care physician workforce will be borne by taxpayers and employers in the form of higher taxes and by increases in premiums and cost-sharing for persons who have health insurance coverage.

#### **Primary Care is the Best Medicine for Better Care and Lower Cost**

A fundamental goal of delivery system reform should be to recognize and support the value of primary care in improving outcomes; reducing preventable over-utilization of emergency rooms, hospitals and testing facilities; and achieving overall costs savings.

More than 100 studies, referenced in ACP’s recent paper, *How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?*, demonstrate that primary care is consistently associated with better outcomes and lower costs of care. Highlights of that paper include:

- When compared with other developed countries, the United States ranked lowest in its primary care functions and lowest in health care outcomes, yet highest in health care spending.<sup>15 16 17</sup>
- Primary care has the potential to reduce costs while still maintaining quality.<sup>18 19 20 21 22</sup>
- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke.<sup>23 24</sup>

- Individuals living in states with a higher ratio of primary care physicians to population are more likely to report good health than those living in states with a lower such ratio.<sup>25</sup>
- The supply of primary care physicians is also associated with an increase in life span.<sup>26 27</sup> An increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons.<sup>28</sup>
- Primary care physicians have also been shown to provide better preventive care compared to specialists, reflecting their ability to better manage the whole health of patients.<sup>29 30 31</sup>
- The preventive care that primary care physicians provide can help to reduce hospitalization rates.<sup>32 33 34 35 36</sup> During the year 2000, an estimated 5 million admissions to U.S. hospitals involved hospitalizations that may have been preventable with high quality primary and preventive care treatment; the resulting cost was more than \$26.5 billion. Assuming an average cost of \$5,300 per hospital admission, a 5 percent decrease in the rate of potentially avoidable hospitalizations alone could reduce inpatient costs by more than \$1.3 billion.<sup>37</sup>
- Hospital admission rates for five of 16 ambulatory care-sensitive conditions "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease," increased between 1994 and 2003, suggesting worsening in ambulatory care access or quality for those conditions.<sup>38 39</sup> Studies of certain ambulatory care-sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.<sup>40</sup>
- One study found that an increase of 1 primary care physician per 10,000 population in a state was associated with a rise in that state's quality rank *and a reduction in overall spending by \$684 per Medicare beneficiary.*<sup>41</sup> By comparison, an increase of 1 specialist per 10,000 people was estimated to result in a drop in overall quality rank of nearly 9 places and increase overall spending by \$526 per Medicare beneficiary.

### **Solutions to Improving the Primary Care Workforce**

**1. ESTABLISH A NATIONAL HEALTH CARE WORKFORCE POLICY:** The federal government should develop a national health care workforce policy that includes sufficient support to educate and train a supply of health professionals that meets the nation's health care needs and specifically to ensure an adequate supply and spectrum of primary care physicians trained to manage care for the whole patient. General internists, who provide long-term, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults, and the elderly, should be a crucial component of a high functioning primary care system.

***Rationale:***

In the U.S., the numbers and types of health care professionals being trained are largely determined by the availability of training programs, the number of applicants, and inpatient service needs of academic medical centers. But, institutional service needs are a poor indicator of national health workforce requirements, particularly as patient care has continued to shift from inpatient to outpatient settings. The nation needs sound research methodologies embedded in its workforce policy to determine the nation's current and future needs for appropriate numbers of physicians by specialty and geographic areas. The Council on Graduate Medical Education has made numerous calls on the federal government to establish of a national health care workforce policy, most recently in September 2007. In its December 2008 report, the Institute of Medicine did so as well, recommending that the Department of Health and Human Services, along with other public and private partners, "develop a comprehensive national strategy to assess and address current and projected gaps in the number, professional mix, geographical distribution, and diversity" of the health care workforce.

In June 2006, the AAMC recommended a 30 percent increase in U.S. medical school enrollment and an expansion of Graduate Medical Education (GME) positions to accommodate this growth.<sup>42</sup> The current Medicare GME-funding limits on residency training positions are impeding the establishment of new residency programs and additional training positions in existing programs. While medical schools have done their part to expand class sizes, this effort will not increase the total number of physicians in the country unless GME capacity is increased as well. ACP has considered the option of increasing the number of overall GME positions to increase the supply of physicians, but concluded that increasing the overall pool of physicians would not assure that adequate numbers enter and remain in practice in primary care. Instead, ACP recommends a more targeted approach, recognizing the nation's increasing demographic demands for health care and the dwindling supply of primary care physicians. ACP recommends strategically increasing the number of Medicare-funded GME positions in adult primary care specialties. For internal medicine, the College recommends that the positions be increased in IM- primary care positions rather than IM categorical positions.

With an estimated shortage of 44,000 – 46,000 primary care physicians anticipated by 2025, the federal government must act now to eliminate such a deficit. Since it takes 7 years to educate and train a primary care physician, this expansion of GME positions must start now to avert the predicted shortfall.

***2. INVEST IN THE PRIMARY CARE PIPELINE***

**Incentives for Medical Students:** The federal government should create incentives for medical students to pursue careers in primary care and practice in areas of the nation with greatest need by developing or expanding programs that eliminate student debt for physicians choosing primary care linked to a reasonable service obligation in the field and creating incentives for these physicians to remain in underserved areas after completing their service obligation. This should include:

- a. New loan repayment and medical school scholarship programs in exchange for primary care service in critical shortage health facilities and geographic areas.
- b. Increase funding for scholarships and loan repayment programs under Title VII.
- c. Increase funding for National Health Service Corps (NHSC) scholarships and loan repayment programs.

***Rationale:***

**New loan repayment and scholarship programs:** There are many health care facilities across the country facing shortages of primary care physicians. A Critical Shortage Health Facility is defined as a public or private nonprofit health facility that does not serve a health professional shortage area (HPSA), but has a critical shortage of primary care physicians. ACP proposes the establishment of scholarships (not to exceed \$30,000 per year to a maximum of four years) in family practice, internal medicine and pediatrics through the Department of Health & Humans Services (HHS) that require graduates to practice in critical shortage health facilities for a minimum of two years and up to four years for each year that such scholarship is awarded.

The College also calls for the establishment of a loan repayment program to primary care physicians in the fields of family practice, internal medicine and pediatrics who agree to practice in an area of the country that is not a health professional shortage area (as designated under section 332), but has a critical shortage of primary care physicians (as determined by the Secretary) in such fields. A maximum of \$35,000 per year in loan repayment (principal and interest) should be provided for each year of such service obligation.

These programs would require service in specific health facilities that are experiencing critical shortages of primary care physicians, or in a physician office or other facility in a geographic area of the country that is experiencing a critical primary care shortage. They offer an alternative option to service in HPSAs through National Health Service Corps (NHSC) and would offer a broader impact on increasing the primary care workforces as they would be limited to primary care physicians and would allow them to meet their service obligation in more areas of the country and in more facilities that are experiencing a critical primary care shortage. Since the NHSC requires that physicians practice in designated HPSAs, it excludes many areas of the country and facilities that are experiencing critical shortages.

**Increase funding for Title VII:** The Primary Care Loan (PCL) program awards funds to accredited schools for medical students who agree to enter and complete residency training in primary care within four years after graduation and practice in primary care for the life of the loan. Such loans can serve as a great incentive for medical students considering careers in primary care.

The Faculty Loan Repayment Program is designed to assist degree-trained health professionals from disadvantaged backgrounds in pursuing academic careers. Individuals selected agree to serve on the faculty of an accredited health professions college or university for a minimum of two years for payment of up to \$20,000 of their educational loans. In FY 2004, this program received 148 applications, but only 43 were funded.

The Scholarships for Disadvantaged Students Programs provides scholarships to full-time, financially needy students from disadvantaged backgrounds, enrolled in health professions and nursing programs. In FY2008, the Scholarships for Disadvantaged Students program distributed \$42.3 million in scholarship funds to 224 colleges and universities, ranging from \$1,548 to \$1,781,268; the average award was \$189,121. Such scholarships help greatly in diversifying the health care workforce.

**Increase funding for the National Health Service Corps:** The NHSC scholarship and loan repayment programs provide payment toward tuition/fees or student loans in exchange for service in an underserved area. The programs are available for primary medical, oral, dental, and mental and behavioral professionals. Participation in the NHSC for 4 years or more greatly increases the likelihood that a physician will continue to work in an underserved area after leaving the program. Over the years, the number of clinicians in those programs has grown from 180 to over 4,000. In 2000, the NHSC conducted a large study of NHSC clinicians who had completed their service obligation up to 15 years before and found that 52 percent of those clinicians continued to serve the underserved in their practice.<sup>43</sup> The programs under NHSC have proven to make an impact in meeting the health care needs of the underserved, and with more appropriations, they can do more.

The NHSC estimates that nearly 50 million Americans currently live in health professions shortage areas (HPSAs) - underserved communities which lack adequate access to primary care services - and that 27,000 primary care professionals are needed to adequately serve the people living in HPSAs. Currently, over 4,000 NHSC clinicians are caring for nearly 4 million people.<sup>44</sup> The outstanding need remains unmet.

Limited funding has reduced new NHSC awards from 1,570 in FY 2003 to an estimated 947 in FY 2008, a nearly 40 percent decrease. The NHSC scholarship program already receives seven to fifteen applicants for every award available. The National Advisory Council on the National Health Service Corps has recommended that Congress double the appropriations for the NHSC to more than double its field strength to 10,000 primary care clinicians in underserved areas.<sup>45</sup>

**Deferment of Medical School Loans:** Congress should enact legislation to allow deferment of educational loans throughout the duration of training in primary care residency programs.

***Rationale:***

During residency training, physicians receive a stipend in acknowledgment of the patient care services they provide. However, medical residents receive far less income and



typically work many more hours per week (up to 80 hours) than their counterparts with postgraduate degrees in other professions. Loan repayment in residency makes it even more difficult for physicians-in-training to start or support a family and leaves little discretionary income for products that will advance physicians' professional development (conferences, journal subscriptions, etc.). By deferring payment of interest and principal on medical student loans until after completion of postgraduate training, residents will have increased funds necessary for professional development and more of an opportunity for a reasonable lifestyle. This will reduce financial pressure for residents to moonlight to supplement their income. It will also better enable young physicians who want to enter primary care careers to do so with less pressure to enter a more lucrative specialty in order to pay off their student debts.

### 3. REFORM PAYMENTS TO SUPPORT PRIMARY CARE

#### **Make Payment to Primary Care Physicians Competitive with Other Specialty and**

**Career Choices:** Congress should enact Medicare payment reform so that the career choices of medical students and young physicians are largely unaffected by considerations of differences in earnings expectations. This will require immediate increases in Medicare fee-for-service payments to primary care physicians, starting in the current calendar year, followed by continued annual increases in payments for primary care physicians.

#### ***Rationale:***

Medical students and young physicians should make career decisions based on their interests and skills, instead of being influenced to a great extent by differences in earnings expectations associated with each specialty. Yet there is extensive evidence that choice of specialty is greatly influenced by the under-valuation of primary care by Medicare and other payers compared to other specialties.

- A 2007 survey of the perception of fourth-year medical students pertaining to internal medicine, compared to other specialties they had chosen or considered, is telling. Respondents perceived internal medicine as having lower income potential while requiring more paperwork and a greater breadth of knowledge.<sup>46</sup>
- A recent study compared residency position fill-rates with average starting salaries by specialty and found that U.S. medical students tend to choose more highly compensated specialties. For example, the average starting salary for family medicine was \$130,000 while the highest average starting salaries were in radiology and orthopedic surgery. In 2007, only 42.1 percent of first-year family medicine residency positions were filled by U.S. medical school graduates compared to 88.7 percent in radiology and 93.8 percent in orthopedic surgery.<sup>47</sup>
- A 2008 analysis found a strong direct correlation between higher overall salary and higher fill rates with U.S. graduates.<sup>48</sup>

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties.<sup>49</sup> This

compensation gap is contributing to a growing shortage of primary care physicians, and particularly primary care physicians in smaller practices.

To eliminate differential income as a critical factor in medical student/resident choice of specialty, the average net income for primary care physicians would need to be raised to be competitive with the average net income for all other specialties.

- The level of payment for services provided principally by primary care physicians must be increased to be competitive with other specialty and practice choices, taking into account any additional years of training associated with specialty training programs.
- A target goal for raising primary care reimbursement to make it competitive with other specialty and practice options should be established by the federal government based on, in part, an analysis of the current marketplace and the price sensitivity of physicians with respect to projected income and choice of specialty.

For instance, Medicare and all other payers would need to increase their payments to primary care physicians by 7.5-8 percent per year over a five-year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80 percent of those for all other specialties, all other factors being equal. Achieving 100 percent parity would require annual increases of 12-13 percent over five years.

Such market competitiveness targets could also be adjusted to take into account expansion of existing programs and development of new ones to reduce or eliminate student debt for physicians selecting primary care careers, so that the combined differential between debt and expected earnings is comparable to other specialty choices.

The Medicare Payment Advisory Commission (MedPAC) recommends that Medicare pay a bonus for primary care services furnished by physicians whose practices focus on primary care. While MedPAC would defer to Congress to determine the precise bonus payment amount, it identifies the 10 percent bonus currently paid for services furnished in health professional shortage areas and the 5 percent bonus that was previously provided for services in areas with a low physician-to-population ratio as a starting point for discussion. MedPAC initially made this recommendation in June 2008—when it devoted an entire chapter in its Report to Congress to “Promoting the Use of Primary Care”—and reiterated it in its March 2009 Report to Congress “to emphasize its importance.” The MedPAC rationale for the bonus payment is that primary care services are undervalued and that physicians focused on furnishing primary care services cannot increase the frequency with which they furnish these services—as can be more readily done for tests and procedures—to increase their revenue.

ACP appreciates the MedPAC attention to the payment disparity problem. The MedPAC recommendation that the bonus payment not increase the overall amount that Medicare spends on physician services, however, deviates from the College’s position that the

funding should not be restricted to budget neutral adjustments in the Medicare physician fee schedule and instead should take into consideration the impact of primary care in reducing overall Medicare costs, including costs under Part A associated with reductions in preventable hospital, emergency room and intensive care unit visits associated with primary care.

A better way to fund primary care would be to re-define budget-neutrality rules to consider the impact of paying more for primary care on total aggregate Medicare spending, Parts A, B, C and D combined. A portion of anticipated savings in other parts of Medicare (such as from fewer preventable hospital or emergency room admissions associated with care coordination by primary care physicians) could then be applied to fund increased payments for primary care.

It also is not clear whether MedPAC intends for the adjustment to be a one-time adjustment or one that is sustained and continued over several years until the market compensation gap between primary care and other specialties is closed. The College believes that a one-time adjustment, even if it is as high as 10 percent, will be insufficient to make primary care competitive with other specialties. In addition, the amount of the adjustment should not be left up to Congress to decide each year, but should instead be scheduled in advance so that annual compensation increases in increments until parity reached with other specialties. Such predictability is needed to influence the career decisions of medical students and associates who are contemplating the current and future potential of primary care compensation, as well as to established primary care physicians who may be contemplating a career change or early retirement.

**Support New Primary Care Delivery Models/Patient Centered Medical Home:**

Public and private payers should invest in other new practice models that support the ability of primary care physicians to deliver comprehensive, preventive, and coordinated care to patients. ACP strongly supports the patient centered primary care model of health care delivery and recommends that the current Medicare demonstration be expanded to a pilot project.

***Rationale:***

The Patient-Centered Medical Home is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH practice is responsible for providing for all of a patient's health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues.

The PCMH enjoys the support of a wide range of health care stakeholders, including physician organizations, consumer organizations, employers, health plans, and quality-focused organizations. Policymakers view it as a promising reform model, with Congress authorizing the Medicare Medical Home demonstration project through a 2006 law and supplementing it with dedicated funding and increased ability for expansion through a 2008 law. MedPAC recommends a Medicare medical home pilot project to supplement

the demonstration currently being developed that focuses on practices that use advanced HIT. Other bills have been or are likely to be introduced that would direct additional Medicare medical home test projects.

Numerous states are incorporating PCMH tests into reform of their Medicaid and SCHIP programs. There are a myriad of private payer PCMH tests, many involving multiple health plans, underway or being developed across the country.

Practices must demonstrate that they have the structure and capability to provide patient-centered care to be recognized as a PCMH. The most recently used PCMH recognition module classifies a qualifying practice as one of three medical home levels, each indicating a progressive level of capability. While practices must demonstrate capability beyond what is typical, they have some ability to reach the requisite PCMH recognition score in different ways. ACP is aware that government programs exist that address focused areas that are relevant to the PCMH. The current scope of work governing the Medicare Quality Improvement Organization (QIO) program involves 14 organizations focusing on improving transitions in care, e.g. inpatient to ambulatory setting, in certain geographic areas.<sup>50</sup> The Department of Health and Human Services maintains a program that facilitates the ability of physicians to provide language translation services to patients. The federal government should provide sufficient funding for programs to help smaller physician practices qualify as PCMHs.

In addition, the current Medicare Medical Home Demonstration, which is limited to eight states, should be expanded to a national pilot. CMS should also set a timeline for expeditiously transitioning to a new payment model for all practices nationwide that have voluntarily sought and received recognition as Patient-Centered Medical Homes following completion of the Medicare demonstration/pilot. The budget should also provide states with dedicated federal funding to implement PCMH demos for Medicaid, SCHIP, and all-payer programs.

The Commonwealth Fund's Commission on a High Performing Health Care System recently issued a report that advocates that the federal government "Strengthen and reinforce patient-centered primary care through enhanced payment of primary care services and changing the way we pay for primary care to encourage the adoption of the medical home model to ensure better access, coordination, chronic care management, and disease prevention." The report estimates that widespread implementation of the medical home model would reduce national health care expenditures by \$175 billion over ten years.<sup>51</sup>

**Eliminate Payment Cuts under the Sustainable Growth Rate (SGR):** Congress should eliminate payment cuts, as a result of the flawed SGR, and account for the true costs associated with providing updates. Updates should reflect increases in the costs of medical practice by increasing Medicare baseline spending assumptions.

***Rationale:***

Over the past several years, one of the College's main priorities has been urging Congress to reform Medicare's flawed physician payment formula known as the Sustainable Growth Rate, or SGR. This formula has led to scheduled annual cuts in physician payments for the past seven consecutive years. On January 1, 2010 physicians face a 21 percent Medicare payment decrease unless Congress intervenes to avert this cut. This uncertainty in Medicare reimbursement rates makes it nearly impossible for physicians to plan their budgets for their practices. Although Congress has acted to avert scheduled Medicare payment cuts in the last several years, it has not acted to permanently fix the flawed payment formula. Unless Congress acts to provide the funding necessary to fix this flawed Medicare payment formula, physicians will face continued uncertainty over Medicare reimbursement rates in the future.

The College appreciates that the President's budget recognizes a shortfall in the current Medicare payment formula and intends to dedicate funding to account for "additional expected Medicare payments to physicians over the next 10 years." Accounting for funds needed to reform the flawed sustainable growth rate (SGR) payment formula could remove the greatest single barrier to reaching a consensus on a long-term solution to the SGR payment cuts.

**Summary and Conclusions**

ACP applauds Congress and the Administration for their resolve in addressing major health care reform this year. The College firmly believes that sustaining and improving the primary care workforce is essential to providing patients with access to high-quality care at reduced costs. Congress should take the necessary steps to ensure an adequate primary care workforce by:

- Recognizing that primary care is positively and consistently associated with improved outcomes, reduced mortality, lower utilization of healthcare resources, and lower overall costs of care.
- Developing a national workforce policy to help ensure adequate numbers, availability and distribution of primary care physicians
- Investing in the pipeline of incoming primary care physicians by creating new loan repayment and medical school scholarship programs, increasing funding for Title VII programs, increasing funding for the National Health Service Corps, and allowing deferment of educational loans throughout training in primary care residency programs
- Increasing Medicare payments to primary care physicians to make them competitive with other specialties and career choices
- Modifying Medicare budget neutrality rules to allocate a portion of anticipated savings associated with primary care, such as from reduced preventable hospital and emergency room admissions, to fund increases in payments for primary care services
- Funding programs to support and expand the Patient-Centered Medical Home

- Eliminating payment cuts from the SGR and accounting for the true costs associated with providing updates that reflect increases in the costs of medical practice by increasing Medicare baseline spending assumptions

The College appreciates the opportunity to share its views on the primary care workforce. We look forward to working with this committee on reforms that will expand health insurance coverage to all Americans, improve the quality of care, reduce costs, and ensure that all patients have access to a primary care physician.

<sup>1</sup> R. Graham et al., "Family Practice in the United States: A Status Report," *Journal of the American Medical Association* 288, no. 9 (2002): 1097-1101

<sup>2</sup> Colwill JM, Cultice JM, Kruse RL. Will generalist physician supply meet demands of an increasing and aging population? [published online April 29, 2008]. *Health Aff (Millwood)*. 2008;27(3):232-241. doi:10.1377/hlthaff.27.3.w232.

