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3 HEARING ON ``MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES:

4 IMPROVING ACCESS TO CARE''

5 TUESDAY, MARCH 24, 2009

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

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

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

19 and Barton (ex officio).

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

|
32 Mr. {Pallone.} The hearing is called to order.

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

45 As a Nation, we have made tremendous strides in
46 improving the health of all Americans. However, as numerous
47 reports have highlighted, there remain significant
48 inequalities with respect to both access to health care and
49 the quality of care provided among different ethnic groups in
50 this country. For example, the mortality rate due to heart
51 disease and cancer is higher among populations including
52 African-Americans, Asian-Americans and Pacific Islanders.
53 The rate of new AIDS cases is three times higher among
54 Hispanics than among Caucasians. I personally am also very

55 concerned about the health disparities for American Indians
56 and Alaska Natives. The mortality rate among Indian infants
57 is 150 percent higher than for Caucasian infants, and Indians
58 are nearly three times as likely to be diagnosed with
59 diabetes. These disparities are not limited, however, to
60 ethnic and racial divides but are consistently also found
61 between genders, geographic area and among different income
62 groups. For example, there are significantly more access-to-
63 care obstacles for rural populations than there are for urban
64 populations, and the 2002 Institute of Medicine report found
65 that these disparities persisted even when factors such as
66 insurance coverage and income level remained constant.

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

78 Part of the solution, in my mind, is to strengthen our

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

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

98 [The prepared statement of Mr. Pallone follows:]

99 ***** COMMITTEE INSERT *****

|
100 Mr. {Pallone.} With that I will ask Mr. Deal to begin
101 with an opening statement. Thank you.

102 Mr. {Deal.} Thank you, Mr. Chairman. I want to also
103 express appreciation to all the witnesses for being here
104 today.

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

112 This hearing, of course, is going to focus on access to
113 health care services and various proposals aimed to overcome
114 the obstacles to care. Unfortunately, too many Americans
115 across the country do lack access to quality, affordable
116 medical care. As we all know, there are a variety of reasons
117 why this exists. Physical, geographical, cultural and
118 financial influences all play a role in patient access to
119 health care. While there are scores of obstacles to stand in
120 the way of receiving it, effective reform such as cross-state
121 purchasing of health insurance, association health plans,
122 consumer-driven options that enhance quality and value, and

123 similar options which build upon the doctor-patient
124 relationship would make great strides forward in bridging the
125 gap that exists under today's system.

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

146 Additionally, Congress should also consider other forms

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

160 We are all aware of the significant and growing cost of
161 health care. Unfortunately, with the understandably
162 defensive nature of the health care delivery system in the
163 United States, we can only expect these strains to multiply
164 as the number of Americans receiving care grows. By
165 empowering physicians with the ability to provide needed
166 health care services without the burden of defensive medicine
167 tactics, an estimated \$70 to \$126 billion per year could be
168 saved, outcomes could be improved and utilization of our
169 limited medical resources would be more effectively
170 maximized. Rest assured, I value protection of patients'

171 rights and efforts to reform the medical liability system
172 should not be misconstrued as an effort to infringe upon
173 those rights. If tragedy occurs, then certainly there should
174 be redress for the individual who has been harmed.

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

178 [The prepared statement of Mr. Deal follows:]

179 ***** COMMITTEE INSERT *****

|
180 Mr. {Pallone.} Thank you, Mr. Deal.

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

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

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

200 I look forward to discussing how we can improve Medicaid
201 and Medicare as well. There are parts of the country where
202 two out of three doctors will not see Medicaid patients, in

203 parts of my own district, and it is the heart of Silicone
204 Valley so one might think that even though the Gallop Poll
205 said that it is the most contented district in the country,
206 we still have many gaps where no doctor will take new
207 Medicare patients because they are reimbursed at rates far
208 below their costs. The Geographic Price Cost Index, or the
209 GPCI, has severely skewed doctor reimbursement rates so low
210 in Santa Cruz County that many of my senior constituents have
211 to travel an hour or more over a winding mountain road to see
212 a doctor in another county. So this is just one example of
213 how our health care system is broken and fails too many
214 Americans.

