

Physicians And Their Practices Under Health Care Reform

A REPORT TO THE PRESIDENT and THE CONGRESS

EXECUTIVE SUMMARY

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In the context of the continuing debate about health care reform, the Physicians Foundation saw a need for a critical analysis of how various proposed changes might affect the demand for physicians and the ability of their practices to provide optimum patient care. To that end, the Foundation called upon a small but experienced team of academics to assess the conditions and make recommendations. This report is the product of that effort.

In undertaking this report, the Project Team acknowledged and endorsed the need for health insurance reform to more equitably cover all Americans and to more fairly distribute the financial responsibility for health care, but it did not assess any of the proposals to achieve those goals. Rather, this report addresses the characteristics of physicians and their practices as medical care evolves, regardless of future insurance scenarios.

The Project Team considered seven broad subjects:

- Geographic distribution of health care
- Growth of the health care economy
- Physician supply
- Medical education
- Physicians' roles within an expanded health care workforce
- Generalist physicians and primary care services
- Physician practice infrastructure

Like health care reform, this report is a work in progress, offering insights and recommendations applicable to the current debate while framing questions for the future.

Geographic distribution of health care

Because it is so deeply woven into health care reform discussions, the Project Team began by examining geographic differences in physician distribution, health care utilization, expenditures and outcomes. It found that geographic variation relates primarily to economic and health status at the communal and individual levels:

- Communal wealth: wealthier communities use more services and have better health and better outcomes;
- Individual income: paradoxically, low-income patients use more services, yet they have worse outcomes;
- Health status: patients who are in poorest health use the most health care services and have the poorest outcomes.

The Project Team rejected the interpretation that greater health care utilization in certain regions is due to the overuse of supply-sensitive services. And, while acknowledging that all providers must strive for better efficiencies, it rejected the conclusion that large-scale savings could be achieved by reducing the volume of care in communities where it is greatest. Indeed, the Team noted the striking persistence of variation among communities over the course of many years and the enormous impact that poverty has had on determining the levels of health care services utilized.

Growth of the health care economy

The Project Team chronicled the long-term trends in health care services and spending and critically examined proposed strategies to slow the growth of health care spending through means such as better prevention, greater efficiency and the wider use of health information technology. The Team concluded that health care services are likely to grow more rapidly than the overall economy over the next several decades, though at a pace that will slow over time. It modeled the future demand for physicians and the structure of physician practices on this basis.

Physician supply

Based on an assessment of the future demand for physician services, the Project Team endorsed recent reports showing that physician shortages are developing across all specialties and regions. The Team called upon Congress to assist with an expansion of medical schools. And because Medicare's support of graduate medical education (GME) residency training is so essential, the Team urged Congress to remove the cap on Medicare's support of residency positions, which was established more than a decade ago. The Team also called on academic leaders and health insurers to find an equitable payment formula for GME that encompasses all payers. The Project Team noted that, while expanding medical education is critically important, the long lead time necessary to train physicians means that physician shortages will persist for fifteen years or more. Therefore, while the recommended strategies to expand training are essential for the more distant future, other strategies will be needed to fill the gap during the coming decade.

Medical education

In calling for an expansion of medical education, the Project Team urged academic leaders to re-examine the length and content of training. The educational experience must be realigned with the demands that will be placed on physicians as they enter practice. Training programs must adapt to the realities of tomorrow's clinical practice, where teams of physicians and other clinicians will provide the broad range of services patients need. It is not clear that the combined duration of premedical and medical education must span eight years, nor that residency programs must be as long as they currently are, particularly for residents who then pursue fellowship training, and the pathways to specialization must be streamlined. Changes like these are needed not only to remove waste and redundancies but to decrease the financial burden on trainees and to free up residency positions that could go to additional trainees.

Physicians' roles within an expanded health care workforce

Given the reality of persistent physician shortages, the Project Team recommended that efforts be made to increase training of health care workers at all levels, from physicians to aides. It also recommended that tasks be down-streamed to providers with the competence to perform them. In that way specialists can retain the responsibility for major acute and chronic diseases while delegating the general care of specialty

patients to midlevel clinicians, principally nurse practitioners or physician assistants. Similarly, generalists can retain the responsibility for managing patients with chronic illness and multisystem disease, while midlevel practitioners can provide front-line primary care services, with generalists' consultative oversight. Midlevel practitioners can, in turn, delegate routine tasks to nurses, aides and assistants. Training at all levels must be increased immediately, recognizing that the time-frame of training is different for each. Caregivers with the least complex tasks can be trained most quickly, while physicians will take the longest. The result will be a strengthened, cost-effective and broadly available health care workforce prepared to address today's needs and ready to adapt to tomorrow's challenges.