<sup>3</sup> Becoming An MD-Choosing A Specialty AMA <http://www.ama-assn.org/ama/pub/category/2375.html>.

<sup>4</sup> The Complexities of Physician Supply and Demand: Projections Through 2025. AAMC November 2008.

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Mr. PALLONE. Thank you.  
Dr. Bean.

**STATEMENT OF JAMES R. BEAN**

Dr. BEAN. Thank you, Chairman Pallone and Ranking Member Deal and members of the Health Subcommittee for the opportunity to address you about patient access to medical care. My name is Jim Bean. I practice neurosurgery in Lexington, Kentucky, for the past 29 years. I serve currently as president of the American Association of Neurological Surgeons, and this is a member organization of Doctors for Medical Liability Reform, the Health Coalition on Liability and Access, and the Alliance of Specialty Medicine.

Access to effective medical care depends on a number of factors and we have talked about them, but one that is too often neglected is a barrier to access that is created by a malfunctioning medical liability system. I think it is safe to say there is near-universal agreement among physicians, patients and policymakers that our medical liability system is broken. Defining how is the issue. In 2005, Senators Hillary Clinton and Barack Obama acknowledged this when they co-sponsored medical liability legislation to deal with the mounting access-to-care crisis. A 2008 white paper, Call to Action, released by Senate Finance Committee Chair Max Baucus, also acknowledges that the current legal environment leads to the practice of defensive medicine and calls for alternatives to civil litigation so that the administrative costs associated with litigation, which account for 60 percent of malpractice premiums, can be reduced. Those at the forefront of health care reform understand that it will do little good to achieve universal insurance coverage if the doctors who actually supply critical aspects of care are either driven from practice or retire early or simply shun the lifesaving procedures that need to be done because of uncontrolled risk.

The problem of access to care is especially critical for high-risk specialties. We have been talking a lot about primary care but we should not forget that the specialty care has to be rendered in a safe system. Specialties such as neurosurgery, obstetrics, orthopedics, general surgery, emergency medicine and others, these specialties have been hit particularly hard by lawsuits and rising insurance premiums and they are the same ones who provide critical emergency services, and when they leave, they leave enormous gaps. The crisis persists despite a clear record of successful reform in some States. Mississippi and West Virginia both faced critical loss of medical services because of a doctor exodus because of skyrocketing liability costs. Mississippi lost a substantial number of obstetricians. Both States, West Virginia and Mississippi, lost enough neurosurgeons to endanger their emergency care system. Liability State reforms dramatically reversed the trend and doctors have begun to return. All States should have the same advantage. Perhaps the most dramatic example is Texas. We have heard about it. Before reform in 2003 doctors fled the State. Texas ranked 48th out of 50 States in physician manpower, and since medical liability reform, 69 underserved counties have seen a net gain in emergency physicians and a number of other specialists. Access to care was clearly improved.

While we strongly believe that comprehensive reforms passed in Texas should be applied nationwide, other proposed reforms may help as well. They include early offers, specialized health courts and a presumptive defense by using evidence-based medicine. The President endorsed such an approach in a New England Journal of Medicine article printed online. It was entitled Modern Health Care for All Americans, and it was published during the presidential campaign on September 24, 2008. I have a copy if you would like. He wrote that he would be open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance and he further wrote, "I will also support legislation dictating that if you practice care in line with your medical society's recommendations, you cannot be sued." We strongly support the President's announced position and look forward to its implementation as policy.

Our President and this Congress are dedicated to reforming our health care system and ensuring access to care, but access to quality care must come first and ensuring patient access to care means acting out to fix a critically ill medically liability system.

Mr. Chairman, thank you.

[The prepared statement of Dr. Bean follows:]

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**Statement of**

**James R. Bean, MD**

**on behalf of the**

**American Association of Neurological Surgeons  
Congress of Neurological Surgeons**

**Making Health Care Work for American Families:  
Improving Access to Care**

**before the**

**Subcommittee on Health  
Committee on Energy and Commerce  
U.S. House of Representatives  
March 24, 2009**

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### ***Introduction***

Thank you, Chairman Pallone and Ranking Member Deal, and the entire Energy and Commerce Subcommittee on Health for giving me this opportunity to address you on the critical issue of patient access to medical care.

First, if I might, let me briefly give you my background:

My name is Dr. James R. Bean. My practice is based in Lexington, Kentucky, where I have been a neurosurgeon for the past 25 years. I am currently serving as President of the American Association of Neurological Surgeons, which is a member organization of Doctors for Medical Liability Reform, the Health Coalition on Liability and Access, and the Alliance of Specialty Medicine. I have spoken widely across the country, and have testified numerous times before both the Kentucky State Legislature and this Congress, on issues related to medical liability reform, health care costs and managed care.

Access to effective medical care depends on a number of factors, but one that's too often neglected is the barrier to access created by a malfunctioning medical liability system.

### ***We All Recognize That the System Is Broken***

I think we can safely say that there is near universal agreement among physicians, patients, policy experts, opinion leaders, and policy makers on both sides of the aisle that our current medical liability system is broken and does not best serve the needs of patients or physicians.

When then-Senators Hillary Clinton and Barack Obama co-sponsored legislation in 2005 designed to deal with the mounting access-to-care crisis, they authored an article in the *New England Journal of Medicine* pointing to the deleterious effects of our broken system. Rising premiums, they wrote, are "forcing physicians to give up performing certain high-risk procedures, leaving patients without access to a full range of medical services."<sup>1</sup>

This last October, then-candidate Barack Obama returned to the pages of the *New England Journal of Medicine* to reiterate his basic point, writing that he would be "open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance," and adding forcefully, "We must make the practice of medicine rewarding again."

I would further note that the 2008 white paper released by Senate Finance Committee Chairman Max Baucus, widely considered a kind of "first draft" for healthcare reform, also explicitly acknowledges that "the current legal environment leads to the practice of defensive medicine," and calls for "alternatives to civil litigation...so that administrative costs associated with litigation, which account for 60 percent of malpractice premiums, can be reduced."<sup>2</sup>

In other words, those at the forefront of health care reform understand that it will do little good to achieve universal insurance coverage or even the most up-to-date healthcare IT, if the doctors who

<sup>1</sup> Stuart L. Weinstein, M.D., "Sen. Clinton admits lawsuits harm patient health care," June 2007, at [www.protectpatientsnow.org](http://www.protectpatientsnow.org).

<sup>2</sup> "Call to Action: Health Reform 2009," Senate Finance Chairman Max Baucus, November 12, 2008.

actually supply the care are being driven from business, forced to retire early, or shun potentially risky, life-saving procedures because of our broken medical liability system.

***Controlling the Costs of Defensive Medicine is Critical to Health Care Reform***

It is also widely recognized that we will never be able to control costs – a critical component of any health care reform that works and is sustainable over time – if we don't do something about the constantly overhanging fear of lawsuits that drive physicians and hospitals to increasingly practice defensive medicine.

Elliot Fisher of the Dartmouth Institute for Health Policy is one the leading intellectual fathers of health care reform, and is someone on whom key policymakers rely. According to Dr. Fisher's analysis, the overuse of imaging services driven by medical liability fears was associated with an increase in total Medicare spending of more than \$15 billion between 2000 and 2003.<sup>3</sup> Updated figures for the findings of a 2003 HHS report on the overall costs of defensive medicine, put it at an astounding \$170 billion per year.<sup>4</sup>

***A System That Is Out of Control***

To those of us who work everyday in the field of medicine – the doctors on the front lines, as it were, tending patients in trauma centers, operating rooms and clinics – none of this is surprising. Allow me for a moment to examine the real-life circumstances that doctors face:

- Lawsuit abuse has gotten so out-of-control that about one-third of orthopaedists, obstetricians, trauma surgeons, emergency room doctors and plastic surgeons can expect to be sued in any given year.<sup>5</sup>
- Practicing neurosurgeons can expect to be sued even more often -- every two years, on average.<sup>6</sup>
- And nearly three out of five OB-GYNs have been sued at least twice in their careers.<sup>7</sup>

Most of these cases are meritless: data for 2006 show that some 71% of cases are dropped or dismissed, and only 1% of cases result in a verdict for the plaintiff. Nevertheless, the cost is staggering, with even those cases that result in no payment to the plaintiff costing an average of \$25,000 to defend against.<sup>8</sup> Meanwhile, the average jury award escalated from about \$347,000 in 1997 to \$637,000 in 2006.<sup>9</sup>

As I've mentioned, the effect on patient access to care and the physician population has been so severe that many doctors have been forced to retire early, move out of those states where the crisis is most

<sup>3</sup> "Malpractice Liability Costs and the Practice of Medicine in the Medicare Program," by Katherine Baicker, Elliott S. Fisher, and Amitabh Chandra, *Health Affairs*, volume 26, number 3.

<sup>4</sup> "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care 11," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (2003).

<sup>5</sup> "Defending the Practice of Medicine," by Richard E. Anderson, M.D., *Archives of Internal Medicine*, June 2004.

<sup>6</sup> "Effective Legal reform and the Malpractice Insurance Crisis," by Richard E. Anderson, M.D., *Yale Journal of Health Policy, Law and Ethics*, December 2004.

<sup>7</sup> "Malpractice Maladies: Doctors continue to flee states with out-of-control medical injury verdicts," *Manhattan Institute*, 2005.

<sup>8</sup> Physicians Insurance Association of America Data Sharing Project.

<sup>9</sup> Physician Insurers Association of America, PIAA Claim Trend Analysis: 2006 ed. (2007)

acute, and cut back on the kinds of life-saving and life-enhancing medical procedures that expose them to greater risk of lawsuit abuse. A number of surveys of hospitals and physicians have highlighted the alarming trends:

- A survey by the American Hospital Association found that fifty-five percent of hospitals reported difficulty recruiting doctors because of the medical liability crisis;<sup>10</sup>
- Three out of four emergency rooms report diverting ambulances due to a shortage of specialists, and more than twenty-five percent of hospitals have lost specialist coverage due to the medical liability crisis;<sup>11</sup>
- Forty-four percent of neurosurgeons have had to limit the type of patients they treat, and of these, seventy-one percent no longer perform aneurysm surgery, twenty-three percent no longer treat brain tumors and seventy-five percent no longer operate on children;<sup>12</sup>
- Fifty-five percent of orthopaedic surgeons avoid some procedures due to liability concerns; one out of five has stopped performing emergency room calls; six percent have eliminated all surgery and one out of twenty has retired early;<sup>13</sup>
- A survey by the American College of Obstetricians and Gynecologists found that liability concerns have forced seventy percent of all OB-GYNs to make changes in their practice and have driven some seven to eight percent to stop practicing obstetrics all together.<sup>14</sup> According to ACOG's 2007 survey, 89 percent of all OB-GYNs have had at least one liability claim filed against them, with an average of 2.6 claims per obstetrician.<sup>15</sup>

#### *A Bleak Prognosis for the Future*

While the immediate shortages of physician care caused by the liability crisis are severe, the outlook for the future is even more troubling, as fears of exposure to lawsuit abuse are causing medical students and residents to avoid high-risk specialties and more litigious states:

- Sixty-two percent of medical residents report that liability issues are their top concern;<sup>16</sup>
- And half of all medical students responding to an AMA survey said that the liability situation was a factor in their specialty choice.<sup>17</sup>

<sup>10</sup> American Hospital Association, *Professional Liability Insurance: A Growing Crisis*, March 2003.

<sup>11</sup> The Schumacher Group, 2004 Hospital Emergency Department Administration Survey; cited in "Federal Medical Liability Reform," Alliance of Specialty Medicine, July 2005.

<sup>12</sup> American Association of Neurological Surgeons and Congress of Neurological Surgeons, 2004 Survey; cited in "Federal Medical Liability Reform," Alliance of Specialty Medicine, July 2005.

<sup>13</sup> American Association of Orthopaedic Surgeons; cited in "Federal Medical Liability Reform," Alliance of Specialty Medicine, July 2005.

<sup>14</sup> ACOG Survey, The American College of Obstetricians and Gynecologists, November 3, 2006

<sup>15</sup> ACOG Survey, The American College of Obstetricians and Gynecologists, November 3, 2006

<sup>16</sup> Meritt, Hawkins & Associates, Summary Report: 2003 Survey of Final Year Medical Residents 5 (2003)

<sup>17</sup> Division of Market Research & Analysis, American Medical Association, AMA Survey; Medical Student's Opinion of the Current Medical Liability Environment (2003).

One particularly representative example of the access to care crisis is the state of Pennsylvania, where 17 maternity wards have closed down since 1997<sup>18</sup> and there is presently no trauma center to treat the half million residents of the Philadelphia suburb of Chester County.<sup>19</sup>

I bring up Pennsylvania because it demonstrates that the outlook for the future is much much more disturbing than even the present numbers indicate. Newly graduated doctors educated in Pennsylvania are setting up their practices elsewhere because of the deteriorating liability climate. In 1992, 60 percent of residents stayed in Pennsylvania when they finished their training. Now only 20 percent do so.<sup>20</sup> In some specialties, more than 40 percent of the practicing physicians are more than 50 years old<sup>21</sup> and only years away from retirement, creating a bleak future for medical care in that state – and to the extent this is representative, I would say a bleak future for our nation as a whole.

### *The Crisis Continues*

The mechanism by which doctors are driven away from medicine is no mystery. As abuse of the legal system mounts, medical liability insurance premiums skyrocket. Like the temperature on a thermometer, the rise in premiums is a strong indication of the health of our present system and how acute the crisis is from one year to the next. As rates began to slow their rapid climb and level off in 2006, some were tempted to say that the crisis had passed. In fact, while rates have declined somewhat, they remain at or near historically high levels.

According to the Medical Liability Monitor for 2008, more than 50 percent of rates did not change between 2007 and 2008. Some seven percent of premiums increased. While the remaining 43 percent of rates decreased, most of those decreases were small—less than 10 percent.<sup>22</sup> This is after premium increases over 100 percent a year in some states without comprehensive medical liability reforms in place.<sup>23</sup>

The charts in the appendix give a graphic depiction of the run-up in insurance rates since the year 2000 for three representative specialty groups.<sup>24</sup> For the years 2000 to 2008:

- Premiums rose 221 percent for OB-GYNs in Philadelphia, Pennsylvania;
- Premiums rose 149 percent for general surgeons in New Jersey;
- Premiums rose 348 percent for internists in Connecticut.

In other words, the modest improvement in rates looks more like a temporary “market correction” rather than a reversal of on-going trends. From a national perspective, none of the underlying realities that produced the six-year run up have changed and the pressures remain unabated.

<sup>18</sup> “Building for Babies,” *Bucks County Courier Times*, February 23, 2009.

<sup>19</sup> “It’s time for a Chester County trauma center,” *West Chester Daily Local News*, July 6, 2008.

<sup>20</sup> “Pennsylvania Is Driving Its Doctors Away,” *Wall Street Journal*, October 25, 2008.

<sup>21</sup> “Pennsylvania Is Driving Its Doctors Away,” *Wall Street Journal*, October 25, 2008.

<sup>22</sup> *Medical Liability Monitor Rate Survey Issue Results* (October 2008)

<sup>23</sup> Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Special Update on Medical Liability Crisis (2002), cited in *Medical Liability Monitor Rate Survey Issue Results*.

<sup>24</sup> *Medical Liability Monitor Rate Survey Year-by-year Results*

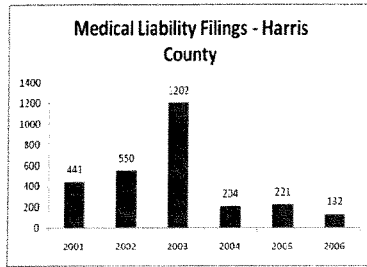
*The Proven Track Record of Comprehensive Reform – the Texas Miracle*

The continuing crisis persists despite a clear record of successful reform in some states. Perhaps the most dramatic – because its condition was so dire before reforms were enacted – is Texas.

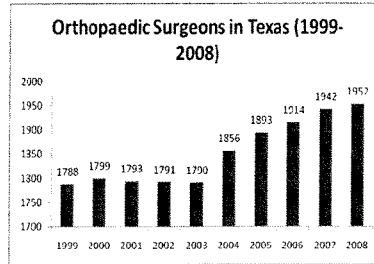
Before reform, doctors were fleeing the state, and patients suffered. Texas ranked 48<sup>th</sup> out of the 50 states in physician manpower, with just 152 MDs for every 100,000 people, well below the national average of 196.<sup>25</sup> In just four years, Texas physicians had seen their premiums rise between 22.5 and 128 percent, premiums paid by hospitals more than doubled, and nursing homes saw their rates soar 2000 percent.<sup>26</sup> In some parts of the state, there were 300 lawsuits for every 100 doctors,<sup>27</sup> helping to earn the state its designation by the American Tort Reform Association as one of America's foremost "judicial hellholes."

In 2003, voters passed Proposition 12, a constitutional amendment locking in the limits on non-economic damages passed earlier by the legislature. The result has become known as the Texas Miracle. The first effect is that so many doctors have come flooding back into the state that Texas's biggest problem became a backlog in the state's ability to license them.

The charts below give a graphic illustration of the success of reform, as liability filings dropped precipitously and previous declines in the number of specialists were turned into major increases:



*Harris County District Clerk's Office*



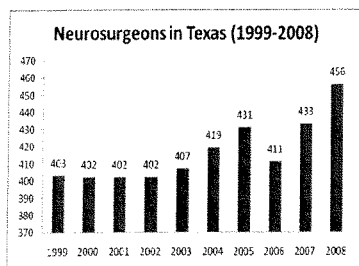
*Texas Medical Board*

<sup>25</sup> Texas Tech Law Review, cited in "A Miracle in the Making: How Texas Became a Model for Medical Liability Reform," at [www.protectpatientsnow.org](http://www.protectpatientsnow.org)

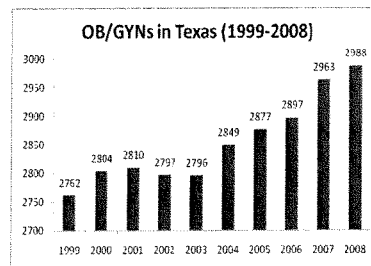
<sup>26</sup> "A Miracle in the Making: How Texas Became a Model for Medical Liability Reform," at [www.protectpatientsnow.org](http://www.protectpatientsnow.org)

<sup>27</sup> "Ten Gallon Tort Reform," *The Wall Street Journal*, June 6, 2003.





*Texas Medical Board*



*Texas Medical Board*

Since medical liability reform, the six largest insurers have cut their rates, with Texas Medical Liability Trust clocking a full 31.3 percent decrease, and many other private firms have entered the market.<sup>28</sup> Seventy-six counties have experienced a net gain in emergency physicians since the passage of medical liability reforms in 2003, including 39 medically underserved counties and 30 counties that are partially medically underserved.<sup>29</sup> As you know, the Texas reforms were so successful that they became the basis for reform legislation introduced in the U.S. Congress in 2006.

We strongly believe that comprehensive reforms of the kind passed in Texas should be applied nationwide. At the same time, we understand the political realities of the current Congress and believe that other reforms measures may help to ameliorate the current crisis in access to care and should be considered.

#### ***Early Offers***

Among these are calls an “early disclosure” or “early offer” model, such as that contained in the Baucus Report. The early-offer process would allow defendants to make a financial offer covering the claimant’s economic damages and attorneys’ fees. If the offer were accepted, further legal action would be foreclosed. If the early offer were rejected, the claimant’s burden of proof at any subsequent trial would be increased.<sup>30</sup> Savings to the system come from the elimination of non-economic damages and the lower attorney’s fees that result from the speedier resolution of the case.

In a report prepared for the Department of Health and Human Services, an analysis of cases between 1988 and 2002 found that an early offers system would reduce claim costs by an average of approximately \$556,000 per claim and by more than \$1 million per claim for severe injuries.<sup>31</sup>

<sup>28</sup> Texas Medical Association.

<sup>29</sup> “Emergency Medicine Physicians Announce Significant Increase In Doctors Providing Emergency Care Across Texas,” *Blanco County News*, February 11, 2009.

<sup>30</sup> “Evaluation of Early Offer Reform of Medical Malpractice Claims: Final Report,” US Dept of HHS, June 5, 2006.

<sup>31</sup> “Medical Malpractice Reform Plan Pays Off for Victims and Health Care Providers,” University of Virginia Press Release, January 10, 2007.

### *Specialized Health Courts*

The Baucus Report also called for the consideration of specialized health courts. As in so many other proposals, health courts carry a certain promise if the details are done right. If the court's findings are not binding and further appeals are not foreclosed, it will be critical that – as with early offers – the claimant's burden of proof at any subsequent trial would be increased. Otherwise, such courts will just add one more venue in which doctors can be sued, and will do little to improve the current situation.

### *Evidence-Based Medicine*

The American Recovery and Reinvestment Act of 2009 -- more commonly known as the stimulus bill -- contained \$1.1 billion in funding to coordinate comparative clinical effectiveness research.

