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Testimony for the Record
House Appropriations Labor/HHS/Education Subcommittee
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FY 2010 FUNDING LEVELS
SECTION 747 PRIMARY CARE MEDICINE AND DENTISTRY CLUSTER
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
NATIONAL INSTITUTES OF HEALTH

Mr. Chairman, I am Jerry Kruse, MD, MSPH, Professor and Chairman, the Department of Family and Community Medicine at Southern Illinois University. I am here on behalf of the Society of Teachers of Family Medicine, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, and the North American Primary Care Research Group. I thank you for the opportunity to provide this testimony in support of funding for family medicine training in health professions training, the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH).

Health Care Reform Requires a Robust Primary Care Workforce:

Health care reform without measures to address the need for more primary care physicians will never be comprehensive or effective; it will not be able to help the most vulnerable populations, and it will not address the significant cost and quality issues currently so problematic in the United States. Increased access for patients in terms of insurance coverage is critical, but not sufficient to resolve the growing shortage of primary care physicians. In fact increased coverage, without increased numbers of primary care physicians is a recipe for disaster.

Solving the problem of the primary care crisis requires a multi-faceted solution. One key element is to increase the value of primary care, both in terms of payment rates and loan forgiveness, and through other avenues to make primary care an attractive specialty choice for medical students. A second is to change the incentives and rules surrounding training under the Medicare graduate medical education (GME) system. A third is to increase funding of programs that are effective in producing more primary care physicians, such as the primary care medicine and dentistry cluster of the health professions training programs. And the fourth is to support research regarding the

clinical needs of most people seeking care, relating to the most common acute, chronic, and comorbid conditions routinely cared for by primary care physicians.

It is the latter two building blocks: funding for primary care physician training programs and funding for primary care research that come under this subcommittee's jurisdiction and that we are here to speak to today.

Health Professions: Primary Care Medicine and Dentistry (Title VII, Section 747)

We recommend that Congress build on the investment in primary care medicine training made in the *American Recovery and Reinvestment Act (ARRA)* by providing an appropriation of \$215 million for primary care medicine and dentistry health professions training grants. The FY 2009 omnibus appropriations bill only provided \$500,000 more for these programs than in FY2008. This funding level (\$48.4 million) is less than half of the funding these programs received in FY2003. We appreciate your efforts in that the House had proposed to double that account in the *ARRA*. We applaud the \$300 million included for the National Health Service Corps, but we do not know how the remaining \$200 million in workforce funds will be distributed between the many other workforce programs included in the *ARRA*.

Key Advisory Committees Know These Programs are Effective:

- The **Institute of Medicine (IOM)** calls the Title VII program an “undervalued asset.” Title VII, section 747, administered by HRSA, is the only program aimed directly at training primary care physicians. On December 12, 2008, the Institute of Medicine released “HHS in the 21st Century: Charting a New Course for a Healthier America,” which points to the drastic decline in Title VII funding. Within that report, the IOM terms Title VII an “undervalued asset.”
- The **HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry**¹ recommends an annual minimum level of \$215 million for the Title VII, section 747 grant program. The Committee reasoned that:

Title VII funds are essential to support major primary care training programs that train the providers who work with vulnerable populations ... additional funding is also necessary to prepare current and future primary care providers for their critical role in responding to healthcare challenges including demographic changes in the population, increased prevalence of chronic conditions, decreased access to care, and a need for effective first-response strategies in instances of acts of terrorism or natural disasters.

- The **Congressional Research Service (CRS)** also found that reduced funding for the primary care medicine and dentistry cluster had a deleterious impact on the effectiveness of these programs – at a time when more, rather than less primary care is needed. For example, “In FY2006, the program supported a total of 17,870 individuals in clinical

¹ *The Role of Title VII, Section 747 in Preparing Primary Care Practitioners to Care for the Underserved and Other High-Risk Groups and Vulnerable Populations.* Sixth Annual Report to the Secretary of the U.S. Department of Health and Human Services and to Congress

training in underserved areas, a decrease from the support of 31,153 individuals in FY2005.”² This is a decrease of almost 43%, in only one year.

- A study in the *Annals of Family Medicine* (**September/October 2008**) shows that medical schools that receive primary care training dollars produce more physicians who work in Community Health Centers (CHCs) and serve in the National Health Service Corps (NHSC) compared to schools without Title VII primary care funding. In spite of an effort to double the capacity of CHCs between 2002 and 2006, CHCs have found it difficult to recruit a sufficient number of primary care physicians and have hundreds of vacant positions.

Programs are Economic Drivers of Cost-savings and Higher Quality

- A *Health Affairs* (**April 2004**) article found a lower quality of care in states with higher levels of Medicare spending. The authors from the Dartmouth Center for the Evaluative Clinical Sciences found that states with more specialists and fewer primary care physicians had significantly higher costs and lower quality. A small increase in the number of primary care physicians in a state was associated with a large boost in that state's quality ranking. Indeed, states at the 75th percentile in number of primary care physicians per capita recorded Medicare costs \$1600 less per Medicare beneficiary per year and higher quality indicators than states at the 25th percentile. If all states were to move to this level of primary care services, higher quality care could be delivered at a savings of \$60 billion or more per year for Medicare patients alone. Increased funding for Title VII, section 747 could train more family doctors to be available to provide this much needed high-quality, lower-cost care.
- The **Government Accountability Office (GAO)** and the **Medicare Payment Advisory Commission (MedPAC)** have noted research indicating that access to primary care is associated with better health outcomes and lower health care costs. The GAO states “Ample research in recent years concludes that the nation’s over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient. At the same time, research shows that preventive care, care coordination for the chronically ill, and continuity of care --- all hallmarks of primary care medicine – **can achieve improved outcomes and cost savings.**”³ [emphasis added]
- According to a report prepared by the **National Association of Community Health Centers, The Robert Graham Center, and Capitol Link**⁴, “There is a growing consensus among the nation’s political and industry leaders that the U.S. health care crisis has shifted from the realm of the poor and disenfranchised, to the doorstep of middle-class America.” Additionally, they cite the following:

² CRS Report to Congress. February 7, 2008 Title VII Health Professions Education and Training: Issues in Reauthorization (Order Code RL32546)

³ Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate. Primary Care Professionals: Recent Supply Trends, Projections and Valuation of Services. Statement of A. Bruce Steinwald, Director Health Care, United States Accountability Office. February 12, 2008 GAO-08-472T

⁴ Access Granted: The Primary Care Payoff, August 2007, National Association of Community Health Centers, The Robert Graham Center, Capitol Link (pgs 1-2)

“If every American made use of primary care, the health care system would see \$67 billion in savings annually. This reflects not only those who do not have access to primary care, but also those who rely extensively on costly specialists for most of their care, leading to inefficiencies in the system. More specifically, the expansion of Medical homes can even more dramatically facilitate effective use of health care, improve health outcomes, minimize health disparities, and lower overall costs of care.”

- Another study by the **Robert Graham Center**⁵, found that the economic impact of one family physician to his or her community was just over \$900,000 annually. Family physicians are the specialty most widely distributed throughout the US. Using the data from their study on the economic impact of family physicians in their communities, they estimate that family physicians generate a nationwide economic impact of more than \$46 billion per year. This is a conservative estimate, and does not include a number of intangible and other tangible economic benefits of family physicians, such as their contribution to the generation of income for other local health care organizations such as hospitals and nursing homes. In addition, while most medical specialties tend to cluster in urban areas and near academic health centers, family physicians are the specialists that are most likely to work in the poorest rural and urban areas. These underdeveloped geographies are also the ones most likely to be medically underserved.
- Multiple studies from the **Johns Hopkins Bloomberg School of Public Health** have demonstrated that disparities in health care outcomes due to income inequality and socioeconomic status are reduced when there is an adequate supply of primary care.

The Agency for Health Care Research and Quality (AHRQ) and the Institutes of Health (NIH) – Health Care Reform Requires New Areas of Endeavor

Research related to the most common acute, chronic, and comorbid conditions that primary care clinicians care for on a daily basis is currently lacking. Primary care physicians are in the best position to design and implement research of the common clinical questions confronted in practice. Funding should be increased both for the training of primary care researchers and for this type of clinical research. Such training is necessary to impart critical research skills to the primary care workforce and to contribute to the body of knowledge necessary to put primary care on similar footing with other specialties that have established research infrastructures. We are pleased with the infusion of funding through the ARRA for comparative effectiveness research, but there is a need to provide new funding directly toward specific clinical and translational endeavors.

AHRQ: AHRQ supports research to improve health care quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. While targeted funding increases in recent years have moved AHRQ in the right direction, more core funding is needed to help AHRQ fulfill its mission. We support the request of the Friends of AHRQ which recommends an FY 2010 base funding level of \$405 million, an increase of \$32 million over the FY 2009 level. This increase will preserve AHRQ’s current initiatives and get the agency on track to a base budget of \$500 million by 2013.

⁵The Family Physician as Economic Stimulus, <http://www.graham-center.org/online/graham/home/tools-resources/directors-corner/dc-economic-stimulus.html>

The Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001) recommended a much larger investment in AHRQ. It recommended \$1 billion a year for AHRQ to "develop strategies, goals, and action plans for achieving substantial improvements in quality in the next 5 years..." AHRQ is critical to retooling the American health care system.

One of the hallmarks of the Patient-Centered Medical Home is evidence-based medicine. Comparative effectiveness clinical research, compares the impact of different options for treating a given medical condition, and is vital to improving the quality of health care. Studies comparing various treatments (e.g. competing drugs) or differing approaches (e.g. surgery vs. drug therapy) can inform clinical decisions by analyzing not only costs but the relative medical benefits and risks for particular patient populations.

NIH: Historically, the NIH has placed little emphasis on the research questions asked by primary care physicians and in primary care settings. We have been encouraged by the development of the NIH Roadmap and the Clinical and Translational Science Awards (CTSA), along with the establishment, in statute, of a funding stream that would make NIH more relevant to where most people receive care. We support an increase in NIH funding. In addition, we would like to see some report language that would help NIH ensure that the promise of "bench to bedside" research truly becomes "bench to bedside to community" – and community to bedside to bench.

We support the inclusion of the following language in the report to accompany the Labor/HHS appropriations bills for FY10:

"Translational Research has been identified by the former Director of the National Institutes of Health (NIH) as a road map initiative. The committee supports this effort and encourages NIH to integrate such research as a permanent component of the research portfolio of each institute and center. The committee urges NIH to work with the primary care community to determine how best to facilitate progress in translating existing research findings and to disseminate and integrate research findings into community practice. Translational research should also include the discovery and application of knowledge within the practice setting using such laboratories as practice-based research networks. This research spans biological systems, patients, and communities, and arises from questions of importance to patients and their physicians, particularly those practicing primary care. The Committee requests that the Director of NIH include a progress update in next year's Budget Justification."

Conclusion:

As the US moves toward major health care reform, we urge the committee to support programs needed to ensure the proper supply of primary care physicians and the type of research that will work together to improve health care outcomes, enhance equity in care, and lower health care costs. We support increases in these three important programs: health professions primary care medicine and dentistry training, AHRQ, and NIH.