Generalist physicians and primary care services

Primary care has been a central focus of health care reform. In modeling the future workforce, the Project Team acknowledged the critical importance of primary care services and the role of generalist physicians in providing them. However, the Team rejected the claim by Starfield and others of lower mortality in regions with more family practitioners as a statistical anomaly, and it questioned the wisdom of deploying generalist physicians to take responsibility for the proposed medical homes. Indeed, faced with deep and prolonged physician shortages, it saw no need for physicians to expend effort on uncomplicated primary care. Rather, the Team saw an opportunity for program leaders in family medicine and general internal medicine to refocus generalist care for adults in a single specialty that would undertake the responsibility for patients with multisystem disease and chronic disorders and offer consultation for nurse practitioners and other front-line primary care providers. In addition, the Project Team urged that attention be focused on training programs that specifically train physicians for rural practice.

Physician practice infrastructure

Finally, the Project Team expressed support for efforts to enhance information systems and expand medical effectiveness research, with the belief that, with adequate financial support, physicians' practices will be able to embrace both. However, it discouraged the use of practice incentives, such as "pay-for-value," that are linked to particular outcomes, because they fail to consider essential outcomes and distort the orderly process of care. It also opposed penalties for events, such as readmissions, that are strongly associated with patients' socioeconomic status. And it urged repeal of Medicare's Sustainable Growth Rate (SGR) formula for physician reimbursement, recognizing that the growth of health care spending overall will exceed economic growth and that physician reimbursement must follow accordingly.

GOALS for HEALTH CARE REFORM

Based on its analysis of the health care landscape, the Project Team formulated the following six goals for Health Care Reform:

1. Physician workforce

Undertake a major expansion of the physician workforce by enlarging the infrastructure of medical school and residency education. Many actions will be necessary, but removing Medicare's caps on support for residency positions is essential. Because these efforts will not reach fruition for fifteen years or more, other near-term strategies will be needed.

2. Team building

Build the workforce of midlevel practitioners, particularly nurse practitioners and physician assistants, who will be critical members of clinical teams and important providers of primary care. Simultaneously build the workforce of nurses, aides, technicians and others, and downstream tasks from more highly trained clinicians to those who have less-complex training but the requisite skills to provide care competently.

3. Primary care

Build a broad system of front-line primary care and public health services that reach deep into communities and that recognize the varied patient needs in different income groups.

4. Specialty mix

Faced with physician shortages, emphasize physician training in areas where physicians are uniquely capable of providing care, predominately in the medical and surgical specialties. At the same time, reshape the career paths of generalist physicians to take advantage of their capacity to manage chronic illness and multisystem diseases and their parallel abilities to give consultative support to midlevel primary care providers.

5. Education

Shorten the length of medical education from premed through residency, and realign medical education with the realities of clinical practice and the necessary roles of physicians in the future in both urban and rural settings.

6. Autonomy

Equip physicians with better information technology and more access to medical effectiveness research, but do not burden physicians with practice incentives that fail to recognize the vast differences in socioeconomic characteristics among patients and among regions. At the same time, create a Medicare reimbursement formula that is grounded in the reality that physician services will continue to grow in quantity and complexity. And recognize that, ultimately, physician autonomy is the friend of quality.

Achieving these six goals will set America on a path toward preparing a broadly skilled and cost-effective workforce of physicians and other health care workers who are aligned with the broad needs of the public and capable of serving the nation during the difficult period of physician shortages and constrained resources that lie ahead.

HIGHLIGHTS from the FULL REPORT

Health care spending growth is principally a product of the growth of technology and the economic capacity to employ it for the benefit of patients.

The US is a nation of nations, with large differences in health care utilization and outcomes in different regions of the country.

Communities amass health care facilities and personnel at levels that are commensurate with their collective economic capacity -- those with the greatest resources display best outcomes; while individuals use health care services in proportion to their individual needs, which are greatest among the poor -- those who use the most have the poorest outcomes.



No one alive today has carried out health care planning under the circumstances of deep and persistent physician shortages of a magnitude that is now developing.

It is untenable to believe that the large increases in spending that are contemplated by insurance reform will not be matched by substantial increases in the demand for physicians.

Without expanding the supply of physicians, access to medical care will be limited, initially for patients living in rural communities and urban cores but ultimately for patients everywhere.

Training programs must be expanded at every professional level, and care must be distributed throughout the available health care labor force.

The greatest demand for generalist physicians in the coming years will be to serve as consultants in front-line care, rather than as providers, and to direct their principal efforts toward caring for patients with chronic illness and multisystem disease.

If generalists are to focus on providing higher complexity care, the cognitive and managerial skills that are their hallmark must be adequately recognized and compensated.

Ultimately, the strategy adopted for the physician workforce is captive to the evolving physician shortages.



For more than 40 years, the federal government has committed support for residency training through Medicare. This covenant must not be broken.

Increased efforts to evaluate effectiveness could have an enormous impact on the ability of physicians to provide the best care.

It is essential that Medicare undertake a massive process of simplifying its administrative requirements for physicians.

Too often, performance measures and practice incentives intrude into clinical decisions and pervert clinical efforts, while not producing real changes in the desired clinical outcomes.

In the last analysis, quality care depends on the autonomous exercise of clinical judgment by competent and empathic physicians.