Economists and health policy experts have been debating the merits of research that compares the effectiveness of medical treatments,<sup>32</sup> often called "evidence-based medicine" by its supporters. Clearly, such research may have the potential to yield useful information. An ideal outcome for doctors who practice "evidence-based medicine" would be immunity from liability lawsuits, or at a minimum, a greater increase in the burden of proof for the plaintiff.

President Obama, in the *New England Journal of Medicine* article that I referred to earlier, endorsed just such an approach. In the article, which is titled "Modern Health Care for All Americans" and published on-line on September 25, 2008, then-candidate Obama stated that "I will also support legislation dictating that if you practice care in line with your medical societies' recommendations, you cannot be sued."

We strongly support the President's announced position here, and look forward to its implementation as policy. At the same time, we believe that such guidelines should not be interpreted as a "one-size-fits-all" solution that implies negligence has occurred anytime a health care provider uses his/her independent judgment and expertise to offer treatments outside those boundaries.

### *Volunteer Liability*

Finally, we strongly support legislation designed to protect health care professionals from being held liable when they volunteer their services to the victims of a declared disaster or national emergency. We note that Volunteer Liability legislation has garnered significant interest on Capitol Hill is likely to be introduced during the 111<sup>th</sup> Congress. We strongly urge Congress to pass it.

Today, not all states provide adequate protections from state liability lawsuits to physicians and other healthcare professionals who respond to national or state calls for help in major disasters such as hurricanes and earthquakes. In addition, few, if any, states provide such protections for health care providers licensed outside their state who provide care to disaster victims.

The need for such legislation does beg a central issue, however: If even volunteers in disaster areas need to be protected from the abuses of the present system, what does that say about how the system affects providers in their everyday practices?

<sup>32</sup> "U.S. to compare medical treatments," *New York Times*, February 15, 2009.

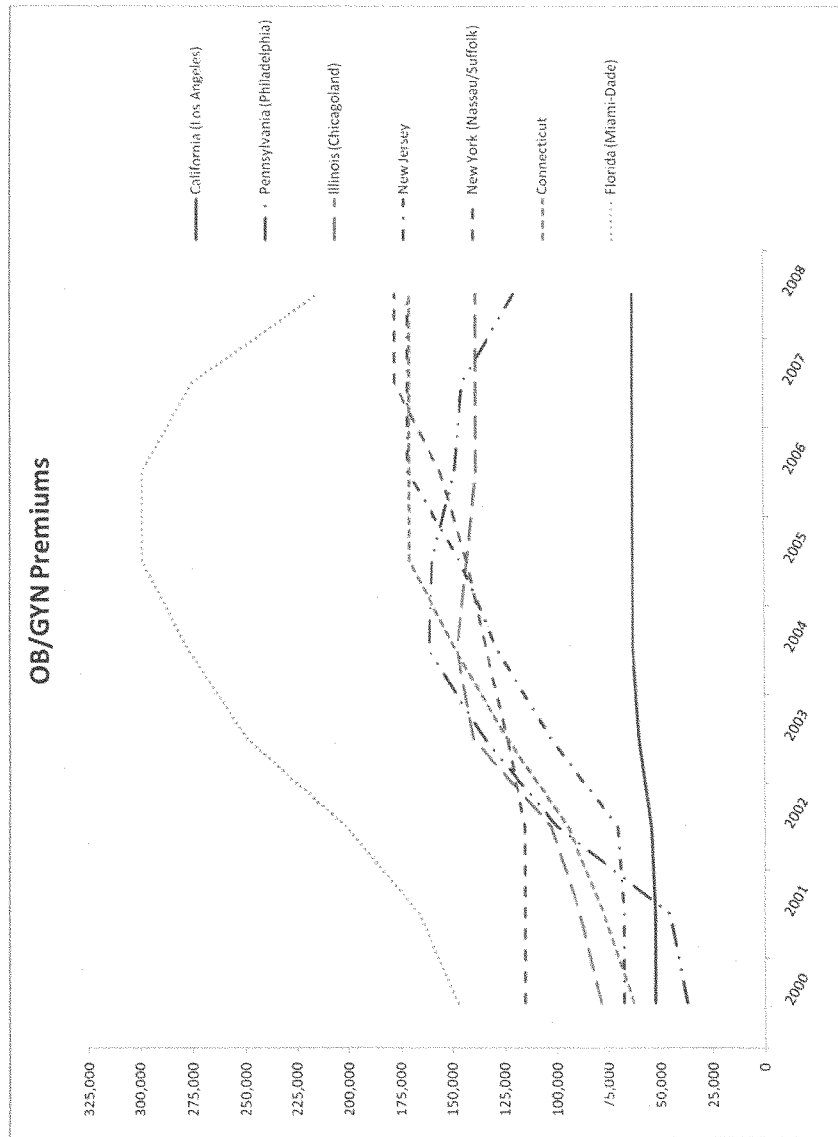
*Conclusion*

In conclusion, allow me to simply restate what we all know: the problem will not go away unless Congress takes effective action, and until it does, patient access to care will continue to be threatened by a broken medical liability system.

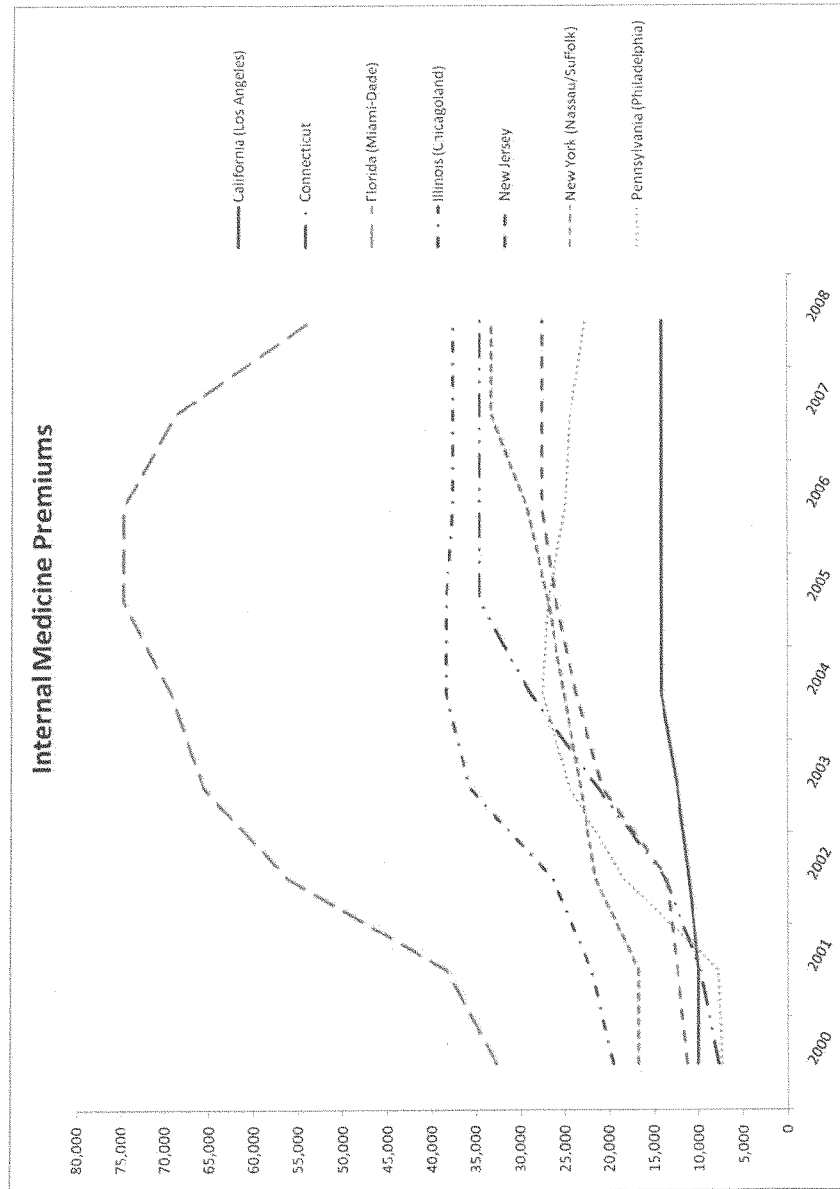
Our President and this Congress are dedicated to reforming our health care system. No other action we undertake as a nation can be so vital. But we know as well that no overall reform of our health care delivery system can be effective if the heart of the system – the physicians who care for patients – are constantly under siege and being driven from practice by an abusive system.

Nor will the future of reform be very bright if our best students, as we have seen, are increasingly becoming discouraged from taking up the arduous calling of medicine.

Access to quality care must come first in overall health care reform. That is what it is all about, after all. And ensuring patient access to care means acting now to fix our critically ill medical liability system.







Mr. PALLONE. Thank you, Dr. Bean.  
Dr. Rowland.

#### STATEMENT OF DIANE ROWLAND

Ms. ROWLAND. Thank you, Chairman Pallone and Ranking Member Deal and members of the committee, for the opportunity today to participate in this hearing on making health care work for American families. My testimony today will address the role public programs have played in improving access and helping to reduce health care disparities. Indeed, health care coverage matters. It may not be enough to assure access, but without it, access to care suffers and disparities rise.

Together today, Medicare and Medicaid provide coverage to over a quarter of our population, 80 million Americans, our oldest, our poorest, our most disabled and among our sickest residents. Both programs for over 40 years have been central to our Nation's efforts to improve access to care and the health care of the American people. Medicare has helped to provide access to care for the elderly by easing the financial burden for care and opening up access to the broad range of medical services and new technology that has helped to both extend life and promote better care. Medicare has helped not only to improve access to medical care but also to reduce racial barriers to care, both through the enforcement of the civil rights legislation that led to the desegregation of health care facilities and by providing equal benefits to all beneficiaries without regard to health status, income, racial or ethnic identity or State of residence.

Medicaid is the workhorse today of the U.S. health care system, providing coverage for almost 60 million Americans left out of private health insurance and with very special health care needs. Medicaid coverage of the low-income population provides access to a comprehensive scope of benefits with limited cost sharing that is geared to meet the health needs and limited financial resources of Medicaid's beneficiaries who tend to be both sicker and poorer than the privately insured low-income population. Medicaid also helps to address racial and ethnic disparities and access to care. Because minority Americans are more likely than whites to be low income and without access to job-based coverage, Medicaid provides an important safety net, today covering one in four non-elderly African-Americans and Latinos. In fact, minority populations compose over half of the Medicaid beneficiaries. The comprehensive scope of Medicaid benefits is critical, given the low incomes and complex health needs of the population Medicaid services including the chronically ill and people with severe disabilities. When the health needs of the beneficiaries on Medicaid are taken into account, Medicaid is in fact a low-cost program. Both adult and child per capita spending are lower in Medicaid than under private health insurance. Medicaid enrollees, however, tend to fare as well as the privately insured on important measures of access to primary care. Uninsured children have significantly higher rates of no usual source of care. Compared to only 4 percent of publicly insured children and 3 percent of privately insured children, one third of uninsured children have no usual source of care. There have been great gains in reducing the share of low-income children who are uninsured

through the expansion of Medicaid and CHIP demonstrating that public programs can provide a solid platform from which to expand coverage.

As the Nation moves forward to consideration of how to provide coverage to the over 45 million uninsured Americans today, Medicaid's role for the low-income population provides a strong platform on which reform efforts can be build as evidenced by the recent experience with children's coverage. One must recall that the uninsured population is predominantly low income, two-thirds with incomes below 200 percent of poverty, or roughly \$44,000 for a family of four a year. Medicaid provides a strong and tested foundation upon which to build these health reform efforts but it could play indeed a stronger role if coverage of the low-income population was improved through expanded eligibility and reduction of enrollment barriers through addressing payment rates and administrative burden to help boost provider participation and promote greater access to primary care especially and through a stabilization of financing so that the periodic cuts in the program that affect reimbursement to providers and coverage for beneficiaries do not need to occur.

In summary, the Medicaid program has an established track record in providing the scope of benefits and range of services to meet the needs of low-income population including those with chronic illness and severely disabling conditions. Drawing on Medicaid's experience in already substantial coverage of the low-income population offers an appropriate starting point for extending coverage to the low-income uninsured population through health care reform. While health insurance coverage is essential to open the door to the health care system for these individuals, broader measures as you have heard discussed today need to also be put in place as a complement to assure that the coverage card is not an empty promise. Thank you.

[The prepared statement of Ms. Rowland follows:]





**THE KAISER COMMISSION ON  
Medicaid and the Uninsured**

**MEDICAID AND ACCESS TO CARE**

**Testimony of Diane Rowland, Sc.D.**

**Executive Vice President, Henry J. Kaiser Family Foundation**

**Executive Director, Kaiser Commission on Medicaid and the Uninsured**

**Before the U.S. House of Representatives**

**Committee on Energy and Commerce**

**Subcommittee on Health**

**"Making Health Care Work for American Families:**

**Improving Access to Care"**

**March 24, 2009**

**Making Health Care Work for American Families:  
Medicaid and Access to Care**

Medicaid is the workhorse of the U.S. healthcare system providing coverage for almost 60 million Americans left out of private health insurance and financing 16 percent of national health spending. Medicaid coverage of the low-income population provides access to a comprehensive scope of benefits with limited cost-sharing that is geared to meet the health needs and limited financial resources of Medicaid's beneficiaries who tend to be sicker and poorer than the privately insured low-income population.

- Medicaid helps to address racial and ethnic disparities in access to care. Because minority Americans are more likely than Whites to be low-income and uninsured, Medicaid provides an important safety net for about 1 in 4 nonelderly African Americans, American Indians/Alaska Natives, and Latinos, and about 1 in 10 Asian/Pacific Americans and Whites. Medicaid covers over a quarter of all children in the U.S., including nearly 1 of every 5 White children, but roughly 2 of every 5 African American and Hispanic children.
- The comprehensive scope of Medicaid benefits is critical given the low-incomes and complex health needs for the population Medicaid serves, including the chronically ill, people with severe disabilities. When the health needs of its beneficiaries are taken into account, Medicaid is a low-cost program; Both adult and child per capita spending are lower in Medicaid than under private insurance.
- Medicaid enrollees tend to fare as well as the privately-insured population on important measures of access to primary care; Uninsured children have significantly higher rates of no usual source of care (32%) compared to only 4% of publicly insured children or 3% of privately insured children.
- Great gains in reducing the share of low-income children who are uninsured have been made through the expansion of Medicaid /CHIP, demonstrating that public programs provide a solid platform from which to expand coverage; Between 1998 and 2007, the uninsured rate among low-income children fell by almost half (28% to 15%).
- Less progress has been made for adults, leaving many uninsured. Over half of the uninsured are low-income adults. Although 44 states have set the Medicaid/CHIP income-eligibility level for children at or above 200% of the federal poverty level, 33 states limit the Medicaid income eligibility for parents to below 100% of the federal poverty level and coverage for childless non-disabled adults remains beyond Medicaid's current scope.

Medicaid provides a strong and tested foundation upon which to build health reform efforts, but could play a stronger role if coverage of the low-income population was improved through expanding eligibility and reducing enrollment barriers; addressing payment rates and administrative burden to boost provider participation; and stabilizing the financing.

Mr. Chairman and members of the Committee on Energy and Commerce, thank you for the opportunity to participate in this hearing on making health care work for American families. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. I am also an Adjunct Professor of Health Policy and Management in the Bloomberg School of Public Health at The Johns Hopkins University. My testimony today will address the role public programs have played in improving access to care and helping to reduce health care disparities, with a focus on the role Medicaid has played for low-income families.

Together, Medicare and Medicaid provide health coverage to over a quarter of our population --- over 80 million Americans (Figure 1). Medicare, as the health financing program for the nation's senior citizens and people with severe disabilities, covers many of those with the greatest health needs due to age and disability. Medicaid, enacted with Medicare in 1965, plays a different and somewhat more complex role as the health and long-term care assistance program for the nation's low-income population.

Medicare has helped to improve access to care for the elderly by easing the financial burden for care and opening up access to the broad range of medical services and new technology that has helped to both extend life and promote better care. Medicare has helped not only to improve access to medical care, but also to reduce racial barriers to care through the enforcement of civil rights legislation leading to the desegregation of health facilities and by providing equal benefits to all beneficiaries without regard to health status, income, racial or ethnic identity, or state of residence. Research has documented that with Medicare, access to care substantially expanded and disparities by race narrowed for the elderly. As the nation now considers health reform, because Medicare covers virtually all of the 37 million elderly Americans, it is the nation's 45 million uninsured under age 65 that are the focus of efforts to broaden coverage.

Medicaid is an equally important part of health coverage today covering almost 60 million low-income Americans and financing 16 percent of national health spending, including 40 percent of spending on long-term care services (Figure 2). Medicaid is the nation's health care safety net providing health coverage to one in four of America's children and many of their parents — 30 million low-income children and 15 million adults who generally have no access to job-based coverage. It is a particularly important source of coverage for both acute and long-term care for 8 million non-elderly people with disabilities and is an essential adjunct to Medicare for the nearly 9 million low-income elderly and disabled Medicare beneficiaries who depend on Medicaid to help with Medicare premiums, fill in gaps in Medicare benefits, and assist with long-term care needs. Without Medicaid to supplement Medicare, the gains achieved in reducing racial disparities and improving access to care would have been more difficult to attain for many of Medicare's poorest beneficiaries. Medicaid financing provides states with the capacity to provide coverage for their low-income families and helps to support safety net clinics and hospitals for the poor and uninsured.

Medicaid is a critical source of coverage for the low-income population, covering 40 percent of those living in poverty and a quarter of the near poor. (Figure 3). Federal law requires states to provide Medicaid coverage to all children in families with incomes below poverty and states have the option of extending coverage to children at higher income levels through Medicaid and Children's Health Insurance Program (CHIP). However, Medicaid eligibility for parents varies widely across the states and is below poverty in all but 17 states and DC, and, under current federal rules, adults without dependent children are ineligible for Medicaid unless they qualify on the basis of a disability (Figures 4 and 5). As a result, Medicaid now provides coverage to half of all low-income children, but only reaches 20 percent of low-income parents and leaves most poor childless adults uninsured.

While Medicaid is often viewed in its role as the health insurer of low-income families, it is important to recognize that children and parents in low-income families

comprise the majority (76%) of Medicaid enrollees, but account for less than a third (30%) of program spending (Figure 6). This is largely driven by the difference in spending per enrollee ---\$1,600 per child compared to \$13,500 per person with disabilities and nearly \$12,000 per elderly enrollee -- due to the greater use of both acute and long-term services by the disabled and elderly (Figure 7). More than 45 percent of Medicaid spending for services is attributable to the dual eligibles, the low-income Medicare beneficiaries who also have Medicaid coverage.

Medicaid spending --- like most health spending --- is highly skewed with a small share of enrollees accounting for a large share of the spending. In 2004, the 5 percent of beneficiaries with the highest health and long-term care costs (over \$20,000 annually) accounted for 57 percent of spending (Figure 8). For many of those with the most extensive health needs, including those with severely disabling conditions, Medicaid provides access to diverse services and long-term care options that often exceed the scope of most private insurance. In these multiple roles, Medicaid has contributed both to promoting access to care and improving health outcomes for the poor and near-poor population, but also to assuring comprehensive coverage for the complex and extensive health needs of many of the chronically ill and those with severe disabilities in our society.

#### Access to Care for the Low-Income Populations

Medicaid financing has helped move many low-income families from dependence on charity care to financial access to both public and private providers. In doing so, it has offered assistance to millions of low-income children and adults and provided a healthier start in life --- and fewer disparities in life --- to many of the nation's children. The coverage provided by Medicaid has helped to narrow the gaps in access to care faced by those without insurance and promoted broader use of preventive and primary care services.

Maintaining a comprehensive scope of benefits and limited cost-sharing is critical for the population Medicaid serves. Cost-sharing can place a disproportionately heavy burden on the tight budgets of low-income families, affecting access to care and health outcomes adversely. Today, a majority of low-income families on Medicaid receive their health coverage through managed care organizations under contract with the state to provide both comprehensive services and a provider network for beneficiaries.

Medicaid's impact can be seen both in the numbers of people served and the access to care provided. Medicaid's success in improving access to care for the low-income population is most notably reflected in the comparability of Medicaid to private insurance on the many access measures where the uninsured fall far behind. For both children and adults, Medicaid like private insurance links families to a usual source of care -- the key entry point into the health care system. With Medicaid coverage, children and adults utilize the health system similarly to those privately insured and face far fewer financial and access barriers to care than the uninsured. Most notably, uninsured children have significantly higher rates of no usual source of care (32%) compared to only 4 percent of publicly-insured children or 3 percent of privately-insured children (Figure 9). Eighty-nine percent of publicly insured low-income children have had a well-child visit compared to 82 percent of privately insured low-income children, and 11 percent of publicly insured low-income adults report no usual source of care compared to 13 percent of privately insured low-income adults (Figure 10 and 11).

