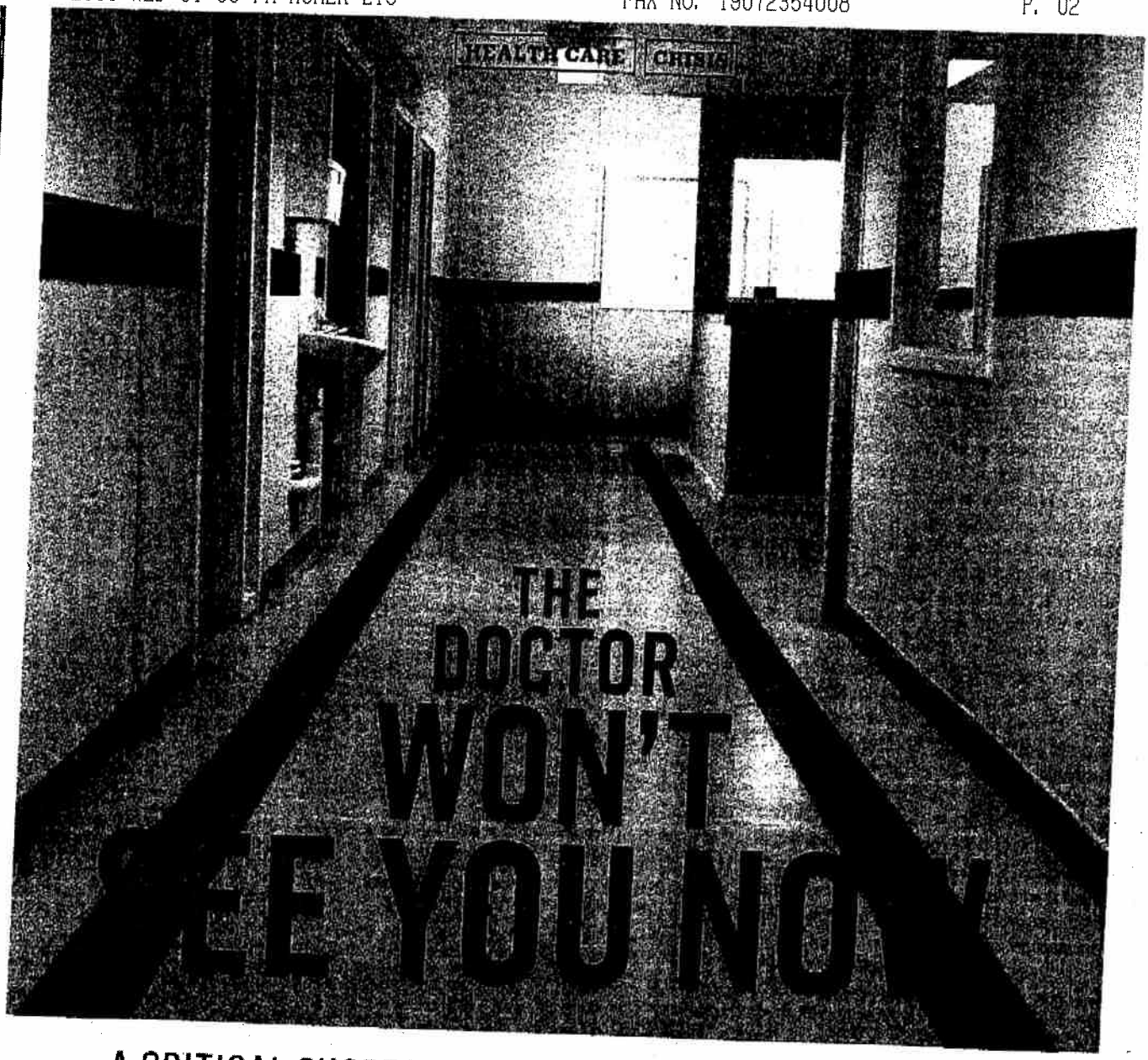
Wayne Aderhold
353 Grubstake Ave
Homer, AK 99603

