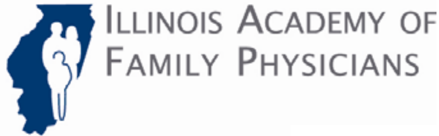

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Asim Jaffer, MD – Board of Directors
Illinois Academy of Family Physicians
Testimony before the Illinois Health Care Reform Implementation Task Force
October 5, 2010 - Peoria, Illinois

Good afternoon and thank you for the opportunity to provide comments to the task force about the challenges and opportunities we face as a state in this new future of health care reform.

My name is Dr. Asim Jaffer, and I am a faculty family physician at the University of Illinois Methodist Medical Center family medicine residency program in Peoria. I am also a member of the Illinois Academy of Family Physicians Board of Directors.

I was asked to provide insight on these topics:

1. Supply and demand of health care workers across the state
2. Scope of practice
3. Payment/reimbursement of providers
4. Re-education and re-training of current workforce with electronic health records.

Let me start with #2 – Scope of practice, because that's the easiest one to answer. Family physicians do it all in providing health care services in our state. Family doctors provide pre-natal care, deliver babies, treat children and care for adults through the end of life. We help keep people well and help them get better when they are sick. No other specialty has a broader scope of expertise.
Family physicians treat people, not parts. And each person is treated as a member of a family, a workforce and a community.

Supply and demand of health care workers across the state

The supply and demand forecasts for primary care physicians currently paint a daunting picture. The U.S. Census report estimates a 36 percent increase in Americans over age 65 that will be on Medicare by the year 2025. Typically the Medicare population comes to us with poor health care status and greater need for services. Many have multiple chronic conditions, requiring many medications, procedures and providers.

At the same time, the Association of American Medical Colleges (AAMC) projects a physician shortfall of more than 130,000 physicians nationwide by 2025. Our national organization, the American Academy of Family Physicians projects that Illinois will need an additional 1,000 family physicians more than our current level to meet demands for services that we will see by the year 2020. **Basically we need to ramp up family physician production by 30 percent.**

The numbers in Illinois are not even close. Illinois has eight medical schools throughout the state. This year, only 89 out of 1,184 - only 8 percent - of Illinois allopathic medical graduates chose family medicine… continuing a poor trend dating back to the mid 1990s.

-MORE-

We are already near the end of the year 2010. Today's first-year medical student could be a practicing family physician by 2017. So if we hope to shore up our supply of family physicians in 2020, we need to start moving those numbers up now.

The AAFP recommends the following to build the rural primary care workforce:
_ That medical education include curriculum and student experiences pertinent to careers in rural medicine.

_ That graduate medical education funding be redesigned to give direct and increased support to rural-based residency training programs, including teaching health centers.

_The AAFP supports partnerships between academic medical centers and rural communities to train rural physicians. These partnerships should be encouraged by financial incentives on the state and federal level.

_The AAFP recognizes that increasing the family physician supply will increase the rural physician supply, since family physicians are more likely than any others to enter rural practice.

Medical students need exposure to primary care in community settings. Illinois just completed a year of the SEARCH program, where the Illinois Primary Health Care Association places health professions students and medical residents in elective rotations at community health centers throughout the state, including the Heartland centers here in the Peoria area. These programs can be instrumental in bringing more professionals into the primary care workforce and into community health centers and other underserved settings. This program needs to be supported and continued.

There are some elements in the health care reform package that will help primary care physicians. There are boosts in programs to provide loan repayment and forgiveness for primary care physicians who work in underserved areas.
There are provisions to increase the number of residency slots in primary care and the opportunities for residency programs to train physicians in the community and not in the hospital.

Payment/Reimbursement

As much as personal mentors and positive experiences can shape a student's decision to pursue primary care and practice in underserved areas, without question money talks. In our current health care system, primary care compensation lags far behind our subspecialty counterparts. A recent report from the Robert Graham Center in Washington, DC compares the annual median income of internal medicine and family medicine physicians against the median compensation for orthopedic surgeons and radiologists.

Since 1981, the median compensation for the two subspecialties has grown from about $100,000 to $400,000. Meanwhile the family physicians and internists have seen their annual income flatten out over the past ten years hovering just over $150,000. As a result, the primary care physician is paid nearly **a quarter of a million dollars LESS per YEAR** than a radiologist. Considering that medical school debt is the same regardless of your specialty, it's easy to see how a student would choose a subspecialty over primary care.

The Council on Graduate Medical Education (COGME) provides ongoing assessment of physician workforce trends and makes recommendations to the U.S. Secretary of Health and Human Services and committees of Congress. Dr. Russell Robertson, chair of the family medicine department at Northwestern University – Feinberg School of Medicine in Chicago chairs this council. In a May 2009 letter, COGME outlined many ways the U.S. can boost the primary care physician workforce.
Correcting the income disparity between primary care and subspecialty physicians is one of their recommendations. COGME's analysis concludes that boosting primary care incomes to at least **60 percent** of the equivalent subspecialty income would turn the tide back toward primary care.

Federal health care reform provides for some temporary increases in Medicare payment favorable to primary care. The federal reform bill also requires state Medicaid programs to match Medicare payment rates for physician services in 2013 and 2014. The federal government will provide the funds for states to make those increased payments. However there is no federal money for those increased Medicaid rates after 2014. It's critical that Illinois continue those higher rates for the providers who care for the millions of Medicaid patients in our state.

The public payers must set the standard in better payment models for primary care so that private payers can follow this lead. We have found very few private payers are willing to lead in moving our system toward one that pays for preventive care, coordination and quality rather than the current system that rewards procedures and perpetuates the income imbalance we see today.

Workforce goals will NOT be realized without payment reform.

Illinois is on the right track with Medicaid's medical homes, built through the Illinois Health Connect program. Along with the disease management program, Your Healthcare Plus, these two programs show promise in providing better care and lowering overall health care costs by preventing unnecessary emergency room visits and hospitalizations.

Both of these programs are powered by primary care physicians and provide patients with a medical home, a first point of care and a physician who knows them. Illinois Health Connect provides increased payments to primary care physicians for coordinating their patients' care beyond the office visit, and for exceeding quality measures. In essence, they pay for the good work that primary care providers have always done, but have not been paid for in the traditional system.

These programs work and are essential to achieving long-term cost-savings in the Medicaid and state health plans. Their success shouldn't be kept secret, but rather should be shared, duplicated and expanded.

And finally, Illinois must address the unstable medical liability climate in our state. Due to the Illinois Supreme Court's decision to strike down the Medical Liability Law from 2005, Illinois once again becomes a daunting place to practice. Physicians may choose another state over Illinois, where premiums are lower and the court system is fair to patients and providers.

Re-education and re-training of current workforce with electronic health records

-IAFP has long advocated for electronic medical records. We helped pass legislation creating the EHR Task Force. Currently, IAFP is involved with and supporting the upcoming Illinois Health Information Exchange. Family medicine is poised to lead in this transition. We know it's essential to providing better, efficient care and reducing errors.

Tomorrow's physicians will grow up using computers and electronic health records. As an Academy, we are committed to helping all practicing family physicians make the challenging but necessary transition with the support of the state's regional extension centers.

We have made a lot of progress in many areas of health care in Illinois. IAFP and family physicians are ready to move full speed ahead in health care reform. We ask that the state follow these recommendations to support today's family physicians in our common mission to recruit and train more high-quality family physicians, providing the best possible care to all patients… of all ages… in every part of the state.

I thank you again for the opportunity to speak and welcome any questions you have.

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