Medicaid's access comparability to private coverage is especially notable given that the Medicaid population is both poorer and sicker than those who are privately insured (Figure 12). Because Medicaid covers a sicker population with more health needs, it is often viewed as more costly than private insurance. However, when the cost per adult and per child for medical care is adjusted for health status, Medicaid spending per person is below that of private insurance. While this is

in part due to lower provider payment rates, it also reflects greater efficiency in program administration and in managing care (Figure 13).

#### Medicaid's Role in Addressing Disparities

In addition to providing coverage that helps level the access to care playing field for millions of low-income children and adults, Medicaid has a particularly strong role in reducing access to care disparities by race and ethnicity. Because they are more likely to be low-income and have jobs without health insurance coverage, a higher proportion of African Americans and Latinos have Medicaid coverage (or are uninsured) than Whites and Asian/Pacific Islanders.

Over a quarter (27%) of African Americans and 24 percent of Latinos rely on Medicaid for their health insurance protection in contrast to 12 percent of Whites (Figure 14). Medicaid's role is even more substantial for children -- covering 2 out of every 5 African-American and Latino children compared to 1 out of every 5 White children. Because Medicaid is such an important source of coverage for minority populations, they make up the majority (56%) of Medicaid enrollees. Among Medicaid beneficiaries, one in four (27%) is of Hispanic ethnicity and one in five (22%) is African American (Figure 15).

Medicaid by providing health insurance coverage serves to promote improved access to care that can help to narrow disparities in access to care (Figure 16). For Whites as well as minorities, being uninsured compromises access to care. Having a usual source of care is associated with better access to primary and preventive care and better care coordination within the health care system. Across all racial and ethnic groups, public coverage in contrast to being uninsured has been shown to increase substantially the likelihood that an individual has a usual source of care -- thus improving the chances that barriers to receiving timely care and using the health system effectively will be reduced.

Medicaid also plays an important role as a source of coverage in rural areas where there is less employer-sponsored coverage and higher poverty rates than in urban areas. Nearly a fifth of poor children live in rural areas. As a result, nearly a third (32%) of rural children compared to a quarter (26%) of urban children have Medicaid and CHIP for their health insurance coverage. As Medicaid promotes access to care for the low-income rural population enrolled, it also serves as a critical source of payment for rural providers, and helps fill the gap left by the low level of private insurance in rural areas. By enabling hospitals, doctors, and clinics to get financing support for their services, Medicaid helps maintain the availability of health services for all rural residents and helps sustain rural economies.

#### Medicaid as a Platform for Reform

As the nation moves forward to consideration of how to provide coverage to the over 45 million uninsured Americans, Medicaid's role for the low-income population provides a strong platform on which reform efforts can be built as evidenced by the recent experience with children's coverage. Great gains in reducing the number of uninsured low-income children have been made through the expansion of Medicaid/CHIP; between 1998 and 2007 the uninsured rate among low-income children fell by almost half (28% to 15%) due to expansions in these programs.

The uninsured population is predominantly low-income -- two-thirds of the uninsured have incomes below 200 percent of poverty --- roughly \$44,000 for a family of four (Figure 17). Thus, Medicaid provides the framework for comprehensive and affordable coverage for the low-income population and has been an effective vehicle for improving access and health outcomes for the poor and disadvantaged. It is a tested program with an administrative structure in every state that virtually every state health reform effort has built upon in seeking to broaden coverage for their low-income residents.



Medicaid is widely viewed as a cornerstone of state efforts to expand coverage and provides a base for extending coverage that has public support. In surveys of low-income families, over 90 percent of parents with an uninsured child view Medicaid/CHIP as a good program and say they would enroll their child if eligible for public coverage (Figure 18). Public opinion surveys have consistently shown broad support for public coverage programs with 74 percent ranking Medicaid as a very important program compared to 83 percent for Medicare in our 2005 survey of the general public. When asked about approaches to expanding coverage nationally, 70 percent of the public say they favor expanding Medicaid and SCHIP as one way to achieve broader coverage (Figure 19).

To make Medicaid a more effective platform for extending coverage to the low-income population, several options have been raised for reducing gaps and strengthening the program's base. To reach and cover more of the low-income population both expanding eligibility and reducing enrollment barriers could be addressed by: basing Medicaid eligibility solely on income and eliminating the current categorical requirements that exclude childless adults; standardizing income eligibility levels across states for adults to provide a national floor similar to the current requirements for coverage of all children under poverty; and further simplifying enrollment procedures to make coverage more accessible to working families. To improve access to care, greater emphasis could be placed on preventive and primary care combined with improvements in the level of provider payments to promote greater physician participation and assure the availability of care in safety net facilities and medically underserved areas. To meet the health needs of the complex populations served by Medicaid, greater emphasis could be placed on adopting new strategies and technology to better coordinate care and evaluate quality. To underpin these efforts and secure coverage through good and bad economic times, ways to enhance and stabilize federal financing and provide countercyclical aid also need to be addressed.

Conclusion

The Medicaid program serves a disproportionately low income and disadvantaged population, living in poor and often environmentally and physically hazardous neighborhoods, where poverty and complex social needs combine with a multitude of other factors to shape health outcomes. Health coverage alone cannot be expected to reverse the effects of poverty and deprivation on the health and well-being of America's poorest residents, but Medicaid has demonstrated over the last four and a half decades that it is an important lever to help improve access to health services and hopefully the health of America's poorest children and families.

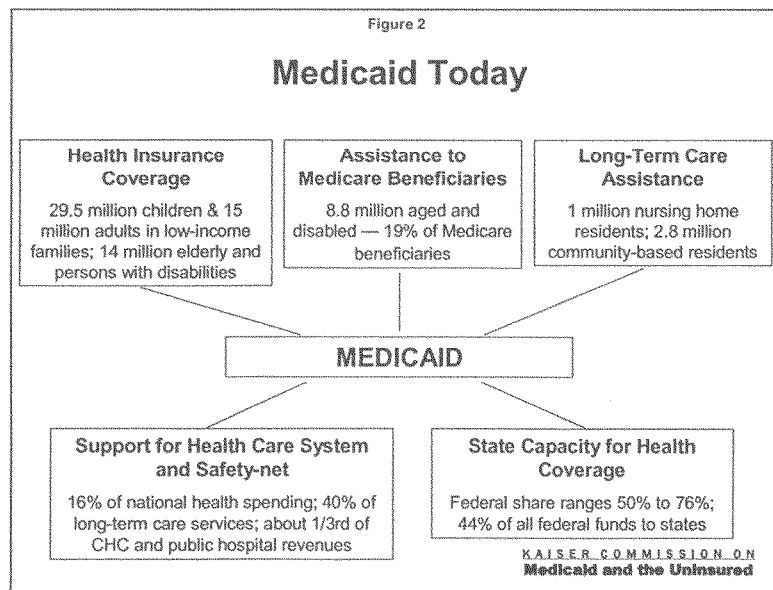
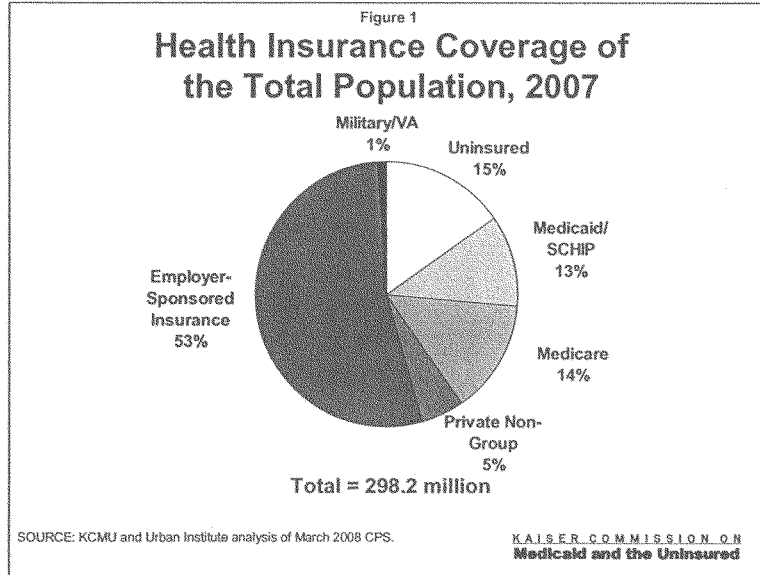
Medicaid continues to provide coverage beyond that of private insurance or Medicare to the most vulnerable and frail in our society - acute and long term care services for persons with chronic mental illness or developmental disabilities; medical and drug therapy for those with HIV/AIDS; assistance with Medicare's premiums, cost-sharing, and coverage gaps for poor Medicare beneficiaries and home-based and institutional care for those with severe physical and mental disabilities that require long-term care. In the absence of Medicaid, it is hard to envision how these enormous societal needs would be met.

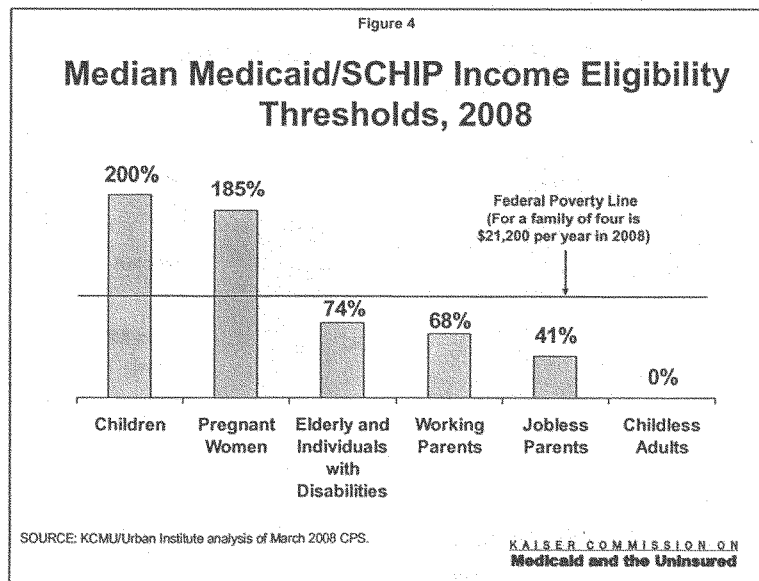
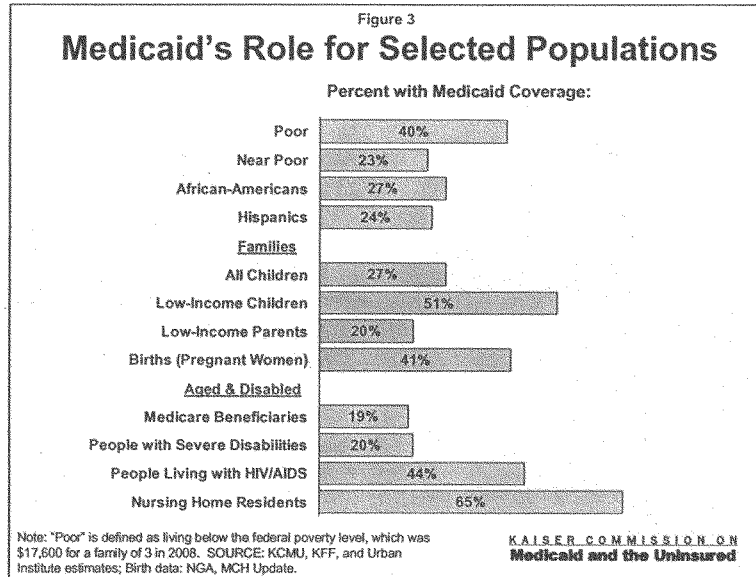
The Medicaid program has an established track record in providing the scope of benefits and range of services to meet the health needs of a low-income population that includes many with chronic illness and severely disabling conditions. Drawing on Medicaid's experience and already substantial coverage of the low-income population offers an appropriate starting point for extending coverage to the low-income uninsured population through health reform.

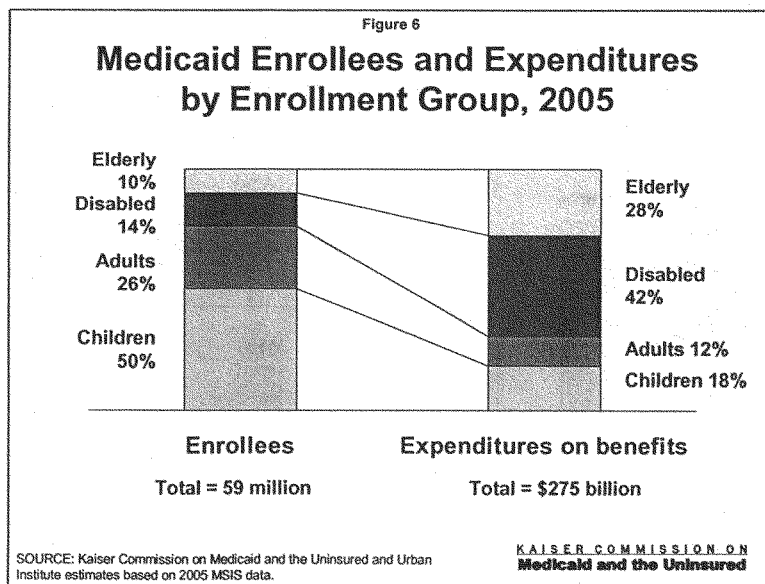
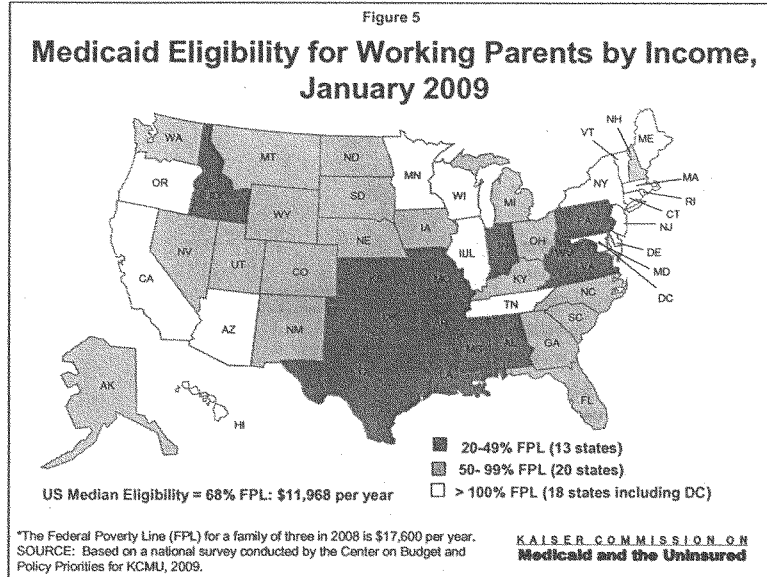
As the nation moves forward to consider health care reform, strengthening the base that Medicaid provides for the low-income population and those with special health needs will help to provide the foundation on which broader health reforms can

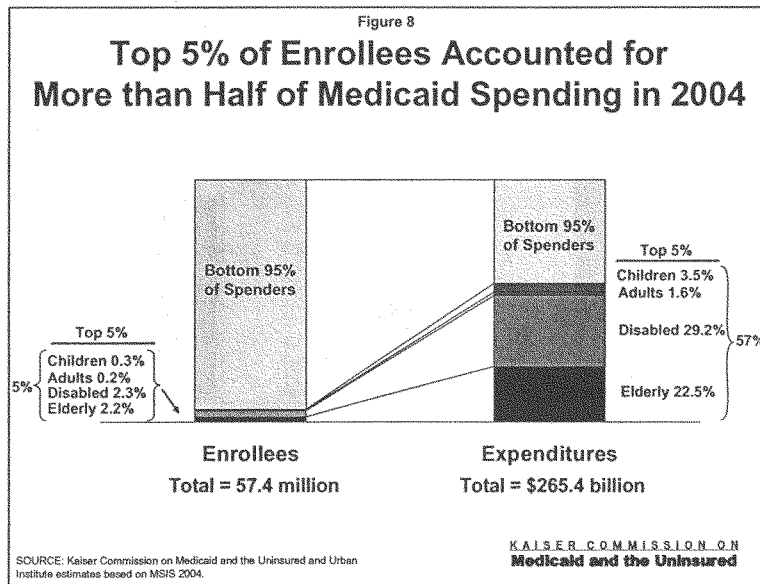
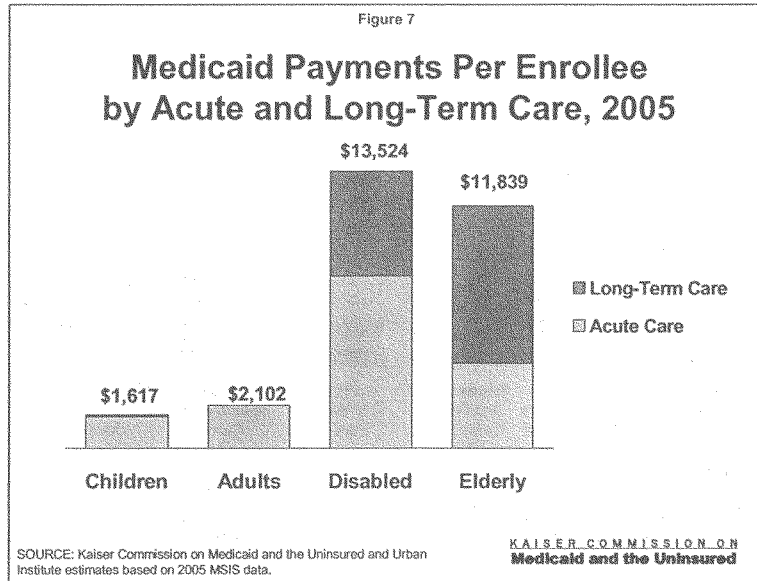
be built. I look forward to working with the Committee as your health reform efforts move forward.

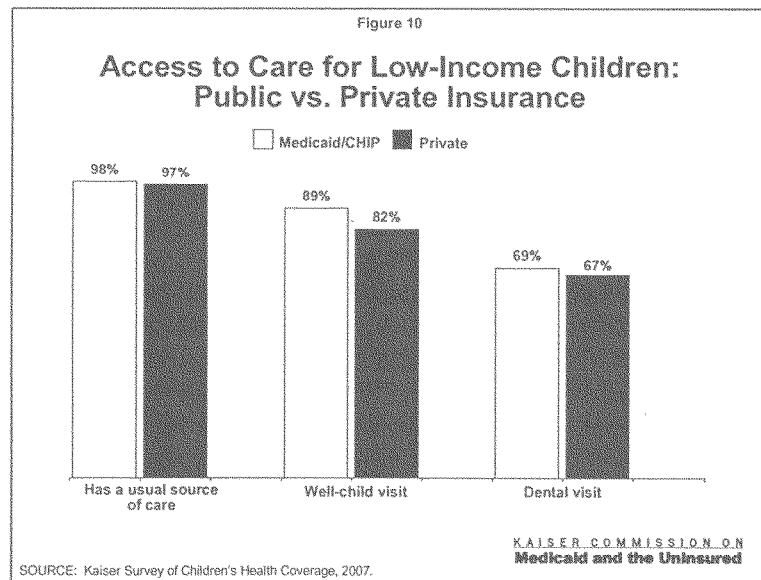
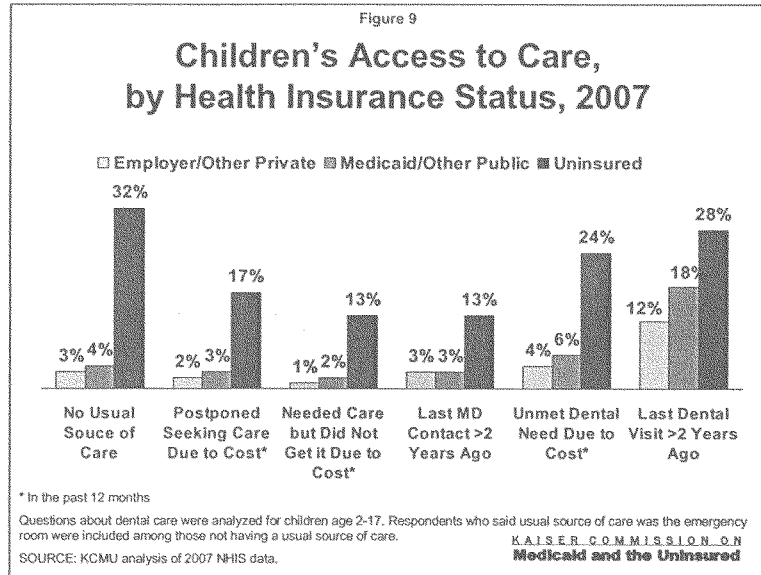
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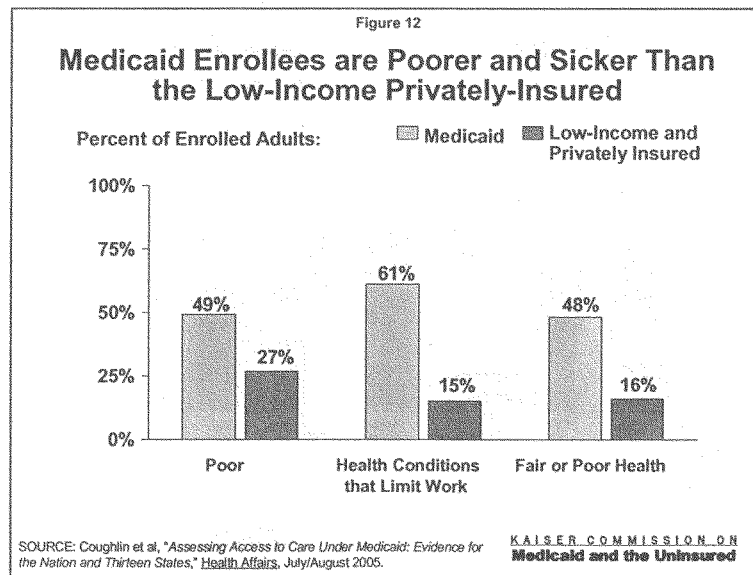
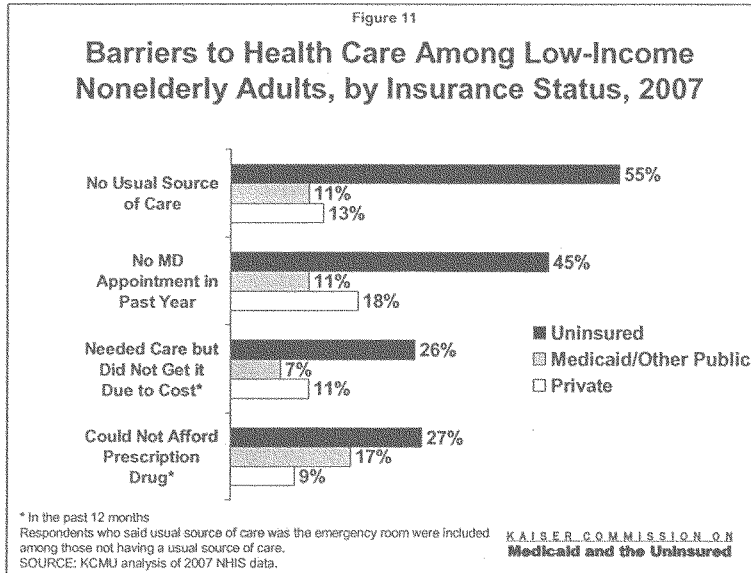