Testimony to House L&C Committee
March 10, 2010
Re: HB 282

- I am 60 yrs old, resident of AK since '74 and utilize Naturopathic Physicians as my **primary care providers** since approx 1993. I see HB 282 as primarily a benefit to consumers like me.
- There are currently at least 2 practicing ND's on the Kenai Peninsula serving many residents of both Homer and Kenai/Soldotna with **primary care** by traveling between our communities on a weekly basis.
- There is currently a **troubling shortage of primary care physicians** both nationwide (ref Newsweek of March 8th) and statewide (ref current legislation by AK Senate to offer monetary incentives to lure primary care physicians to AK)
- Improvement of primary care is the documented solution to containing and even reducing overall healthcare cost to the community.
- HB 282 is the culmination of many year's effort by the ND community and others to both increase the services provided by ND's and improve their governance structure (via a Board) with **NO ADDITIONAL COST to the State.** It is as close to perfection as it can get now.
- Personally, I could have benefitted from both the prescriptive and minor surgical provisions of this bill between '02 and now, had it been enacted earlier. Sooner than I might like to admit, the Medicare provision will also apply to me.
- **There is no logical reason not to move this bill forward immediately** and assure it's passage during this session. Doing so, you will be **safely increasing the utilization** of these skilled and dedicated professionals who have already committed themselves to serving our community and the State of Alaska. Please move HB 282 forward now.

Plus 3 page backup.



A CRITICAL SHORTAGE OF PRIMARY-CARE PHYSICIANS IS YET ANOTHER SYMPTOM OF OUR AILING HEALTH-CARE SYSTEM.

BY MARY CARMICHAEL

AFTER TAKING A MONTH TO REGROUP, the White House has put health care back at the top of its agenda, asking Republicans for new ideas and trying to regain momentum for old ones. But last week's summit came down mostly to the same old talking points. And even if the president does manage to get some version of health-insurance reform passed in the next few months, he and the country are still going to be dealing with the related crisis of America's doctor shortage. Primary-care physicians, family docs, general practitioners—whatever you call them, they're the country's first line of defense, the ones responsible for promoting preventive care, finding ways to keep people from getting sick in the first place, and thus bringing down costs throughout the system. If every American went to one of these doctors regularly, health-care costs might come down as much as 5.6 percent a year, saving $67 billion, according to one estimate. Yet we don't have nearly enough doctors to make that happen, and fewer are being produced every year.

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IN SOME SURVEYS, AS MANY AS HALF OF PRIMARY-CARE PROVIDERS HAVE STOPPED TAKING NEW PATIENTS.

The annual number of American medical students who go into primary care has dropped by more than half since 1997. It's hard to get an appointment with the doctors who remain. In some surveys, as many as half of primary-care providers have stopped taking new patients. The other half are increasingly overworked and harried. Clearly we need to find a way to increase their ranks, and both the congressional health-care bills and President Obama's reform proposal make moves in that direction. But those efforts are somewhat limited, and a more comprehensive solution could be thwarted by the same thing that's stalled the rest of health-care reform so far: politics.

The reason behind America's doctor gap is a matter of money. The average income in primary care is somewhere in the mid-$100,000s, which sounds like a lot but is less than half what specialists such as radiologists and dermatologists make. Given that doctors may graduate with as much as $200,000 in med-school debt, it's easy to see why primary care started hemorrhaging recruits more than a decade ago and why radiology and other well-paid, high-tech specialties took off in popularity.

The field has since entered a vicious cycle. As fewer people have entered primary care, the doctors who are left have been forced by tight schedules to short-change some patients, forgoing the long, meandering chats that used to be a big part of checkups in favor of 15-minute, checklist-style appointments. The close relationships that general practitioners once had with patients drew many idealistic students into the field. Now recruiters face an extra-tough sell: they have to convince bright young would-be docs to pursue a career that won't pay very well and won't be as emotionally fulfilling as it once was.

How can schools entice more aspiring doctors into primary care? The Tufts University School of Medicine, to take one example, offers a $25,000-per-year scholarship for med students who agree to work in primary-care practices in rural Maine for much of their training period. Students on this Maine Track start shadowing doctors on the third day of orientation. This year's program drew 257 applicants for just 36 slots.

The problem with the Maine Track is that it doesn't actually require med students to enter primary care after they graduate. It can't, says Peter Bates, chief medical officer at Maine Medical Center, which jointly administers the program with Tufts. "If you're a bright kid with a great future, being told you have to be a family physician in rural Maine—even if that's what you want to do [now]—might strike you as confining," Bates says. "Why would you close down your opportunities?"

There are dozens of training programs like Tufts's around the country, as well as the National Health Service Corps, which pays back loans and hands out scholarships and stipends in exchange for a few years of service in rural areas, where the shortage of primary-care providers is most acute. Obama and the Senate have both called for an expansion of the program in their proposals for reform, which has already received $200 million in stimulus funds. Several new medical schools, including some that focus on primary care, have also recently opened. But all those changes may not be enough to fill the gap. "We need more than half of doctors in this country doing primary care," says Harris Berman, interim dean of the medical school at Tufts. "It's a bigger problem than we can solve with programs like ours."