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

220 Thank you, Mr. Chairman.

221 [The prepared statement of Ms. Eshoo follows:]

222 ***** COMMITTEE INSERT *****

|
223 Mr. {Pallone.} Thank you, Ms. Eshoo.

224 The gentleman from Illinois, Mr. Shimkus.

225 Mr. {Shimkus.} Thank you, Mr. Chairman.

226 When I started practicing medicine in the same location
227 30 years ago, my malpractice premium with the same insurer
228 was \$10,000 a year. Today my premium is just shy of \$100,000
229 annually. Major malpractice reform with bipartisan support
230 should be a starting point for our country's health care
231 overhaul. Threat of litigation causes an inestimable amount
232 of practice of defensive medicine. It will not take too many
233 rate hikes for those of us providing obstetrical care in
234 rural counties to say enough is enough and that we will not
235 continue to provide high-risk services.

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

245 [The prepared statement of Mr. Shimkus follows:]

246 ***** COMMITTEE INSERT *****

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

251 [The information follows:]

252 ***** COMMITTEE INSERT *****

|
253 Mr. {Pallone.} Without objection, so ordered. We thank
254 the gentleman.

255 The gentleman from Texas, Mr. Green.

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

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

276 problems in the Hispanic community.

277 As we know on this committee, access to quality primary
278 and preventive care leads to a better quality of life and
279 fewer health problems down the road. We will hear today that
280 aside from barriers to primary care, we are facing a shortage
281 of primary care physicians. This is troublesome because even
282 if we reform our system, we may not have enough primary care
283 physicians to serve all the patients who will be entering our
284 health care system.

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

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

297 [The prepared statement of Mr. Green follows:]

298 ***** COMMITTEE INSERT *****

|
299 Mr. {Pallone.} Thank you, Mr. Green.

300 The gentleman from Texas, Mr. Burgess.

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

308 I do look forward to discussing the role of Medicare and
309 Medicaid in providing care and the very serious issues we
310 face in ensuring that our primary care workforce is able to
311 meet the demands of the future and the role of health
312 disparities among the various populations. Some very basic
313 questions that we need to consider. How can we think of
314 going forward until we have some solutions to the problems
315 that we know exist within our public systems today and this
316 hearing might very well serve as a checklist of what we know
317 to be broken within those public systems. The federal
318 programs, Medicare and Medicaid, that cover well over a third
319 of our population, are headed for a budgetary collapse. We
320 expect these programs to service the populations that they do
321 now and in the very near future to serve even more, and the

322 providers in the workforce face the threat of annual Medicare
323 cuts, this year to be at 20 percent unless Congress acts
324 before the end of December, and Medicaid reimbursements that
325 are even worse, and to top it all off, the Association of
326 American Medical Colleges reports that the physician shortage
327 is expected to exceed 124,000 doctors by 2025.

328 I am encouraged to see attention being given to the
329 physician workforce issues. I have been concerned about that
330 for some time. In my home State of Texas, the number of
331 doctors between 1995 and 2005 increased by 46 percent, nearly
332 5,000 doctors, but the State is still well below the national
333 average. I believe that a good start for Congress is to
334 enact legislation that this committee, this subcommittee
335 approved, we approved in full committee that I introduced
336 along with Congressman Gene Green, H.R. 914, the Physician
337 Workforce Enhancement Act of 2009, to create additional
338 residency training programs where historically none have
339 operated in the past. We all know doctors are not very
340 imaginative. We tend to go into practice within 50 miles of
341 where we do our training and this is a bill aimed at
342 capitalizing upon that fact, but it is only one small step.

343 I also represent an area that has a significant minority
344 population who suffers from a lack of direct access to
345 medical services and obviously the health problems that

346 result therefrom. But that is just it, Mr. Chairman. We
347 need a lot of discussion before we proceed on the path of a
348 comprehensive fix but we all know we need to proceed.
349 Coverage does not always equal access. Coverage doesn't help
350 the Medicare or Medicaid patient who cannot find a doctor
351 willing to accept the program, or worse yet, a doctor who can
352 no longer afford to keep their doors open because they have
353 accepted what the government will pay. So simply burdening
354 future generations is not the answer. It is up to us, it is
355 up to this Congress.