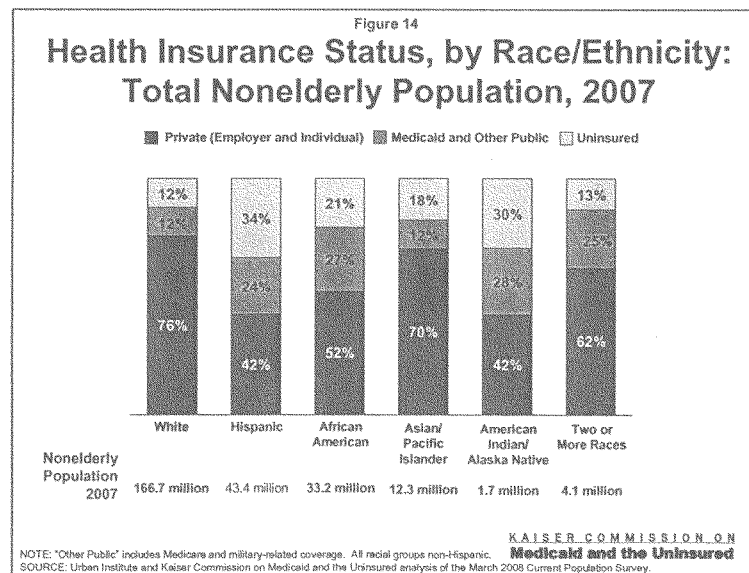
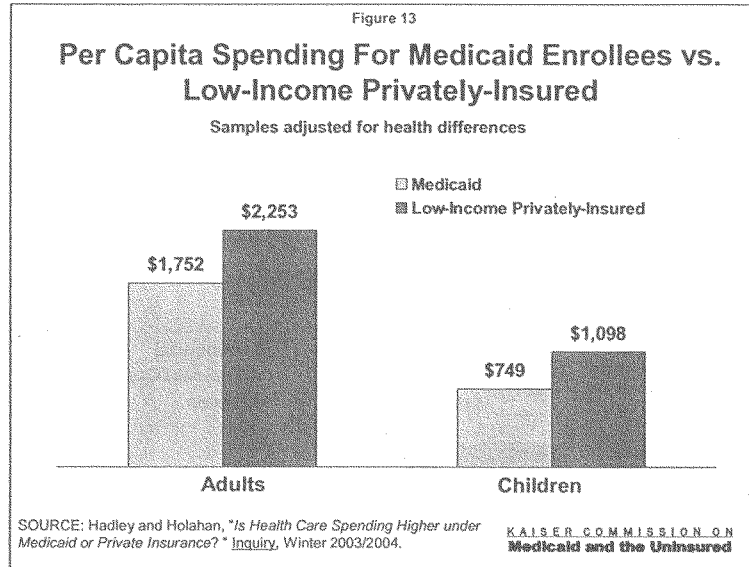


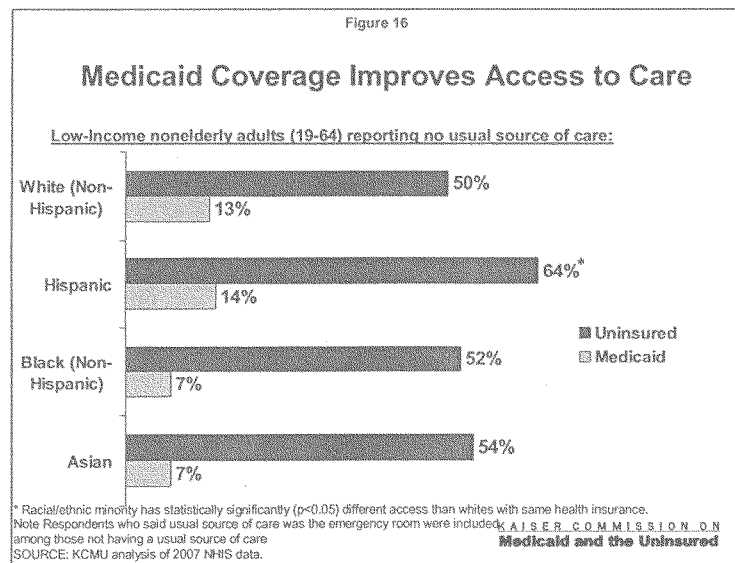
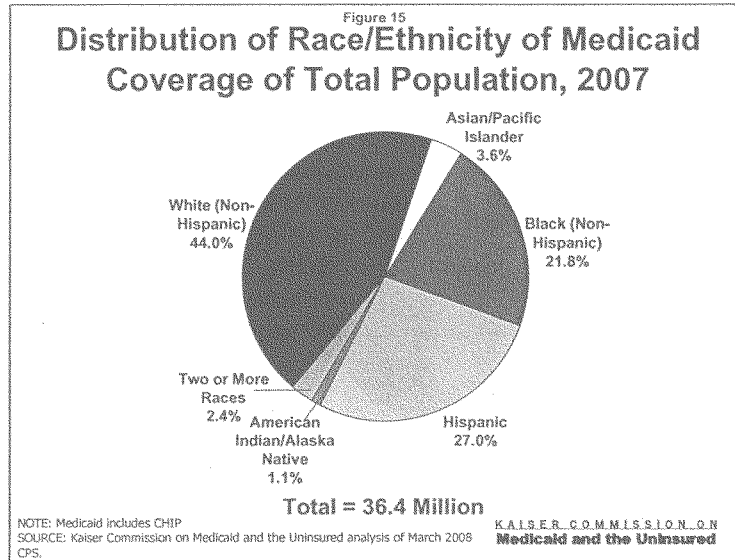


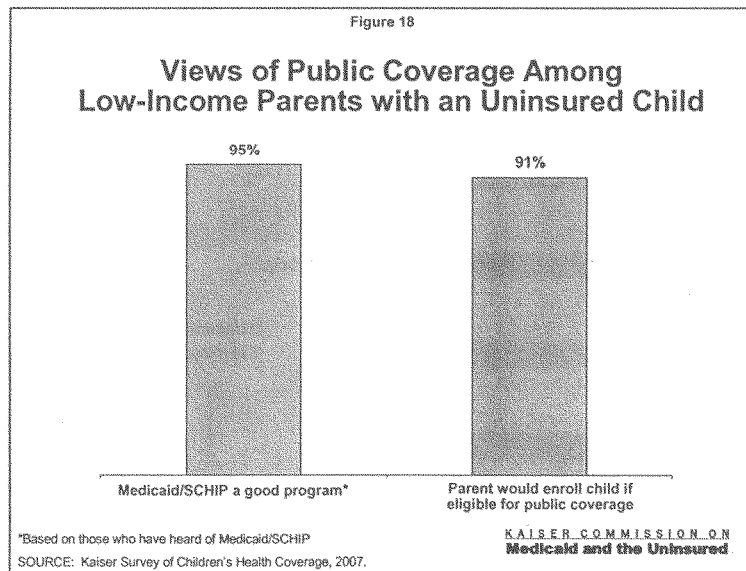
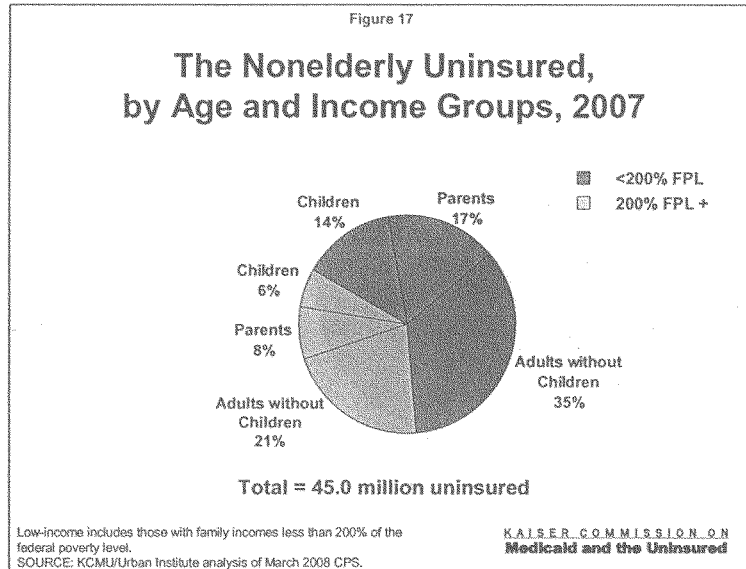


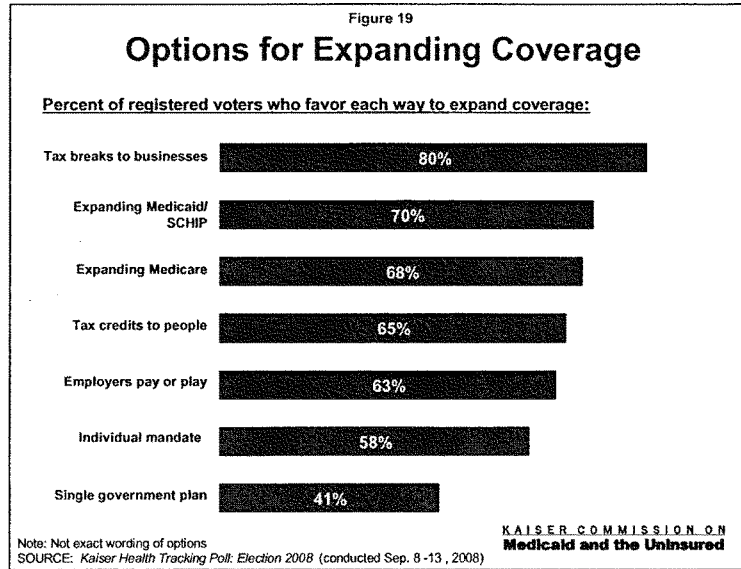












Mr. PALLONE. Thank you, Dr. Rowland, and thank all of you. I know it is a large panel, but you covered a lot of very important areas and we appreciate it. We now have questions from the members and I will start with myself for 5 minutes.

I am going to start with Dr. Mullan and I am going to throw a few things at you here. I don't know if you will have time to answer them all but I am very concerned about the financing of medical education, you know, the whole idea of Medicare financing GMEs. If you were to suggest to me that we probably should have an alternative financing mechanism and not maybe even use Medicare, I would like to hear that. But even more important, my concern is about, you said 30 percent of the doctors are educated abroad. To me, that makes no sense and I don't think any effort is being made to reverse that. If anything, it seems to me that we will probably see a situation where more of our physicians are educated abroad, and that makes no sense to me. You know, I talk about how I attend events in my district with medical doctors who are raising money for Caribbean medical schools rather than for UMDNJ in New Jersey. There were reports in the media a few months ago about foreign medical schools raising money and buying essentially residencies at hospitals in the New York metropolitan areas so that their students would have preference for residencies over graduates of American medical schools. What does this all mean in terms of the quality of physicians that so many are educated abroad, be they Americans that go abroad or immigrants? I mean, where are we going? Some of these schools, they seem to be opening more and more overseas. A lot of them are private, not even government run. I don't know what kind of controls they have. Should we reverse this? I am not even talking about the impact on other countries, potential brain drain on other countries. That concerns me less. Maybe I should be concerned about it but I am not so much. Would you address that? Because I hear about it every day at home. I know it is a lot to ask you but—

Dr. MULLAN. Well, I will try to give the 2-minute synopsis on international medical graduates and how we have gotten to where we have gotten and what we can do about it. Very quickly, we have chronically undertrained. We have not trained sufficient physicians in our medical schools, and over the years we have put a lot of investment from the Congress in particular and from State governments into medical education at the medical school level in the 1960s and 1970s and this had a very good response. We doubled the output of medical schools between 1965 and 1980. At that point everybody said whoa, we are going to overshoot, and funding was throttled back. Schools remain where they were. So between 1980 and 2005, we lost one medical school, a net loss of one, and the graduating class, 16,000, 16,500, every year was the same. Meanwhile over time, the residency opportunities grew, reflecting somewhat the needs of the country, and the opportunity for international graduates who took exams like the U.S. exams, today they take exams that are exactly the same to come and fill residency positions and then remain in practice, grew. So that today about 27 percent of our residents and 25 percent of our doctors in practice are graduates of international schools. A minority of these, about 20 percent today, come from schools in the Caribbean, which are

essentially designed for U.S. students to go abroad and come back as international medical graduates. That is because the need for medical education was not being made onshore. We didn't have enough placements.

Mr. PALLONE. But Doctor, should we be reversing this? I mean, my fear is the quality is good. Is this a way for us to save money so we should say great, let us have everybody educated abroad because the cost is less and let that burden be passed onto someone else? Does it matter? Are we doing anything to change it?

Dr. MULLAN. The answer is yes, we should be reversing it. That is good domestic policy. It is good foreign policy both. It gives more opportunity to domestic students if we have opportunities for them to train onshore and it diminishes the brain drain, which is bad foreign policy around the world. Many governments are resenting the fact that we are pulling their doctors here. The way it is happening and it is happening in a somewhat spontaneous fashion, is that medical schools are now growing again, increasing the opportunities. It is estimated that the medical school positions over the next 3 or 4 years will grow by 25 percent, and what will happen by all estimates is, that as more U.S. graduates come out, they will be selected for residency positions and de facto or in passing, the international medical graduates will have less opportunities. They will be less drawn from abroad. The problem—

Mr. PALLONE. But is that true? I mean, was this an aberration that I read in the New York Times where these foreign medical schools are now essentially buying residencies?

Dr. MULLAN. The foreign medical schools you refer to are the Caribbean commercial schools that are training largely U.S. students abroad and they did conclude—one of them concluded a large agreement with the New York Health and Hospitals Corporation for medical student places on their wards. It is unclear what will happen. U.S. New York-based schools that have placed their students there are in competition for those. Traditionally they have not paid for them. And it will be interesting to see how that plays out. But I think the point is, if the opportunities for practice in the United States for international medical graduates diminish because more and more of our positions are being filled by our own graduates, that business will diminish and we will not be so reliant on foreign graduates, whether they are U.S. citizens to begin with or international citizens.

Mr. PALLONE. So you think we are reversing this policy and we shouldn't worry much about it?

Dr. MULLAN. I think we should remain concerned about it. I think we are in a period where it is going to diminish. Now, we should understand that the number of residency positions in the country has remained relatively fixed. In round numbers, about 100,000 people are in residency every year, about 24,000, 25,000 new people in a residency each year. If we increase GME funding, graduate medical education Medicare funding, we will increase the opportunities and that will again begin to draw on the rest of the world. So right now where the physicians are capped under Medicare, that is Medicare reimbursement is capped, we are not creating more residency positions so the increased number of U.S. medical school graduates will go into a fixed number of positions,

and by doing that it will diminish the number of international graduates that we bring into our country.

Mr. PALLONE. Thank you.

Mr. DEAL.

Mr. DEAL. Thank you.

I would like to follow up on that too. I had a constituent that I asked him what his doctor told him. He said I don't know, I didn't understand a word he said, and that is a continuing problem. I didn't realize the percentages were as great until I read your testimony. With regard to the New York situation that you talked about, if we are funding graduate medical education through Medicare and the hospitals are now entering into private negotiated purchases of those slots, are we in effect funding slots through public funding that are now being in effect sold to foreign medical colleges?

Dr. MULLAN. That is a good question. I think the answer is no, because as I understand the agreement in New York, it is for the training of medical students, not for graduate medical education. The residency slots which Medicare funds remain the same. They are filled by both U.S. graduates and international medical graduates. Remember, I said we graduated about 16,000. If you add in osteopathic medical schools, U.S. based, we graduate about 18,000 every year. We offer 24,000 internship positions, post-graduate year one. So the difference between the 18,000 we graduate and the 24,000 that are offered are filled by international graduates, U.S. international graduates and non-U.S. international graduates. As the U.S. graduate numbers rise with the 24,000 positions to be filled, the international medical graduate numbers will diminish.

Mr. DEAL. Let me go to Dr. Harris because on a related subject to those residency slots, you make the point that we do not have enough residents in their post-graduate education going into the primary care internal medicine slots. How do we correct that? Is that something that the funding should be channeled more in the direction of those residency slots rather than the others, or how would you suggest we fix that?

Dr. HARRIS. Well, we do recommend that there be focused GME funding on expanding the number of primary care spots. We feel that you need to be attentive to that. But the answer comes when you interview young people and ask them why are you not choosing primary care for a career, and the answers are three. One, it gets back to the question about medical education. You can argue that fundamentally there is a design flaw with medical education in that most medical schools in this country are centered around tertiary care centers where most ill people in the States are sent for their care while the most exotic illnesses are sent for very focused care. It is intellectually wonderfully satisfying, it is a wonderful place to spend 4 years, but there is precious little exposure to what the majority of health care is in this country, namely outpatient ambulatory care. So one of the things you need to do is increase that exposure to show young people that following patients longitudinally, knowing them for years, if not decades, is a pleasure. The second thing has to do with the pace and that gets back to the notion of this medical center home or funding for bundled care that allows the expansion of the team that gives physicians time with



their patients. Remember, 20 percent of the Medicare population in this country has five or more chronic illnesses.

Mr. DEAL. Let me stop you because my time is running out. I understand that. I think your point is well made that the traditional residency is in a hospital environment whereas the primary care whereas the primary care physicians that we need to be attracting, their practice is not going to be necessarily in that hospital environment. We need to have a different environment in which for them to complete that exposure. Is that what you are saying?

Dr. HARRIS. We need to increase their exposure to ambulatory medicine during their training.

Mr. DEAL. But doesn't that have to be done under the auspices of a hospital that is providing the residency program?

Dr. HARRIS. Yes.

Mr. DEAL. Okay. Let me go back to Dr. Mullan just a second.

We know that NIH funding has been significantly boosted as a result of the stimulus input. You made a statement in your written testimony talking about the rise in NIH funding from \$2.4 billion in 1970 to \$16.3 billion in 2004, and you say creating a robust culture of research at medical schools that dominates medical school finances, faculty values and school culture. Now, with this huge influx of new money into NIH, is that going to exacerbate this problem about the focus of medical schools and focus it away from increasing primary care training or is it going to help it? Which way it is, or neither?

Dr. MULLAN. Good question. The stimulus money is focused in very practical ways and I think would probably be more practice-friendly perhaps than traditional NIH funding but the point is well taken, and I am not here to talk against NIH funding. I am here to talk for balance and we need to think if our medical schools are being endowed with enormous research money, creating a culture that values research and specialism when the problems in the country are generalism, we need to think about how to rebalance that and medical schools and funding for generalist research is important as well.

Mr. PALLONE. Ms. Christensen.