So what else can be done? Lately, some policymakers have argued that instead of having a primary-care doctor, more people—especially young, healthy patients with simple medical needs—should see a nurse or physician assistant who administers routine care and kicks more complex problems up to a doctor when they arise. "If you're just coming in to have your blood pressure checked and your pulse taken, you really don't need to see a doctor, and you might not need to see a nurse, either," says David Barrett, president and CEO of the Lahey Clinic in Burlington, Mass. "There are three-stripe military sergeants with two-year degrees who can provide excellent primary care. There's absolutely no reason to force all primary-care providers to have an M.D."

The Lahey Clinic is an "integrated group practice"—one of the teamwork-oriented organizations, like the Mayo Clinic and the Cleveland Clinic, that have been lauded for cutting costs and eliminating waste in the health system. In its primary-care service, a "team captain" physician supervises nurses,

PAs, and other health-care professionals who perform tasks like checking blood pressure but don't necessarily make formal diagnoses on their own. The problem with taking this approach nationwide is that nurses and PAs are subject to the same economic forces that drive medical students. Almost half of current nurse practitioners and physician assistants work in specialty practices, where the money is. Then there's the fact that the country already has a nursing shortage. How are nurses going to replace doctors if there aren't enough nurses to begin with?

There's one more group of people, foreign medical graduates, who could theoretically fill in for the missing primary-care providers. The trouble is, they're already doing that. More than a quarter of primary-care doctors currently practicing in the United States have gotten their diplomas abroad. Increasing their numbers would be problematic for both the left (which might object to poaching doctors from developing countries that need them) and the right (which would surely object to recruiting non-Americans to do a job that reliably pulls in six figures, especially when unemployment is high).

Inevitably, then, the solution to the primary-care crisis is going to have to involve something simpler: paying primary-care providers more, so as to draw more bright young physicians into the field. At least it sounds simpler. But even this turns out to be maddeningly complex.

Most primary-care doctors, like all other physicians, are paid bit by bit for each medical task they perform (unless they work somewhere like the Lahey or the Mayo, which pay set annual salaries). Private insurers decide how much they'll reimburse docs for each task partly by looking to Medicare's policies for guidance. Medicare, in turn, makes its decisions by committee. Here is the bad news for primary-care docs: most of the physicians on the committee that sets the reimbursement rates are specialists. Medicare—and, consequently, private insurance—doesn't reimburse primary-care doctors as lavishly as it does their more specialized counterparts. That's why primary-care incomes are relatively low in the first place.

Changing anything about the way primary-care providers are paid will be immensely complicated. For one thing, rural doctors sometimes perform specialized procedures because no one else is available—would they still qualify for a raise? And then, what exactly constitutes a task that should be reimbursed? For a high-tech specialist, this is often clear-cut: each scan or chemical test counts. But what about all the things primary-care doctors do that don't involve technology? "You don't get paid to talk to people and tell them to stop smoking. Nobody values my time to do that," says Joe Gravel, a family physician and chief medical officer at the Greater Lawrence Family Health Center in Massachusetts. "They'll pay for the lung transplants, but they won't pay to prevent 50 people from needing them."

In January, Medicare raised reimbursement rates for some primary-care services by about 4 percent, and its payment committee will call for another small increase this week. That's a good start, says Lori Heim, president of the American Academy of Family Physicians, but "if you're talking about changing the way students view primary care, it needs to be more like 25 percent, and that's on the low side." Both the House and Senate reform bills also include a slight increase in primary-care payments—5 and 10 percent, respectively.

To fund such a pay raise, Congress would either have to spend more money on health care or pinch some from the specialists by lowering their pay rates. The first strategy is clearly controversial—no one wants to increase health-care costs further. The second, budget-neutral strategy is bound to tick off the specialists. Peter Mandell, a spokesman for the American Academy of Orthopaedic Surgeons, sent a clear message last year when the Medicare reimbursement committee suggested a 10 percent shift in payments toward primary-care docs and away from specialists. Telling *The New York Times* that his group had "a problem" with the idea, Mandell added, "If there's less money for hip and knee replacements, fewer of them will be done for people who need them." It's a short step from his polite, reasonable statement to rallies over the specter of rationing.

So here is the fundamental dilemma of the primary-care crisis: One of the solutions with the best chance of working is politically unpalatable, and even those who support it admit it's a bureaucratic nightmare. But without it, we may be heading for an even bigger disaster that nobody wants. Does this sound familiar? The cure for primary care, it turns out, is ultimately going to be the same thing that's needed to fix the rest of the health-care system: political will.

ONE GROUP THAT COULD THEORETICALLY FILL IN FOR THE MISSING DOCS: FOREIGN MEDICAL GRADUATES.

PHIL MCCARTEN—REUTERS

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