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

358 [The prepared statement of Mr. Burgess follows:]

359 ***** COMMITTEE INSERT *****

|
360 Mr. {Pallone.} Thank you.

361 The chairman of our full committee, Mr. Waxman.

362 The {Chairman.} Thank you very much, Chairman Pallone,
363 for holding this hearing.

364 We have already had two productive hearings in this
365 series on health reform. At the first hearing the Institute
366 of Medicine testified that health insurance coverage makes a
367 big difference in personal health. For example, the health
368 of uninsured middle-aged adults who have chronic conditions
369 such as diabetes declines more rapidly than the health of
370 insured adults with these conditions. Overall, uninsured
371 adults are 25 percent more likely to die prematurely than
372 adults with health insurance. The data are overwhelming.
373 Health insurance improves access to care, which in turn
374 improves personal health, while we also know that health
375 insurance coverage does not necessarily guarantee access to
376 needed care. Racial and ethnic minorities often don't get
377 the care they need, even if they are insured. People living
378 in rural areas of our Nation have some of the highest rates
379 of chronic health problems like obesity but some of the
380 lowest numbers of physicians and nurses to address these
381 problems. Communities all over the country in urban and
382 rural areas alike face growing shortages of primary care

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

388 As the Institute of Medicine told us, many more low-
389 income Americans would be uninsured today and at greater risk
390 for poor health and premature death were it not for
391 expansions in public programs like Medicaid and CHIP.
392 Medicaid and CHIP are the Nation's insurers for low-income
393 families and children and individuals with disabilities.
394 However, just as Americans with private health insurance do
395 not always have access to needed care, so those enrolled in
396 Medicaid and CHIP may not always have access to the care they
397 need. When our committee takes up health reform, we will
398 provide coverage for the uninsured. However, I also want to
399 make sure that our legislation addresses the barriers to
400 access that insurance coverage by itself can't fix. Today's
401 hearing will help us craft solutions that will improve access
402 to care for all regardless of race, ethnicity or geography.

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

405 [The prepared statement of Mr. Waxman follows:]

406 ***** COMMITTEE INSERT *****

|
407 Mr. {Pallone.} Thank you, Chairman Waxman.

408 The gentlewoman from Tennessee, Ms. Blackburn.

409 Ms. {Blackburn.} Thank you, Mr. Chairman. Welcome to
410 our guests.

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

426 With reimbursement issues added to the high cost of
427 liability insurance, physicians who are often small business
428 owners must weigh the risk of taking new patients,
429 particularly the uninsured, if costs exceed reimbursement. A

430 physician in my district recently told me without significant
431 and real tort reform, no plan to control increasing health
432 care costs will succeed. While it healthy to consider the
433 best practices for both patients and physicians, the debate
434 must be resolved so the medical system can operate in a more
435 effective fashion and be improved to consistently deliver
436 high quality of care.

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

441 [The information follows:]

442 ***** COMMITTEE INSERT *****

|
443 Mr. {Pallone.} Without objection, so ordered. I thank
444 the gentlewoman.

445 Ms. {Blackburn.} I yield back.

446 [The prepared statement of Ms. Blackburn follows:]

447 ***** COMMITTEE INSERT *****

|
448 Mr. {Pallone.} The chairman emeritus, Mr. Dingell.

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

456 It comes as no surprise that the uninsured have trouble
457 accessing quality health care but access is a problem even
458 for those with insurance coverage. The high cost of health
459 care and lean insurance benefits have led more than 25
460 million people to be classified as underinsured. These
461 people are more likely to forego needed care because of
462 costs. Furthermore, the Commonwealth Fund reports that in
463 addition to gaps in insurance coverage, American packs lack
464 timely access to care, meaning they are not able to see their
465 doctors within 2 days of becoming sick.

466 As we move forward with comprehensive health care reform
467 legislation, there are a few key issues that we must tackle
468 with regarding to expanding access to care. First and most
469 important, we must set a goal that our health care reform
470 bill moves us toward universal coverage. That is why I

471 support a provision that would require everyone to have
472 health insurance. However, we must insure that care is
473 affordable to everyone and I believe that is the only way we
474 can have universal coverage and have it in a fair and proper
475 way. Even if we require everyone to have health insurance,
476 many Americans will still lack access to health care due to a
477 shortage of primary care providers. Strong primary care
478 systems have been shown to reduce costs and improve quality.
479 However, of the 800,000 physicians in the United States, only
480 40 percent are primary care providers. By the year 2025, we
481 will have a shortage of over 40,000 primary care doctors.
482 Our health care payment systems have essentially subsidized
483 specialty care.