Ms. CHRISTENSEN. Thank you, Mr. Chairman. I didn't expect you to come to me that quickly.

I thank all of the panelists as I said, for not only your testimony today but for the work that you have been doing over the years.

Dr. Smedley, and I will probably also ask Dr. Rowland to answer, I am an advocate of building on the public programs to expand coverage but I have a concern that as we reform the system that we don't perpetuate a two-tiered system of care. There have been several studies that I have seen that have shown that despite the increased access that Medicaid patients have to services, they don't have as good outcomes. They have about the same outcomes as the uninsured. So why do you think this is and how can we fix the problem? And is there a role for the public plan that we are talking about in all of this? Dr. Smedley?

Mr. SMEDLEY. Sure. First, I agree with Dr. Rowland's statement that Medicaid has been vitally important for low-income communities and communities of color. I have no doubt that without Medicaid, many more people would have suffered unnecessarily and we

would have had many more premature deaths. By the same token, we know there are some things that need to be fixed and so it is important that we try to address the fact that we have tiered health care insurance systems, and so to the extent that people of color are disproportionately in lower-tier systems, this in itself can be one of the many causes of health care inequality and it is important that we take steps to strengthen Medicaid so that it is not stigmatizing to be a Medicaid patient. I was sharing with you earlier a story. I was surprised to walk into a county health clinic in one of our northeastern States. I walked into a waiting room that was approximately 20 feet by 30 feet, a very small waiting room where you could your name if you were called, but yet along one of the walls there was a sign that said "Medicaid patients only." This was surprising to me because it further stigmatizes Medicaid patients and so to the extent that Congress can take steps to ensure that all of our public plans are comparable to private plans in terms of coverage, quality, quality incentives and performance incentives, I think this will go a long way toward reducing that inequality.

Ms. CHRISTENSEN. Dr. Rowland, we want to make sure that the card isn't an empty promise. It just seems to me that when you have a Medicaid card and another card, you know, it just opens the door for bias.

Ms. ROWLAND. I think there are two things to note here. One is that many of our low-income population live in medically underserved areas so much of the discussion we have had today about bringing more resources into that area is important. I think the second thing to note, however, is that we can do more to make Medicaid payment rates more equalized with the rest of the health care system and that unfortunately as we gave States greater flexibility over their programs, many of them have used that flexibility when they need to cut costs to reduce payment rates, although we do see States improve those payment rates whenever their resources are more abundant. So over the last few years before this economic downturn, many States moved to up their payment rates. I think that the most important thing is to make sure that the card provides people with access to physician services and to primary care service and I think we should note that within the Medicaid program over the last few years the advance of managed care and the use of primary care networks has helped to really secure a better access, so I do worry that in some cases the providers willing to participate in those networks are not the same as the providers willing to provide care to the privately insured.

Ms. CHRISTENSEN. Thank you.

Dr. Lavizzo-Mourey, thank you for the work that Robert Wood Johnson has done, and I was really interested in the family nurse partnership program as well as the others, but we hear an argument and we asked the CBO director, several of us did over and over again about savings that would be realized by prevention and you talk about a savings that you see in the family nurse partnership program. Their argument is that we will spend more money on prevention and so we won't realize any savings and I find this a major obstacle to getting done what we need to get done and making the investment. How would you respond to that?

Dr. LAVIZZO-MOUREY. Thank you for this question. When people talk about prevention, they often lump a number of issues together that really should be separated. First, you referenced the nurse family partnership program. That is a program, for those who don't know, that invests in the relationship between nurses and moms-to-be or young mothers that teaches them how to navigate the health care system but also how to provide better health for themselves and their babies so it is an investment in health that happens in the community. The benefits that accrue from that investment happen over a number of years, not 2 or 3 but really over 10 to 15 years. We continue to see savings up until the child is in their adolescence. So one has to look for the savings over a long enough period of time, first of all, in order to really understand whether there are savings.

Secondly, we often talk about prevention and we are really referring to clinical services, screening tests and the like, and there frankly the results are mixed on whether it is going to provide savings. However, we do know it almost always improves health and produces a better value, but one has to also separate from that prevention that occurs at the community level, community-based investments such as reducing obesity, improving physical activity, reduction of tobacco use. These have been shown time and time again in large public health studies to reduce the overall costs of care because they improve the health, and we really need to focus those three separately if we are going to answer the question of whether prevention saves money.

Mr. PALLONE. The gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Thank you. I am going to try to be quick. It is a huge panel. I appreciate you all coming and I apologize for being in and out like we all have to do when there is business. Let me ask a question, and if you can answer briefly and I will try to get the whole panel. It depends on how quick you answer. You know, Senator Baucus on the other side's basic premise is Medicaid for all, cover the uninsured. Would you support that, Dr. Smedley? We are hearing some bad comments on Medicaid here.

Mr. SMEDLEY. I believe it was Medicare for all, if I am not mistaken, which—

Mr. SHIMKUS. Okay. Well, let us assume that we want to cover the uninsured through Medicaid. Would you support that?

Mr. SMEDLEY. Well, it is important that we ensure that everyone has comprehensive care and that—

Mr. SHIMKUS. So would you support current State-run Medicaid system insuring the uninsured today?

Mr. SMEDLEY. I would support as broad a pool as possible.

Mr. SHIMKUS. So would you support State Medicaid programs covering the uninsured of each State?

Mr. SMEDLEY. That is an option that can work in many States. I am sorry I cannot give you a definitive answer.

Mr. SHIMKUS. Dr. Kitchell?

Dr. KITCHELL. Yes, I think that Medicaid should be expanded but I also think that we should maintain private insurance for patients who need it.

Mr. SHIMKUS. Okay. Thank you.

Dr. KITCHELL. As we—

Mr. SHIMKUS. That is good. I really want to go quick and I don't want to be disrespectful.

Dr. SITORIUS.

Dr. SITORIUS. I am going to second Dr. Smedley. In some States it will work, in others it may not.

Mr. SHIMKUS. Okay.

Dr. SITORIUS. I am not answering your question. I understand that.

Mr. SHIMKUS. All right. That is good to know when you are on the record because that makes a statement about the current Medicaid system.

Ma'am, I don't want to butcher your name. I am sorry.

Dr. LAVIZZO-MOUREY. Lavizzo-Mourey. It is a mouthful, I know. Our foundation does not advocate for specific plans but we do have principles that suggest that there are a broad array of ways to, as Dr. Smedley says, ensure that we can increase the number of—

Mr. SHIMKUS. Okay, but my focus is on Medicaid system in States as we know today. Covering the uninsured through Medicaid system in States, is that a way to insure the uninsured?

Dr. LAVIZZO-MOUREY. It is one way among others.

Mr. SHIMKUS. So you are not going to answer either.

Sir, I don't see your nametag. I apologize.

Dr. MULLAN. Mullan. I would agree it is one of a number of options. It would not be my preferred option.

Mr. SHIMKUS. Great.

Dr. Harris.

Dr. HARRIS. Congressman, in our paper we felt that—

Mr. SHIMKUS. Quicker, please.

Dr. HARRIS [continuing]. Consideration should be given up to 200 percent of the federal poverty limit for covering people. That would capture a sizable number of these people.

Mr. SHIMKUS. So you are saying yes for 200 percent of poverty?

Dr. HARRIS. As part of this overall pool of people. That will in no way capture all of the uninsured.

Dr. BEAN. No. The benefits are wide but the pay is so low, you won't get participation.

Mr. SHIMKUS. Dr. Rowland.

Ms. ROWLAND. For the low-income population, two-third of the uninsured, expanding Medicare would make a lot of sense.

Mr. SHIMKUS. For the uninsured?

Ms. ROWLAND. Yes.

Mr. SHIMKUS. Okay. Let me go with this question. Would you trade your current insurance policy for a Medicaid policy, Dr. Smedley?

Mr. SMEDLEY. No.

Mr. SHIMKUS. Just go down the table. Dr. Kitchell?

Dr. KITCHELL. As I said, some private insurance—

Mr. SHIMKUS. Would you trade yours for a Medicaid policy?

Dr. KITCHELL. No.

Dr. SITORIUS. No.

Dr. LAVIZZO-MOUREY. My plan has things that Medicaid does not have in it.

Mr. SHIMKUS. So that is a no?

Dr. LAVIZZO-MOUREY. That is a no.

Mr. SHIMKUS. Thank you.

Dr. MULLAN. No.

Dr. HARRIS. No.

Dr. BEAN. No.

Ms. ROWLAND. Yes.

Mr. SHIMKUS. Thank you. We may give you that opportunity to do that.

Ms. ROWLAND. Medicaid has low cost sharing and comprehensive benefits and covers a lot of services that private insurance doesn't.

Mr. SHIMKUS. Obviously with the doctor's question about, or your question about someone going into a clinic, being casted as Medicaid only this line versus other lines, that is why I asked that question. It is really a follow-up.

I am really involved, this is my district. I have about 14 community health clinics. They service—Illinois services 1.3 million Medicaid, uninsured, Medicare and for-pay folks. It has been very successful. When I first got elected to Congress, I had zero in my district. Now, the benefits of community health clinics are what? The people who practice there are protected by the Federal Tort Claims Act. It has allowed them to provide health care to the uninsured. Do you think that some model, talking about what happened with Texas, what happened in Illinois, although our legislation is being reviewed by the Supreme Court—we had medical liability reform for my neurologist. There was a time when we did not have a single neurologist south of Springfield because of medical liability. Would moving on a Federal Tort Claims Act provision on medical liability be helpful in access to care and keeping costs down? Dr. Smedley?

Mr. SMEDLEY. I don't know if the evidence speaks to that. Community health centers are successful not solely because of tort issues but because of—

Mr. SHIMKUS. So you are saying that the fact that they don't have liability costs because they are protected, that doesn't affect the way they charge individuals?

Mr. SMEDLEY. No, they are—community health centers have done a marvelous job targeting the needs of low-income and underserved communities. I believe that is the primary reason that they are successful.

Mr. SHIMKUS. I would beg to differ.

Dr. Kitchell.

Dr. KITCHELL. Yes, I think community health centers are a good idea. We have actually—

Mr. SHIMKUS. I am talking about the Federal Tort Claims Act protection on community health centers.

Dr. KITCHELL. That would help, yes.

Dr. SITORIUS. Yes.

Dr. LAVIZZO-MOUREY. I practice in a community health center. I have to agree with Dr. Smedley that the reasons that they are successful have much more to do with other issues.

Mr. SHIMKUS. Do you pay any liability insurance when you practice in the community health center?

Dr. LAVIZZO-MOUREY. No, I do not.

Mr. SHIMKUS. Okay. Thank you.

Dr. MULLAN. Health centers are distinctly successful for other causes. Is the tort protection afforded to providers there useful? Yes.

Mr. SHIMKUS. Dr. Harris.

Dr. HARRIS. I simply agree with Dr. Mullan.

Dr. BEAN. Yes, it would help.

Ms. ROWLAND. I agree with Dr. Mullan.

Mr. SHIMKUS. Thank you, Mr. Chairman. I think tort issues should be part of this health care debate. I yield back.

Mr. PALLONE. Thank you.

Mr. Braley.

Mr. BRALEY. Dr. Kitchell, I want to follow up on some of the points you raised in your opening statement, especially dealing with geographic reimbursement inequities. You mentioned the Geographic Practice Cost Index, also commonly referred to as GPCI, reduced fees for physicians because of where they live. In your best estimate, what is the differential in Medicare fees between the highest GPCI areas and the lowest GPCI areas?

Dr. KITCHELL. The differential is 34 percent between North Dakota, Arkansas, and then the highest area is in California.

Mr. BRALEY. And then to follow up on your point, when you are out looking to replace equipment and looking for durable medical equipment that you use in your practice, have you found a similar inequity of what the cost of that equipment is based upon geographic differences?

Dr. KITCHELL. No. In fact, about 2 years ago when we decided to buy an electronic medical record, that cost of \$21 million for our clinic is exactly the same as anywhere in the country.

Mr. BRALEY. Can you explain in further detail how it is that these reimbursement inequities built upon a flawed GPCI formula impact access to care in rural areas?

Dr. KITCHELL. Well, there are some services that are not even paid as much as the cost of delivering those services. Let me give you an example of a cardiac defibrillator implant. The Medicare reimbursement for that is actually less than the cost of the device. So the payment for the labor, the payment for the rent, the payment for all the other services that that patient needs, Medicare pays less than the cost of that machine.

Mr. BRALEY. Now, one of the solutions that has been proposed is putting a floor on GPCI inequities and we know that by enacting a 1.0 floor on work GPICs we reduce the inequity even though there is still this 8 percent differential you mentioned in your testimony. Do you feel that a 1.0 floor on practice expense GPICs would also decrease rural health care disparities?

Dr. KITCHELL. Yes, that would be our best solution.

Mr. BRALEY. Earlier this year I spoke in this committee about the need for a reimbursement system that rewards quality. Can you explain how a model system might look to provide quality-based reimbursements to physicians?

Dr. KITCHELL. Yes. As I said, the PQRI program is flawed. The hospital system is doing a good job of rewarding quality. Quality needs to be rewarded for teams, groups and systems. Quality is team-based care. The medical home model, the bundled systems, the shared savings, they rely upon physicians working together with non-physicians in teams so we should be encouraging, we

should be incenting physicians to be part of teams, groups and systems, and as I mentioned, the Middlesex, Connecticut, example is a great example where independent physician practices have gotten together in an accountable care organization and they have increased their quality and reduced the costs of care. I think a key point for Americans is to understand that by working together, physicians and non-physicians working together, we can improve quality and we can reduce costs.

Mr. BRALEY. All right. Dr. Bean, I am going to follow up a little bit on your testimony because one thing that was noticeably absent from your testimony was a discussion of preventable medical errors and there has been a lot of testimony from the panel about the importance of an Institute of Medicine finding relating to access to health care but no one has mentioned the seminal Institute of Medicine study in 2000 and the follow-up study identifying the acute problem of preventable medical errors and the costs they impose on the system. So do you agree that the most effective way to reduce malpractice costs in this country is by reducing or eliminating preventable medical errors?

Dr. BEAN. I am afraid I don't agree that is going to eliminate the malpractice crisis in the areas where malpractice is used or abused. I will agree with you that the focus on preventing medical errors is not only laudable but highly necessary.

Mr. BRALEY. Well, can you explain why the existing framework for health quality oversight that is in place in this country primary through the Joint Commission on Accreditation of Health Care Organizations that is hospital specific has failed to make a measurable decrease in preventable medical errors despite the fact that their sentinel-event program has been in place for over a decade, and if you take the IOM numbers of 44,000 to 98,000 preventable medical errors resulting in deaths in hospitals every year and compare that to the sentinel-event statistics from JACO which show that on average only 300 sentinel-event reports are filed per year, don't you agree that there is a gross example of underreporting of the problem and a failure on the part of the community to address it?

Dr. BEAN. No, not at all. First of all, if you look back at the studies that were done where the 44,000 to 98,000 figures were drawn from, these were extracted from hospital charts in about 1982 or 1983. That is almost 30 years ago. So there has been a substantial change in hospital practices and events since then. When that extraction was done, they were extrapolated from acute charts and assumed that this was happened around the country and the medical errors and negligence were equated and that is not necessarily so at all. There are things that do happen that are not negligence so saying that the medical liability system is going to handle—is necessary to prevent all that is wrong. I think that the proper way to do it is what we are doing. We are looking at quality events, and in fact if the reporting is low, maybe that review should be done again to see if that is the reason. Maybe there has been a change over the past 30 years.

Mr. BRALEY. Do you think there are only 300 preventable medical errors a year happening in hospitals in this country? Is that your testimony?

Dr. BEAN. No, I think that, number one, if you are asking hospitals to report things or doctors to report things in the face of a medical liability system where they can be sued for millions of dollars, your incentive to be open is blunted considerably. Change the liability system. Make it possible like airlines to report things without being so open to suits that can run you out of practice, and we can have a better system for finding and correcting errors.

Mr. BRALEY. Thank you, Mr. Chairman. I would just like to point out that the reporting system I am referring to at JACO is a closed system that is not open to the public.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman, and that is an excellent point, Dr. Bean, and I am so glad you made it because the IOM study was in fact published 10 years ago and it was from data collected 20 and 30 years ago. It is high time, Mr. Chairman, we asked the Institute of Medicine to update that study. The sentinel reporting techniques have been around for 10 years. Maybe we should look again and see whether we have made any progress. I suspect we have, because even then the data from 1982 and 1983 and the data from 1992 showed significant improvement between that 10-year span and that was not accounted for in the publication, *To Err is Human*.

Since Mr. Shimkus took my questions, Dr. Rowland, let me just ask you, you described a Medicaid program that I just scarcely recognized. In my practice, it wasn't a workhorse, it was more like a Trojan horse and all the people got inside and then you were in trouble. But let us think about it for just a minute. You were the only one who answered affirmatively to changing what you had now for what would be available in the Medicaid system. I offered an amendment during our SCHIP debate and I may well offer it as stand-alone legislation that would allow members of Congress the option of entering the Medicaid system so perhaps they could see for themselves firsthand what patients encounter. Would that be a good idea?

Ms. ROWLAND. Well, first of all, I think, sir, that you come from the State of Texas and that Medicaid programs are different in different States and so one of the issues that needs to be addressed if one is going to build on the Medicaid foundation is to perhaps make the program more standard.

Mr. BURGESS. But we had no other member from Texas on the panel here today but everyone declined the opportunity for taking an adventure into the Medicaid system. I just offer that for what it is worth. Do you think I will get many cosponsors on that legislation from Members of Congress?

Ms. ROWLAND. I actually doubt it.

Mr. BURGESS. Yes, I do too.

Ms. ROWLAND. But I think that it does point out that the program does need improvement as a building—

Mr. BURGESS. There is no question that the program needs improvement and I did take Medicaid patients in my obstetrics practice, and the biggest problem I had was finding a specialist to whom to refer a patient when she had a problem that was beyond my scope and capabilities, and that I think really speaks to the



problem that many primary care doctors have when they open their doors to Medicaid patients. If they get a complicated abscess, if they get a complicated cardiology patient, they literally have no place to send that patient, and as a consequence they may be practicing well over their heads, and that is a patient safety issue that really should not go unaddressed.

Dr. Bean, I want to thank you too for your comments about the medical liability system. Texas has I think done an excellent job. I can't take any credit for it. I have introduced the Texas legislation in Congress. The bill number is 1468, for anyone keeping scoring at home. This bill actually scores as a savings by the Congressional Budget Office. It is \$3.8 billion over 4 years. It is not a huge savings. We spend trillions of dollars at the drop of a hat now. But still, \$3.4 billion to \$3.8 billion means something to someone somewhere and I just offer this, Mr. Chairman, as a gift to help balance the budget wherever it might be helpful. I will be glad to make my modest little Texas medical liability bill available so that other States can in fact enjoy some of the things that have happened in Texas.

Dr. Kitchell, in my remaining time, I couldn't help but notice that your notes were handwritten so I assume you haven't purchased that \$21 million record system that is available to you?

Dr. KITCHELL. We are in the process of phasing it in, yes.

Mr. BURGESS. I understand why because even from across the street, I can tell that your partners cannot read your handwriting. Let me just ask you a couple of questions because you have some great testimony about the PQRI which I thought was a mistake when our side pushed it at the end of 2006. You say it doesn't actually reward quality it rewards reporting. There was a great article in the Journal of the American Medical Association a little less than a year ago. I unfortunately don't remember the author. It was tongue in cheek. It recommended that we diagnose liberally, don't be stingy with your diagnoses. If you make more people in your patient panel class 2 diabetics, your hemoglobin A1Cs are going to look a lot better and as a consequence you are going to get a better—your payment is going to improve. You reward, you incent the wrong type of behavior when you go down the PQRI road but I do wonder, and you have the statement that there are methodological problems, are these fatal flaws or could these be corrected? And of course, one of the biggest problems with PQRI is, we didn't pay a darn thing for anyone to gather the data. It was more expensive to try to participate than any bonus that you would get at the out end on PQRI but are the problems inherent in PQRI, are they so fatal that the program cannot be salvaged and we just need to move to a different scheme?

Dr. KITCHELL. Let me just preface this slightly. The American Medical Association physician consortium for performance improvement is developing measures of quality so we cannot only measure, we can reward quality. The AMA should take a lot of credit for developing this. They have taken the lead in measuring and rewarding quality. The PQRI program has chosen to use individual measures. The consortium is now working on more team and system measures. That is where I think we need to go. The problem with the individual measures as a physician, we don't want to be

profiled. We don't want to be tiered. We don't want to be rated individuals because our patients vary. Sometimes three physicians are seeing one patient so who gets the credit, who gets the blame. That is an attribution problem. So these individual measures continue to promote fragmentation of care rather than coordination of care by teams and systems. We need to think about how we deliver care and we will do better with raising quality, giving patients safety, improving the value of their care if we measure by teams, groups and systems. So my proposal would be to change the focus of PQRI to get away from reporting. Let us do measures. And we have some composite measures now and some groups, accountable care organizations are willing to be accountable for quality and for cost. It is time we allowed those groups of physicians who are willing to be accountable for quality and willing to be accountable for their costs to let them do that.

Mr. BURGESS. Are these along the lines of the physician group practice demonstration model that CMS has been doing?

Dr. KITCHELL. Yes.

Mr. BURGESS. And I would——

Mr. PALLONE. Dr. Burgess, just one more and then——

Mr. BURGESS. I would very much favor us considering in the Medicare system, which is a federal program, if a group practice is under that accountable model, to allow them, allow that group for their Medicare patients coverage under the Federal Tort Claims Act and I think we can go a long way towards pushing what is I think a very effective policy and getting doctors to buy in, and I will yield back the balance of my time.

Dr. KITCHELL. Can I just——

Mr. PALLONE. You can answer.

Dr. KITCHELL. One last comment, and just so you understand, the physician group practice demonstration project also included independent physicians. They were not a group, a formal group. They were independent practicing physicians and they got together in groups.

Mr. PALLONE. Thank you.

The gentleman from New York, Mr. Weiner.

Mr. WEINER. Thank you, Mr. Chairman.

Some of my colleagues on the other side have been engaged in a furious process of erecting straw men and then burning them down. So let me just clarify a couple of things with your help. First of all, my understanding is, the proposal by some is Medicare for all, the idea being that it is a model that people are somewhat comfortable with. It is in some interpretations this problem with this debate is that some people have gotten stirred about the idea of socialized medicine, forgetting that in fact what the social compact in Medicare has been with the exception of problems with cost reduction and things that need to be fixed, it has been a success that people appreciate. The other false choice that has been offered to us is the idea that not whether Members of Congress should be offered Medicaid but whether Medicaid citizens should be offered what Members of Congress have. That is the choice that we confront. What we are trying to do is trying to take programs that are obviously deficient and replace them with models that work better. So perhaps my colleague from Texas should offer legislation offer-

ing anyone on Medicaid the same plan that Members of Congress have. That would truly be a constructive step forward. It is the premise of our entire discussion that the Medicaid system doesn't work very well and it doesn't treat people as well as it should or treat physicians the way it should or reimburse States the way it should. That is a given, and to set the straw man up that, oh, well, we have to have Medicaid for everyone, wouldn't that be a terrible thing, yes, it probably would not be anyone's desired outcome and I don't think any of the collective wisdom of the panelists would suggest that that is the seminal question despite the somewhat overly yes, no, get your answer ready kind of inquisition.

Let me just now ask a question, if I could. It strikes me that Medicaid is a pretty good deal for hospitals and physicians when compared to no insurance. We actually have an experience in New York City that when there is a Medicaid patient coming in the door, a lot of the hospitals in New York are gleeful. At least they have someone with some kind of coverage, some kind of predictable repayment, some kind of a process that they know that they are going to get compensated. So yes, Medicaid looks pretty problematic to a lot of physicians except when compared to what a lot of people have, which is no coverage at all. But I want to ask a question about the impetus to get more physicians to go into primary care. It seems to me that the market is not functioning efficiently, that while there is a demand for more of those, while there are more hospitals that are looking and more of our system seems to want it, it doesn't seem like the incentives are getting built in properly. As we figure out how to contract the incentives differently in the context of a national health care plan, should we be saying we will pay you more? Should we be saying we will pay more of your medical education if you go into primary care? Should we say we are going to penalize you if you decide to be a dermatologist? I mean, what would be the model if we are going to start from scratch which to some degree we are. What would be the model that would be—and Dr. Mullan, you were the one who I heard speak most articulately about it. What do you think that we should be doing to structure it so that being a primary care physician seems like a better deal?

Dr. MULLAN. I think the important thing to know is unfortunately there is not a single prescription, a single diagnosis and single prescription here, and it is along this continuum. I think there are things that need to be done in the pipeline. There are things that need to be done in practice. And as you rightly observed, the market is not working. The market is not calibrated in practice to support people very well in primary care and that is a financial matter in terms of reimbursement. It is also a structure model in terms of the hamster in the maze or hamster on the runner-type environment that has been created by the need to churn out as many patients as possible simply to pay the rent. So the restructuring of primary care with incentives from federal payers as well as others will be hugely important to creating a primary care environment which is attractive to make the market better. But if you don't have the pipeline geared to do that, you will have ill-prepared people coming and therefore the investments, Title VII, how do we—what do we do about the medical school environment, the cul-

ture to make it more friendly to primary care, community medicine, ambulatory care and the like, and with graduate medical education how do we get more people training in those areas with very heavy federal investment in that area.

Mr. WEINER. Can I squeeze in one more question? Is there a whole different tier of health care that we maybe need to create on the preventive side, on the diagnostic side, on the nutritional side, on the testing side? I mean, should we not think about maybe having kind of clinics or mobile things or something that go out and find people before they would go and—who might be disinclined to go into a doctor's office or a hospital? You know, we have a whole collection of senior centers, for example, in New York City that seem like a perfect place to kind of capture people, you know, in a non-medical—I don't know exactly what I am describing. I guess it is something before even primary care, you know, to kind of be a gateway thing that would—you know, we seem to all worship at the altar of getting people early, doing more diagnostic, nutrition, all these different things, but should we maybe just think about a non—I know it is tough asking, you know, a panel of doctors, but should we be thinking about maybe an extra medical type of structure that grabs people in a way that maybe gets them to do the things that might keep them out of even primary care? I don't know who is best equipped to answer that.

Dr. LAVIZZO-MOUREY. I will make a couple of points and I am sure my colleagues will as well. One of the things that we know about improving the health of people is that if you can take interventions to where they live and work and learn, you can do a much better job of improving their overall health. We have learned this through school-based health clinics. We know it through community-based investments in prevention, some of which I have referenced before, investments in increasing people's physical activity, reducing obesity and so on. So I would agree with you that there is an investment that needs to be made in going to where people actually spend the bulk of their time, which is not in a doctor's office or a health care setting.

The other point I would like to just make is that we have talked a lot about reimbursement and adjusting that. We haven't really talked about the ways in which medical practice has changed and needing to keep up a reimbursement system that mirrors that. Patients want to get care, not visits. They want to get phone calls, e-mails and other ways to allow them to manage their own care outside of a doctor's office. We don't really have a reimbursement system that encourages and incents that.

Mr. WEINER. Thank you.

Mr. PALLONE. The gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, I thank you. I just want to say before I get into the questions that this straw man scenario that my friend from New York said we Republicans have adopted has been taken to perfection by the Democratic majority including President Obama, and I think it is probably time for both sides to stop doing that as we work in a bipartisan fashion to try to solve this health care reform issue. It is hugely important, and I think we can do it. I sincerely believe that we can do it.

With that, let me turn to Dr. Bean actually. Dr. Bean, in your testimony you noted in his health care reform white paper, Senator Baucus acknowledged that the current legal environment leads to the practice of defensive medicine. That was his quote. I would like for you to elaborate on what constitutes defensive medicine and discuss the costs associated with this practice. If you remember, during the debate between former President Bush and candidate Senator John Kerry, in one of the debates that was brought up, and Senator Kerry said well, you know, the actual premium cost of malpractice insurance is although high for the individual doctor, not a significant number, but that is not the real cost and I wish you would explain to my fellow colleagues on the committee and those in the room what the real costs are in regard to that.

Dr. BEAN. Mark McClellan did a study back in the 1990s, I think it was. The Health and Human Services used that as a basis of a 2003 study and found that the excessive tests prescribed to be certain and protect yourself from liability would cost at that time somewhere between about \$45 to \$129 billion. Now, that updated—

Mr. GINGREY. Per year?

Dr. BEAN. Per year in the health care system. That updated today would be about \$170 billion, and the study is debated but I think it is difficult truly to tell what is in the back of a doctor's mind. There is the diagnostic thing but there is the fear that is lingering in the back that if you don't cover everything, you are subject to unmerciful liability, unprotected liability. If this were taken care of, I think there would be a substantial reduction. The other issue about the premium, it is quoted to be a half percent of medical costs. Of course it is trivial because it is just a small proportion of doctors with population sustaining it. It is that bigger cost, if it is a cost issue that can be saved.

Mr. GINGREY. Dr. Bean, thank you, and I am going to turn now to Dr. Harris because I actually back in 2005 when I introduced liability reform, tort reform here in the House, I got a letter from American College of Physicians and it said of course supporting my position on medical liability reform legislation. The American College of Physicians stated that there is "strong evidence that the health care liability crisis resulted in many patients not receiving or delaying much-needed medical care." Dr. Harris, could you please explain to us how the medical liability crisis has negatively impacted access to needed medical care for millions of Americans?

Dr. HARRIS. Well, I think that gets to the point that Dr. Bean was making and whether there is an element of apprehension about doing things by virtue of the threat of malpractice. I mean, it is our belief that liability reform should be part of this large effort to reform the health care system in this country, and as you know, we favor putting a cap on non-economic damages but we also think that in the middle of all this there needs to be some thought and look at the potential for other options. As you are all aware, the testing of expert courts is one that has been considered, but before making such a momentous step, we would applaud looking broadly to see what are the other options.

Mr. GINGREY. Thank you, Dr. Harris.

And in my remaining time—Mr. Chairman, remember I did waive my opening statement—Dr. Rowland, in your testimony you

talked about the Medicaid program and that you recommended maybe Medicaid as a platform for extending coverage to the 45 million or so uninsured and maybe not quite that many who are underinsured. You know, when I practiced, I can tell you that there is a bias against Medicaid recipients. Of course, some doctors won't even accept Medicaid because of the low payment, but even though they do, I think that there probably is a stigma, and certainly if we use the best Medicaid program in the country, of course, all 50 are different but if you took the best as the model to offer to those who are uninsured, how do you get beyond that stigma? Maybe in the brief time, I guess I have at least another minute, for you to respond to that question?

Ms. ROWLAND. Thank you. What we have seen in the implementation of the CHIP program as a companion to Medicaid and many States restructured, renamed their Medicaid program and tried to eliminate some of the stigma attached with it being a heritage program from the welfare days and have found that in Connecticut, for example, the HUSKY program was very popularly received and people didn't distinguish it. When we do surveys of the individuals who have uninsured children and ask them about access to public programs, they say they would enroll if they were eligible. They aren't always aware that they are eligible and perceive these programs to be a good program. I think the other point though that one has to make is that when we look at all the survey research over the years, Medicaid and private insurance do relatively the same in terms of access to care and access to care measures for the populations they serve always far better obviously than being uninsured. So while we have a provider participation issue and that could be corrected obviously by improving the way in which providers are paid and we have a primary care delivery system now that is being used in many States to promote better care, it is important to really look at the overall structure and eliminate some of these State-by-State variations so that it is a better base program for those low-income individuals for whom private insurance with high deductibles and large amounts of cost sharing may not be adequate, but especially for the population that Medicaid now serves, those with severe disabilities and chronic illness where the scope of benefits for Medicaid is equally important to the fact that it has low levels of cost sharing. So I think you really need to look at the population being served. And finally, I would say you also need to recognize that Medicaid is far more than a health insurance program and that the majority of its dollars are spent on long-term care and assistance to the elderly and people with disabilities that go well beyond what we are talking about in terms of the federal health insurance benefit plan or any other private health insurance plan.

Mr. GINGREY. Dr. Rowland, thank you, and Mr. Chairman, thank you for your indulgence.

Mr. PALLONE. Thank you.

Ms. Capps.

Ms. CAPPS. First of all, let me thank the panel for your persistence and endurance, I guess, with this long morning, and I was called many other places but I couldn't miss coming back to address your statement, Dr. Lavizzo-Mourey. Thank you for high-

lighting the role of nurses and our nursing shortage. It is not the only topic on the table but it is often not on the table so I want to thank you for being here and to present that large element in health care. In your written testimony you mentioned the need to increase the number of nurses with baccalaureate degrees to create larger pools of nurses who would qualify among other things for careers in teaching. What efforts do we need to do? I would like to really zero in on this, and then one other topic, school-based health clinics that I know you are very good at as well to bring to our attention and get on the record here. What efforts need to occur at the federal level to increase the proportion of nurses with this level of education?

Dr. LAVIZZO-MOUREY. One of the key issues is funding for scholarships and other financial aid programs for nurses at the baccalaureate level and for nurses who are transitioning from associate to baccalaureate. We know that these programs over the last 20 years have decreased and in the past have been a major source of financial support for nurses and I would encourage every effort to be made to enhance those.

Ms. CAPPS. Thank you, and it is so clear that given the cost-of-living increases, we have less money from federal dollars in nursing education today than we did in the 1970s, and with our shortage, this is something I hope we can do our part in remedying. Of course, recruitment and financial aid is one piece of it. Retention is another. You mentioned, I would love to have you explain a little bit more for all of us, the need to retain newly licensed nurses at the bedside and particularly the work of the Robert Wood Johnson Foundation in the area that you are calling Transforming Care at the Bedside project. Briefly describe this because I still want to get to school-based health clinics so that we can understand that this is a very important example and there are other examples as well as to how we can keep nurses engaged in the delivery of health care.

Dr. LAVIZZO-MOUREY. One of the things we recognize is that the pipeline for nurses entering the field is being eroded by the number of nurses that are leaving the field and these are often among the most experienced clinicians and they have demonstrated, particularly when they are trained at the baccalaureate or above level, that it decreases medical errors, poor outcomes and the like. So efforts that will enhance the retention of experienced nurses will directly impact the shortage.

The program that you mentioned, Transforming Care at the Bedside, really focuses on trying to develop a cadre of nurses who understand the needs at the bedside and can make changes at the nursing level but then also disseminate those changes throughout the hospital and to other hospitals that empower nurses to do the best for patients, improve the patient centeredness and in the process improve the quality of care. So it really speaks to the issues that nurses often give for leaving the profession or leaving a particular institution that are non-financial, that is, not being able to deliver the quality of care that they feel they were trained to deliver. That is really the core issue that Transforming Care at the Bedside addresses.

Ms. CAPPS. It is very important, thank you, that we have this ingredient really strong front and center in our efforts to reform health care delivery. One other thing, you mentioned the work of the Robert Wood Johnson Foundation in addressing health care needs of our Nation's children by investing in school-based centers across the country. I have long felt this. It is not just a bias because I have been a school nurse for so many years. Families trust their neighborhood schools. They will come there, not just the schoolchildren but the whole family. That is a good place to deliver care and we should be thinking about this as a cost-effective means and I would like to have you address it, because one of the problems is—and I know this very personally—is the shortage of school nurses and others. Nurse practitioners can deliver great care within the school setting but that is exactly where we are short supply.

Dr. LAVIZZO-MOUREY. Your points are very well taken. There are 1,500 school-based clinics around the country and they have demonstrated that by providing care in the local environment, the school is a local environment, it is a trusted area that is close to where people need to get care, you can improve mental health services, you can improve primary care services and other services that the children and, as you mentioned, their families would not otherwise receive. So these are cost-effective ways of delivering care in the community that addresses, I think, some of the issues that Dr. Smedley was mentioning. People need to be able to get care close to where they live.

Ms. CAPPS. Thank you, and I only wish I had time to ask some of the others on the panel for your thoughts because it seemed like I picked the one person who talked about nurses but I think there might be other agreements among the panel members that these are areas that we should rightly pursue. Thank you very much.

Mr. PALLONE. Thank you.

The gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. Thanks to the panel. Congresswoman Capps, you needn't have worried that the topic won't be continued because I am going to ask you the same questions, particularly about school-based health clinics. It is great that we have 1,500 school-based clinics across the country but that is a complete drop in the bucket in terms of what we could use them for, and Representative Weiner introduced this concept of sort of creating a different kind of infrastructure for delivering certain kinds of care. I am very interested, and the school-based health clinic falls right within this, in the concept of place-based health care, and I think you addressed this, but let us go where people are. I mean, we can walk down the hall here and there is a clinic. There is a nursing station suite that we can stop into and it makes perfect sense to have those resources on site where you can capture certain populations. It is so obvious to me and clearly other members of the committee as well and members here in Congress that our schools represent a huge opportunity to do this. I practiced health care law for 18 years but for 8 of those years I was part time as a health care attorney and part time working 20 hours for the State superintendent of schools so I was in schools, and of course what I kept seeing was the impediments to education that



were represented by the health status of so many of the students and the need they had to get these services.

So I would like any others who would like to join this conversation to talk about this concept of place-based health care, and we can also view it—I would like you to speak in terms of addressing the workforce issues, internships, residencies and other things that are associated with those structures, and I would add as well the concept of medical home which is typically talked about when you are addressing the individual's care but I think we should be thinking in terms of the medical home for certain communities, so in other words, the medical home for a school is that clinic. The medical home for a naturally occurring retirement community where people are aging in place, you know, in significant levels would be a clinic. In the school, it could be a clinic that is being staffed by not just nurses but pediatricians so you can get the workforce issue there. In a clinic where people are aging in place, it is a way to expand the geriatrician workforce, et cetera, et cetera. So speak to place-based health care as really potentially being a revolution in the way we address a lot of these needs and the public health needs. Anybody who wants to jump in?

Mr. SMEDLEY. Congressman, I would just echo your thoughts. A focus on place and on communities can help us to really think more creatively about how to prevent illness in the first place and as a result lower health care costs. The examples that Representative Weiner gave of beginning to emphasize prevention are critically important. One of the things that we haven't talked about is good community-based primary prevention. A recent report by the Prevention Institute showed that if we invest just \$10 per person per year for 5 years, we can save \$16 billion in health care costs by helping people to avoid illness in the first place.

Mr. SARBANES. Anyone else? Yes.

Dr. HARRIS. The American College of Physicians I don't believe has policy per se about community-based clinics. However, obviously the notion of primary care physicians in schools, pediatricians and then the family practitioners and internists in settings in adult settings, we have said that the patient-centered medical home is not the only solution, that we may need to redefine, and the ultimate product will be quite different and perhaps along the lines that you are suggesting.

The last point which I believe is relevant to this is what was alluded to, the role of nurses or nurse practitioners in this outreach program. The American College of Physicians met with much of the leadership of the nurse practitioner community last July to talk about we can work collaboratively to try and expand in this team-based concept, and Mr. Sarbanes, as you may be aware, we just published a paper in which we felt that this Medicare demonstration projection with the notion that homes may in certain areas be headed by a nurse practitioner, not necessarily a physician, obviously within the scope of practice of nurse practitioners, but it does get to the idea that the end product of this discussion will probably be a very varied set of options and not one simple solution to our health care needs.

Mr. SARBANES. Thank you all. The other day I was thinking about which level of schools is it most important to have these

health centers in, so elementary, you think about elementary and it is obvious why you should have that kind of resource there. Then you think about middle school and it is absolutely obvious why you would need it there. And think you think about high school and it is beyond obvious why you would need it there. So 1,500, like I said, it is a starting point and we also have to make sure that the financing mechanism for these centers is one that is not subject to the typical way education gets funding because then they will just sort of come and go depending on the situations that the schools face. So anyway, we will continue to pursue this topic. Thank you for your testimony.

Mr. PALLONE. The gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you very much.

Just picking up on what Mr. Sarbanes and Ms. Capps were saying, I want to ask a quick SCHIP question. Years ago the precursor to SCHIP started in Florida under Governor Lawton Chiles. It was conceived early on as making it as easy as possible for parents to enroll their children in health insurance when they started school, when they started the school year. Unfortunately, in the intervening years the political leadership in Florida changed and folks there saw enrolling kids as a cost rather than an investment and we lost a lot of ground and we lost that link between the start of school and signing up children for health insurance, making sure they got their checkups and immunizations. Are States across the country, do other States still have that link?

Ms. ROWLAND. Many states really use and the Johnson Foundation has helped to promote through its Covering Kids initiative the first day of school as a real day to try and alert parents to the fact that their children may be eligible. There is more than can be done to use the schools as an enrollment facility and to simplify the enrollment but it has been one of the main outreach focuses for many of the States in their efforts to enroll more children and I think it is a very critical place in the community for people to come. One of the things I was going to note is in New Orleans where Katrina destroyed so much of the health care system, they are rebuilding it community by community and using the schools as really the focus for where they put their clinics and for where they organize their services which will also help contribute to more people being able to gain access and participate.

Dr. LAVIZZO-MOUREY. I would just add that there are other ways for people to find out about SCHIP but there are other areas, other locations where people naturally gather than can be used to increase enrollment and tying enrollment to other kinds of services like school lunch programs and the like, makes it easier for parents to make that linkage and not have to go to extraordinary ends to actually get enrolled and stay enrolled.