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

495 primary care and prevention.

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

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

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

511 [The prepared statement of Mr. Dingell follows:]

512 ***** COMMITTEE INSERT *****

|
513 Mr. {Pallone.} Thank you, Chairman Dingell.

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

516 Mr. {Barton.} Thank you, Mr. Chairman. I appreciate
517 you holding this hearing on issues related to improving
518 access to care.

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

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

534 My home State of Texas is a perfect example of how
535 medical liability reform improves people's health care. In

536 2003, Texas voters approved a constitutional amendment that
537 included a limited on non-economic damages while continuing
538 to allow injured parties to be fully compensated for economic
539 damages. Prior to that reform, skyrocketing insurance
540 premiums were forcing doctors to flee the State, quit
541 medicine or cut back on complex, lifesaving procedures. At
542 the height of the crisis, Texas ranked 48th out of the 50
543 States in per capita physicians. In the years since the
544 reform was passed, Texas has been transformed from a State in
545 turmoil to a model. Doctors are coming back to Texas,
546 patients are getting better care. More doctors mean improved
547 access, especially for those Texans that are living in poor
548 and medically underserved areas. I would urge this
549 committee, Mr. Chairman, to take a serious look at liability
550 reform as we move into the overall issue of health care
551 reform.

552 I also believe that we should look at what is working in
553 communities across this country to increase access to care.
554 Last year we heard from a doctor in Louisiana whose community
555 was ravaged by Hurricane Katrina. Hospitals were closed and
556 residents were without access to needed medical services.
557 Physicians in that community came together to run a
558 physician-owned hospital that provided the quality of medical
559 care the residents so sorely need. Now, I know it is not the

560 popular conventional wisdom to suggest that people helping
561 their community can make a difference without the bureaucrats
562 in Washington telling them what to do but it is true. Who
563 knows what happens when communities actually work together
564 themselves and don't look to Washington for the solution. It
565 is certainly not the Washington elite who have all the
566 answers. We should applaud the people who have stepped up to
567 the plate and expanded access to quality medicine in their
568 own neighborhoods. This committee has a long history of
569 being involved in the issue of physician-owned hospitals.
570 These facilities have consistently demonstrated that they
571 provide high-quality care for patients and achieve high
572 patient satisfaction. Patients like receiving their care at
573 these facilities. Physicians and nurses like working at
574 these facilities and these facilities continue to top the
575 charts in terms of health care quality. You don't have to
576 take my word for it. Visit any physician-run hospital and
577 you can see for yourself. I would extend an open invitation
578 to anybody on this committee to come to my district and visit
579 a number of physician-owned hospital facilities in my
580 district if they don't have them in their own district. When
581 physicians have a stake in the system, they raise the
582 standard of quality care to a level that patients then expect
583 and demand from all providers. As we discuss access to care

584 today, we need to keep this in mind. We should be expanding
585 the number of providers, not limiting the number of
586 providers.

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

592 Mr. {Pallone.} I am sorry. What is it that you want to
593 submit?

594 Mr. {Barton.} A letter from a physician-owned hospital
595 in my district.

596 Mr. {Pallone.} Without objection, so ordered.

597 [The information follows:]

598 ***** COMMITTEE INSERT *****

|

599 Mr. {Barton.} Thank you, Mr. Chairman.

600 [The prepared statement of Mr. Barton follows:]

601 ***** COMMITTEE INSERT *****

|
602 Mr. {Pallone.} Thank you, Mr. Barton.

603 Our full committee vice chair, Ms. DeGette.

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

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

618 I do think though that we need to address the issue of
619 what is happening with doctors' insurance rates because
620 doctors' insurance rates have consistently increased over the
621 years, even in States like my State and Texas and other
622 States where we have had caps on non-economic damages for
623 some years, and I think we need to put all of this into the
624 mix, but I think it is unfair to try to claim that we haven't

625 addressed this, that we haven't looked at it or that medical
626 malpractice rates are causing the terrible cost overruns that
627 we have in our system.