Ms. CASTOR. Yes, I was surprised to learn when I had my local housing authority director paying a visit on a totally separate topic, he said back a few decades ago the housing authorities used to have very expansive clinics in some urban areas. That makes a lot of sense. In my urban county in Tampa, Florida, it is Hillsborough County, it is about 1.2 million people, about 15 years ago there was a fork in the road. They were paying for very expensive care in our emergency rooms out of property taxes. I said there must be a bet-

ter way, and said instead, let us shift from property taxes to a different revenue source. We would take a half-cent sales tax and develop this collaborative effort with the hospitals and doctors and community health centers and have established a number of neighborhood clinics that really out in the neighborhoods. Some community health centers and then other hospitals have their own clinics where their doctors have to take turns and teaching hospitals, a lot of the residents from the University of South Florida are there, and it is a model program, and I know there are some other models in San Antonio and I believe in Oakland. How do we—as part of this health care reform effort, how do we incentivize these communities? What is going to be the role? I don't want health care reform to happen in a vacuum. There are some good things going on out in the world.

Dr. LAVIZZO-MOUREY. I am familiar with some of those programs because our foundation helped fund many of them, and I think before I address the issue of incentives, let me just speak to one of the major disincentives that was operational in many of those programs. They were, as you say, locally generated, addressed the needs of the local population but many of them found that they could not sustain themselves because the base was not large enough to cover the costs of people's insurance and health needs over a longer period of time, and that is really one of the things that has made us favor federal programs that can ensure that these locally generated programs actually have the funding base to provide care not just in prosperous times but also in times when the community is not as prosperous.

In terms of the incentives, I think one of the things we saw in putting out applications for these kinds of programs is that communities do know the kinds of services that they need and they will come together and organize to provide those kinds of services, so I think that providing that kind of a mechanism is going to be a valuable incentive.

Ms. CASTOR. And it takes money. The administrative costs are very low. They aren't any HMOs involved. It is administered by the county and the hospitals love it because they are getting compensated for medical services that otherwise would go uncompensated and charity care. But if you have some other ideas and examples of communities that have programs like that that are working, I would appreciate it.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. I think that concludes our questions but I really want to thank you all for being here today. I know it was a large panel, it covered a lot of things, but it was very worthwhile in our efforts to put together reform legislation. The way it works, you may get additional questions in writing and then we would ask you to respond in writing, I think within the next 10 days or so. But again, thank you for your input. As you can see, there is really a lot to cover here but we are determined to move forward with reform this year.

So without objection, the meeting of the subcommittee is adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



**BLUNT STATEMENT FOR E&C SUBCOMMITTEE ON HEALTH**

**MARCH 24, 2009**

Mr. Chairman,

Thank you for holding this hearing on improving access to health care.

There are a variety of barriers that can prevent access to care.

An important issue to consider when discussing access issues is medical liability reform. In many areas around the country, doctors are simply unable to afford their medical liability premiums. Small practices cannot afford to stay in business when they have to factor these fast-rising premiums in with other overhead costs. This has forced doctors out of practice or into lower-risk disciplines, which can cause provider shortages. This can especially affect rural areas that might already have difficulty accessing health care. According to the AMA, many states' premiums have more than doubled over the course of a few years. In my own state of Missouri, lawsuit reform was enacted in 2005. From 2005 to 2006, total claims against doctors fell 61 percent. Since that legislation was passed and signed into law, doctors have seen claims drop by more than 70 percent. The reduced amount of lawsuits has provided hospitals and practices significant savings that they can use to invest in improving patient care. For some this might mean investing in health IT, while others may need to hire more doctors or buy new, updated equipment. The bottom line is that Missouri doctors now have more resources to take care of other Missourians.



As we work to ensure increased access to Americans, we also need to make sure that we are protecting those that currently have coverage. I am concerned that a government-run plan option would threaten those that already have private coverage through their employers. A study conducted by the Lewin Group in December found that almost 120 million Americans would lose their private coverage if a government plan was put into place. Introducing a new government-run plan into the mix is simply a slower path to a single-payer system as the government will eventually force out other competitors.

I'm hopeful this subcommittee can find ideas and solutions to help improve access to quality care. I look forward to working with you Mr. Chairman, with Mr. Deal and the subcommittee, as well as my colleagues in the full committee to achieve good policy in a bipartisan way.

## *Ahmed Plastic Surgery*

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March 19, 2009

TO: Congressman John Shimkus

FROM: Noor Ahmed, M.D., President  
Madison County Medical Society

RE: Medical Malpractice Reform

*As a 30 year practicing surgeon in Madison County, IL, I can tell you **malpractice cost are not at all a small cost in the overall health system as the trial lawyers might like you to believe. They are the major problem.***

When I started practicing medicine, in the same location, 30 years ago my malpractice premium with the same insurer was \$10,000 a year. Today, my premium is just shy of \$100,000 annually.

You must also factor in the malpractice/liability cost paid by the hospital or surgery center, the lab and physicians who read the pathology results, radiology and anesthesiologist, as well as other ancillary providers that might get involved like physical therapy, home health care, the pharmacy and even the manufacturer of a product or device that may have been used.

One must also consider how these additional cost then funnel down to an employer trying to provide group health insurance. How many of our factories have gone belly up with one of the primary reasons being the high cost of provided group health care. When you put it all together it snow balls into monumental numbers that must be curtailed or the cost will escalate and quality of our healthcare system will erode.

It's a fact that as a method of self preservation physicians practice defensive medicine or may be forced to do more or less, as the case might be, because our community has lost our specialist, family practitioners, etc.

If what we are doing now were the answer, or if doctors just needed to improve quality of care as John McDonough, a top health adviser to Senator Edward Kennedy told a group of urologist this week, we surely would see a strong correlation between the increase of malpractice cost and the decline of measurable malpractice but we don't.

Malpractice is a real thing; mistakes are made..... but it cannot be improved by allowing the cost of malpractice to continue to escalate. Most medical outcomes are positive. Medicine is an inexact science and there are a myriad of variables. A reduction in adverse events and outcomes can only come through education, sharing of experiences among peers and continued education of health care providers and patients alike.

The sad thing is that most feel it is the doctors and trial lawyers who have the most at stake. It's really the patient. Linda Lipsen, senior vice president of public affairs at the American Association for Justice says,

"changing the legal system will not make anyone healthier or save one life." I respectfully disagree. It would put us in a position of spending more money for the healthcare of those who cannot afford it; perhaps getting us to President Obama's goal of every citizen having good health care, doing more research, practicing preventive, proactive medicine rather than reactive, defensive medicine.

Major malpractice reform with bipartisan support should be the starting point of our country's health care overhaul.

na/sih DBNR

FROM :

FAX NO. : 6184672595

Mar. 19 2009 05:41PM P1

From: Robert F. Hamilton, M.D.  
 4003 Stoneledge Court  
 Godfrey, IL 62035  
 Fax # 618-467-2595  
 Illinois State Medical Society District 6 Trustee  
 To: Hon. John Shimkus  
 Fax#: 618-344-4215  
 Fax#: 202-225-5880

Dear Congressman Shimkus:

I am writing this letter to emphasize the effect that unrestrained medical malpractice litigation has on the availability and cost of medical care. After practicing general and vascular surgery in Alton, Illinois in Madison County for thirty years, I have gained considerable insight into the problem of litigation abuse.

Injured patients should have the right to seek compensation commensurate with their economic loss. However, allegations in suits filed in Madison County often bear little resemblance to the actual events that occurred in the treatment of the patient. The most important stimuli for the filing of such lawsuits are potentially excessive non-economic awards for the patient and enormous fees for the plaintiff's attorney. A \$1 million economic injury may result in a non-economic award of \$10 million, or even \$20 million.

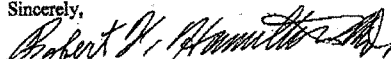
Most medical malpractice insurance companies left Illinois in 2002 because of litigation abuse, and those remaining were forced to raise their insurance premiums for physicians, especially in high risk areas like Chicago-Cook County and Madison and St. Clair Counties. As a result, the latter two counties lost 170 physicians between 2002 and 2004 through early retirement and relocation. Many of the remaining physicians had to become hospital employees in order to have medical malpractice coverage. I know one superb general surgeon whose premium reached \$195,000 before he became a hospital employee.

Plaintiffs' attorneys blame the insurance companies. This is absurd. If that were the case, the companies wouldn't have fled the state, leaving primarily the physician-owned Illinois State Medical Insurance Exchange Mutual to cover physicians.

Threat of litigation causes an inestimable amount of the practice of defensive medicine. After years of practicing under this kind of threat, defensive medicine has become ingrained, subliminal and sometimes even irrational.

I hope these comments will assist you in your efforts in Washington. I am also faxing a Letter to the Editor by Madison County Medical Society President Dr. Noor Ahmed and me to the regional newspapers regarding possible overturn of the 2005 malpractice tort reform law by the Illinois Supreme Court. I have been active in this arena for 35 years including numerous newspaper articles and appearances on several radio and television broadcasts, including the Lehrer News Hour. If I can be of any assistance, please don't hesitate to ask.

Sincerely,

  
 Robert F. Hamilton, M.D.



**Subject:** Shimkus letter

----- Forwarded message -----

**From:** Phillip Johnson

**Date:** Sun, Mar 22, 2009 at 2:46 PM

**Subject:** Shimkus letter Al I am in Rome without a fax please forward

**To:** Allen Adomite

Dear Congressman Shimkus:

I am writing in support of your efforts to bring to your congressional colleagues the news that the cost of medical malpractice is still an issue.

It was only about five and six years ago that southern Illinois witnessed the exodus of physicians from our area due to the escalating costs of insurance. This was a direct cause of the escalating awards and settlements in malpractice insurance cases against doctors hospitals.

The rates have stabilized because of the changes made then, and this has allowed physician services to be restored. If our elected leaders do not continue to guard these legislative changes, the trial lawyers will only too quickly take us back to the days of escalating malpractice settlements and awards, and lead us again into another round of rising insurance rates, and departing doctors.

Even though the state insurance rates have remained stable at the state level, the insurance rates for our rural county are slated to jump this July due to higher than expected insurance pay outs attributed to doctors in our county. I have personally never lost an insurance claim against me. I have not had a claim against me in over ten years. But my rates are slated to increase due to the insurance companies experience in our county over the past few years. That is the nature of insurance. The statewide news of no increase in insurance does not reflect the reality of any one county.

There is a very fragile balance now in medicine with our insurance rates. The family physicians of our county continue to provide obstetrical care to the women of our county and area. That includes a significant portion of women who are on public assistance. It will not take too many rate hikes before those of us providing obstetrical care in our rural county say enough is enough, and that we will not continue to provide high risk services. Then the women of our area, many who can least afford the cost of travel, will be in a situation of needing to drive forty to sixty, or more miles for care. When access to care for pregnant women decreases the outcome does also.

Now is not the time to decrease our protection of physicians trying to stay in medicine, and provide high risk care to people with high risk issues in high risks areas. Southern and rural Illinois remains at risk for a return to the crisis of only a few years ago. ~~the crisis of only~~ <sup>the crisis of only</sup>

Sincerely,

Phil Johnson M.D.  
Litchfield, IL  
Montgomery County

FROM : S MOHYUDDINMD

FAX NO. : 16184661950

Mar. 20 2009 03:14PM P2

**MOHYUDDIN MEDICAL CENTER, LTD.  
SADIQ MOHYUDDIN, M.D., President**

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MEDICAL EXCHANGE: (618) 463-0046  
FAX: (618) 466-1950

Hon Congressman John Shimkus  
Capital Building  
Washington D.C.

Dear Mr. Shimkus,

Last night I was informed by my friend Dr. Noor Ahmed, President of Madison county Medical Society that you will be participating in Special committee meeting dealing with Physician Malpractice reform legislation.

It is about time, congress is busy in doing so many other reforms Tort reform deserves special consideration.

We, the physicians of Madison County are disproportionately affected. During the last five years over eighty doctors have either left the county or taken early retirement.

I have been a delegate to Illinois State Medical Society for 18 years representing Madison County submitted several resolution on this subject. About four years ago St. Clair and Madison County Doctors spear headed Tort reform and we were successful in getting \$500,000 caps on non economic losses.

We would like to see some comprehensive malpractice reform at Federal level.

Please arrange for Congressional hearing and I will be more than happy to testify my concerns and experiences.

These days malpractice insurance premiums are prohibitive we have not been able to recruit new doctors, in the area particularly in surgical specialty due to excessive premium.

Thanks for your consideration and your few back please do let me know about the outcome of these meetings.

With Kind regards

Yours Sincerely

Sadiq Mohyuddin M.D.  
Past President Madison  
County Medical Society

MAR-20-2009 15:30

ADMIN

6182884088 P.01/01



March 20, 2009

Steve Tomaszewski  
Press Secretary  
Office of Congressman John Shimkus

Representative John Shimkus and Steve Tomaszewski:

I am pleased to provide this letter regarding the medical liability environment related to healthcare cost. I believe that any comprehensive and meaningful healthcare reform must address medical liability in that it contributes toward a costly system with unequal access to care.

The current healthcare system relies on state legislation to set parameters on medical liability. This has resulted in an uneven distribution of medical providers. In 2004, Illinois began its third medical malpractice crisis in the past 30 years. Insurance carriers left the market with the remaining carriers passing on 30%+ annual premium increases to Illinois physicians. This resulted in an exodus of physicians from already underserved areas of Illinois. The economics of medical practice due to medical liability issues simply drove physicians out of the state because of the practice expense premium in malpractice expenses for the physicians electing to practice in Illinois. Furthermore, the practice environment for physicians due to unpredictable malpractice awards and the higher than average frequency of claims has lead to the practice of "defensive medicine". This practice causes physicians to order medical tests and procedures that are not needed for clinical information in instead are needed primarily to defend medical decisions in order to protect themselves in a hostile medical liability environment. This practice occurs every day in this country and adds significantly and directly to the cost of healthcare in the United States. Addressing medical liability reform in healthcare reform will free millions of dollars that can be directed toward improving care and access to care. It will also provide for a better distribution of physicians as the recruitment and retention of physicians is greatly influenced by the medical liability environment of each state.

Please contact me if I can provide additional information at [pagek@andersonhospital.org](mailto:pagek@andersonhospital.org) or (618) 391-5406.

Sincerely,

A handwritten signature in black ink, appearing to read "Keith A. Page".

Keith A. Page, FACHE  
President & Chief Executive Officer

■■■  
6800 State Route 162  
Maryville, Illinois 62062  
618-288-5711

TOTAL P.01

Mar-20-2009 02:04 PM mturner@memhosp.com 6182576766

1/1

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MARK J. TURNER, PRESIDENT



March 20, 2009

Congressman John Shimkus  
 2452 Rayburn House Office Building  
 Washington, DC 20515

Post-It™ brand fax transmittal memo 7671		# of pages
To	From	
CONGRESSMAN SHIMKUS	MARK TURNER	
Co.	Co.	
WASHINGTON OFFICE	MEMORIAL-BELLEVILLE	
Dept.	Phone #	
	618-257-5642	
Fax #	Fax #	
202-225-5880	618-257-6766	

Dear Congressman Shimkus:

Thank you for the opportunity to comment on the pending medical malpractice reform issues being debated on Capitol Hill. As you well know, the metro-east cannot afford a replay of the past when it comes to medical malpractice issues. It has taken over three years and hundreds of thousands of dollars to try and rebuild from the "physician flight" that took place in Madison and St. Clair Counties as a result of skyrocketing medical malpractice insurance premiums. While Memorial has been fortunate to have had some success in recruiting and retaining physicians since over 100 doctors left the two-county area in early and mid part of this decade – no one can afford to take a step backward.

Continued survival of hospitals in our area depends upon responsible and reasonable legislation. During the height of the malpractice crisis over four years ago, many hospitals suffered substantial financial losses which can be attributed to the exodus of physicians, as well as increased medical malpractice insurance and litigation costs. Any repeat of this, especially during these challenging economic times undoubtedly would be devastating forcing the elimination of critical services for patients as well as the loss of healthcare jobs.

As you and your colleagues continue the debate on this issue, I encourage you to relay some of the "horror" stories from 2003 and 2004 when the medical malpractice issue had a powerful impact on hospitals, physicians and patients throughout Southwestern Illinois.

Again, I appreciate the chance to provide you with information regarding this matter. Please let me know if I can be of further assistance as this issue is debated.

Sincerely,

Mark J. Turner  
 President and CEO

Mark F. Weber, FACHE, President



Saint Anthony's Way, P.O. Box 340, Alton, IL 62002-0340  
(618) 465-4301

March 23, 2009

The Honorable John Shimkus  
2452 Rayburn House Office Building  
Washington, DC 20515

Dear Congressman Shimkus:

Greetings Congressman Shimkus – I hope all is well with you. With the renewed focus on national health care reform, I wanted to share my thoughts on reform efforts relative to the medical malpractice issue. As a member of the House Energy and Commerce Subcommittee on Health, you have been supportive to the Sisters and Mission Partners of Saint Anthony's Health Center, as well as other area hospitals and physicians, and we truly appreciate all that you do.

As you know, Saint Anthony's Health Center was at the epicenter of the medical liability crisis of just a few years ago – by the mere fact that we are located in Madison County. Over a four year period, area residents saw 42 primary care physicians and specialists leave Saint Anthony's Medical Staff because of skyrocketing malpractice premiums. With this loss of physicians, patients had limited access to health care and began leaving Illinois and travelling to Missouri for primary care, where environment is more stable for physicians. As a matter of fact, several of our physicians crossed over the river into Missouri and realized a decrease of as much as 80 percent in their premiums. Even today, a base rate for an internal medicine physician in Madison County, IL is \$33,919; in Missouri, \$18,879, according to Medicus Resource Group.

At the time during the med mal crisis, we heard from OB/GYN physicians who paid premiums in the range of \$90,000 in 2003; in 2004, their quotes ranged from \$263,000 to \$280,000. Also at that time, one of our internal medicine physicians – who had not had a claim in his 20+ years of practicing medicine – experienced a ten-fold increase in premiums. In 2001, his malpractice premium was \$5,600. In 2003, he paid \$18,000 and for 2004, his premium was \$55,000.

Today, we have a much different story to tell with medical liability reform: OB/GYN physicians in our area have malpractice premiums around \$130,000; current premiums for primary care physicians in the CompPAS medical group associated with Saint Anthony's now range from \$9,100 to \$21,600.

With the signing of the medical liability reform bill signed by the Governor at our very own facility in 2005, we have experienced a more calming environment for recruitment of physicians back into the area. Successful efforts to bring physicians back to Alton are occurring, but we estimate that it will take three to four years to replace each physician that left, requiring us to put more of our resources into the very challenging task of recruiting new physicians to the area (recent studies show that it costs \$250,000 to replace a physician). Our current outmigration of patients leaving the Alton area for health care in Missouri is 35 percent – we are hopeful that this number will decrease with the rebuilding of our medical staff.

Our Health Center will spend more than \$1,500,000 this year for malpractice insurance coverage. Unfortunately, we as hospitals and our physicians must acquire our insurance from the payments we

*To serve God is to serve His people.*

receive for providing care. We are compensated like the average hospital or physician in Illinois or Missouri, irrespective of the cost we have for malpractice insurance.

We respectfully ask that any national health care reform legislation include an overhaul of the medical liability system. In addition, we believe that health care reform should begin with expanding coverage for all. Reducing the deficit, enacting health care reform and retooling our nation's safety net programs all warrant the attention of Congress.

I would be happy to discuss this further with you. Thank you again for your support, Congressman.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark F. Weber".

Mark F. Weber, FACHE  
President/Chief Executive Officer



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**Thomas M. Gose**  
 President and Chief Operating Officer

January 22, 2007

David A. Cook, Esq.  
 Executive Director  
 Medical Association of Georgia  
 1330 W. Peachtree Street, NW  
 Suite 500  
 Atlanta, GA 30309

Re: Is Tort Reform Working?

Dear David:

Physicians, legislators, and the media are asking for proof that tort reform in Georgia is working; particularly the "cap".

The \$350,000 "cap" on non-economic damages applies only to medical incidents occurring after February 16, 2005. Unfortunately it takes 3-5 years for an incident to become a lawsuit and be finally resolved by jury verdict. Thus the cap has had no impact yet on jury verdicts rendered since the cap. However, the cap is affecting claim settlements in a positive way. The average payment to a plaintiff fell in 2006 to \$322,300 from \$421,800 in 2005, some 23% lower.

We also have additional preliminary data to show that tort reform is working:

1. Between 2000 and 2004, the losses we paid in Georgia jumped from a total of \$42.2 million in 2000 to \$61.7 million in 2004, an increase of 46%. In 2005, following tort reform, loss payments fell to \$59.3, and in 2006 fell again to \$50.8 million, a drop of 18% from 2004.
2. In 2004 we opened 1,128 Georgia medical liability claims against physicians. In 2005, 799 claims were opened, and in 2006, only 741 claims were opened, a 34.3% reduction since enactment of tort reform.
3. Our Georgia claims paid of \$1,000,000 or more fell from 14 in 2004 to 12 in 2005, and to 10 claims in 2006.

Tort reform is already leading to lower rates for physicians, more competition among insurers, and improved access to affordable quality health care for patients. Now we must wait to see if the Georgia Supreme Court upholds the cap and thus ensures that these benefits will continue.

Best regards,

*Tom*

TMG:jb