628 Thank you, Mr. Chairman.

629 [The prepared statement of Ms. DeGette follows:]

630 ***** COMMITTEE INSERT *****

|
631 Mr. {Pallone.} Thank you.

632 The gentleman from Pennsylvania, Mr. Murphy.

633 Mr. {Murphy of Pennsylvania.} Thank you, Mr. Chairman,
634 and thank you to all the doctors present here. We have
635 enough to open up a sizable hospital, I guess. Who is
636 minding the patients?

637 All of our concern is to improve access to care and I
638 believe that has to include--

639 Mr. {Pallone.} Is your microphone not working?

640 Mr. {Murphy of Pennsylvania.} It was going off and on,
641 sir. I don't know. Maybe someone on that side of the aisle
642 is--

643 Mr. {Pallone.} All right.

644 Mr. {Murphy of Pennsylvania.} But don't do that to me,
645 because I agree. Hold the clock there too.

646 Mr. {Pallone.} We will try it. Go ahead.

647 Mr. {Murphy of Pennsylvania.} Thank you, Mr. Chairman.

648 I am concerned about some of the inefficiencies that we
649 put into the system itself which drive providers away, such
650 as why aren't doctors more willing to be Medicaid and
651 Medicare providers? Why are the rules we set forth a
652 problem? Why does a person diagnosed with multiple sclerosis
653 have to wait 2 years before they can be given medication?

654 Why don't we pay for disease management of a diabetic but are
655 willing to pay to have their legs amputated when they have
656 complications? Why won't we pay an oncologist to do lab work
657 on the day of chemotherapy if they are trying to determine if
658 a patient can have the chemotherapy? There are so many
659 questions that we have in this area that I think are barriers
660 to access and I am hoping as part of the testimony we hear it
661 will include how we can improve the health system the
662 government runs through the Medicare, Medicaid and VA systems
663 and learn to take down the barriers that stand in the way of
664 access to care.

665 Thank you very much.

666 [The prepared statement of Mr. Murphy of Pennsylvania
667 follows:]

668 ***** COMMITTEE INSERT *****

|
669 Mr. {Pallone.} The gentlewoman from California, Ms.
670 Capps.

671 Ms. {Capps.} Thank you, Mr. Pallone, and thank you to
672 each of our witnesses today. We have a stellar panel here
673 and thank you for coming.

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

688 I look forward to the testimony. I yield back.

689 [The prepared statement of Ms. Capps follows:]

690 ***** COMMITTEE INSERT *****

|
691 Mr. {Pallone.} Thank you.

692 The gentleman from Michigan, Mr. Rogers.

693 Mr. {Rogers.} Thank you, Mr. Chairman, and thanks to
694 the panelists.

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

708 In finding solutions to address the 15 percent problem,
709 we must be careful not to destroy a system that does work for
710 tens of millions of Americans. I am concerned that some
711 proposals addressed today would do just that. Forcing
712 millions of Americans who already have health insurance to
713 accept fewer benefits, reduced access and higher costs is

714 hardly a solution. I believe we can find solutions to
715 provide universal access to health care, lower costs and
716 better quality for all Americans. I believe we can strength
717 critical safety net programs like Medicaid, Medicare and
718 SCHIP but we must work together to achieve this goal.

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

722 [The prepared statement of Mr. Rogers follows:]

723 ***** COMMITTEE INSERT *****

|
724 Mr. {Pallone.} Thank you.

725 The gentlewoman from Wisconsin, Ms. Baldwin.

726 Ms. {Baldwin.} Thank you, Mr. Chairman. It is notable
727 that we are holding this hearing on ensuring access to care
728 during Cover the Uninsured Week.

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

747 Let me quickly also express my strong concern about our
748 existing and looming primary care shortages. To address one
749 small aspect of this problem, I offer bipartisan legislation
750 that would provide reimbursement for the costs of graduate
751 degrees in nursing in exchange for a commitment to teach
752 nursing for at least 4 years. Without the worry of
753 educational debt, nurses will be able to devote time to
754 training the next generation of the frontline primary care
755 workforce.

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

758 [The prepared statement of Ms. Baldwin follows:]

759 ***** COMMITTEE INSERT *****

|
760 Mr. {Pallone.} Thank you.

761 The gentleman from Kentucky, Mr. Whitfield.

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

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

781 [The prepared statement of Mr. Whitfield follows:]

782 ***** COMMITTEE INSERT *****

|
783 Mr. {Pallone.} Thank you.

784 The gentlewoman from the Virgin Islands, Ms.

785 Christensen.

786 Ms. {Christensen.} Thank you, Chairman Pallone, and
787 thank you again for this series of hearings that continue to
788 inform and guide us as we prepare to reform health care this
789 year.

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

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

802 [The prepared statement of Ms. Christensen follows:]

803 ***** COMMITTEE INSERT *****

|
804 Mr. {Pallone.} Thank you.

805 The gentleman from Georgia, Mr. Gingrey.

806 Mr. {Gingrey.} Thank you, Mr. Chairman. Before I waive
807 my opening remarks, I want to ask unanimous consent to submit
808 for the record a letter, Mr. Chairman, from the Georgia
809 Mutual Insurance Company to the Medical Association of
810 Georgia on the question of is tort reform working in the
811 State of Georgia; the response, most definitely. I ask
812 unanimous consent to submit this letter for the record.

813 [The prepared statement of Mr. Gingrey follows:]

814 ***** COMMITTEE INSERT *****

|
815 Mr. {Pallone.} Thank you. Without objection, so
816 ordered.

817 [The information follows:]

818 ***** COMMITTEE INSERT *****

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

824 Mr. {Deal.} Mr. Chairman.

825 Mr. {Pallone.} Yes, Mr. Deal.

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

832 Mr. {Pallone.} Without objection, so ordered. Thank
833 you.

834 [The information follows:]

835 ***** COMMITTEE INSERT *****

|
836 Mr. {Pallone.} Next is the gentlewoman from Florida,
837 Ms. Castor.

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

846 Dr. Mullan, your workforce analysis was particularly
847 terrific, I thought, and your recommendations to improve
848 primary care professionals very helpful along with Dr.
849 Harris's recommendations for a national health care workforce
850 policy. Thank you for highlighting the arbitrary and
851 outdated caps on physician resident slots that is really
852 harming high-growth States like mine, the State of Florida.
853 You also had constructive recommendations on the primary care
854 pipeline. I want to thank your organization for endorsing my
855 bill, the Primary Care Incentive Act, that provides that
856 tuition reimbursement for folks that go and work in community
857 health centers and clinics and devote a number of years of
858 community service. Dr. Lavizzo-Mourey, you also had some

859 very creative solutions, also picked up on a lot of the
860 workforce issues that Congresswoman Capps has taken the lead
861 on in nursing, physician assistants, and I appreciate that.
862 Dr. Smedley, your analysis and statistics were very eye-
863 opening and just demonstrated how health care is really our
864 civil rights struggle for our time. Thank you.

865 [The prepared statement of Ms. Castor follows:]

866 ***** COMMITTEE INSERT *****

|

867 Mr. {Pallone.} Thank you.

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

870 [The prepared statement of Ms. Myrick follows:]

871 ***** COMMITTEE INSERT *****

|
872 Mr. {Pallone.} The gentleman from Connecticut, Mr.
873 Murphy.

874 Mr. {Murphy of Connecticut.} Thank you very much, Mr.
875 Chairman. We are going to talk a lot over the course of the
876 next few months about making sure that people have insurance
877 but I know today we are going to spend time on what should be
878 our second priority, making sure that people that have
879 insurance actually have access to care, and I would like to
880 just share one particularly important story from Connecticut.

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

895 offered dental coverage in the first place.

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

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

903 [The prepared statement of Mr. Murphy of Connecticut
904 follows:]

905 ***** COMMITTEE INSERT *****

|
906 Mr. {Pallone.} Thank you.

907 The gentleman from Ohio, Mr. Space.

908 Mr. {Space.} Thank you, Mr. Chairman, for holding this
909 important hearing, and specifically as it relates to rural
910 health care disparities.

911 I had a chance to review some of the testimony for today
912 and I couldn't help but be struck by some of the statistics
913 highlight by Dr. Kitchell from Iowa in his testimony. Twenty
914 percent of the Nation's population resides in rural areas yet
915 9 percent of our Nation's physicians reside in rural areas.
916 Rural physicians see up to 30 percent more patients per
917 physician. The cost of running a rural physician's practice
918 is considerably higher than running an urban or suburban city
919 physician practice, and the rural physicians' expenses,
920 despite being greater, their Medicare reimbursements are far
921 less. It is no wonder that some of the counties that I
922 represent have one or two practicing physicians serving the
923 entire county, requiring many of my constituents to drive
924 long distances for basic care and that doesn't even cover the
925 specialists. While the primary care focus is one that we
926 need to be concerned with, it applies to other realms in the
927 health care delivery field as well. Home health nurses,
928 medical assistants and other professionals are in short

929 supply.

930 One of the critical elements of this issue is the impact
931 that it will have on our economy. Developing and training a
932 workforce to meet the needs that are glaring in rural
933 American right now will not only enhance access to quality
934 health care, it will provide an important avenue for economic
935 opportunity in an area of the country that desperately that
936 needs it, so I would like to thank those who have come before
937 the committee this morning and look forward to hearing all
938 your testimony.

939 [The prepared statement of Mr. Space follows:]

940 ***** COMMITTEE INSERT *****

|
941 Mr. {Pallone.} Thank you.

942 The gentleman from Iowa, Mr. Braley.

943 Mr. {Braley.} Thank you, Chairman Pallone. I have been
944 looking forward to this hearing because access to care is a
945 primary care of mine and a primary concern of health care
946 providers in Iowa and their patients.

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

961 Last Congress I introduced the Medicare Equity and
962 Accessibility Act, which addresses the GPCI problems. I am
963 going to continue fighting for a solution to the GPCIs but in

964 fact this is only a Band-Aid for a broader problem of
965 disparity of care in rural areas. I look forward to hearing
966 more about access to care in rural areas in today's hearing.

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

974 [The prepared statement of Mr. Braley follows:]

975 ***** COMMITTEE INSERT *****

|
976 Mr. {Pallone.} Thank you.

977 The gentlewoman from California, Ms. Harman.

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

983 Access is tough for the insured and uninsured,
984 especially in California where low reimbursement for Medicaid
985 is pushing more and more doctors out of the program. In my
986 district, we are lucky to have places like the Venice Family
987 Clinic that provide free quality health care to low-income
988 minority population that lacks private coverage. Eighty-one
989 percent of the patients seen at the clinic are minorities so
990 the clinic places an emphasis on volunteer translator
991 recruitment and medical tutorial programs. Remarkable
992 volunteers are the arteries that keep the clinic going. My
993 late father, a physician, devoted his time and passion to
994 serving three generations of patients, like father, like
995 daughter, and as a former VFC board member, I am a huge
996 supporter of their work. As the Nation's largest free
997 clinic, 24,000 patients last year, this is the only place for
998 most of its patients to access care, helping them to avoid

999 emergency room visits and other serious consequences.
1000 Unfortunately, many places in the country don't have Venice
1001 Family Clinics and that is a model that we should try to
1002 include as we draft the access part of the bill.

1003 Thank you, Mr. Chairman.

1004 [The prepared statement of Ms. Harman follows:]

1005 ***** COMMITTEE INSERT *****

1006 Mr. {Pallone.} The gentleman from Georgia, Mr. Barrow.

1007 Mr. {Barrow.} Thank you, Mr. Chairman.

1008 When we talk about access to health care, we are talking
1009 about different things to different folks. In rural parts of
1010 the country, the problem is physical access. You got
1011 specialist doctors and nurses that don't want to practice in
1012 rural areas but you also have groups who live in those areas
1013 who are slower to seek care in the first place. You have a
1014 combination of an underserved community of high-risk
1015 patients. That is a bad combination. On the other hand, you
1016 have access problems that are financial in nature and we have
1017 different programs to try to make health care available to
1018 different groups of folks. We have Medicaid for the poor, we
1019 have Medicare for the elderly. We have programs like SCHIP
1020 for the kids and folks who make too much to qualify for
1021 Medicaid but not enough to get insurance on their own.

1022 There is another group that is underserved for whom the
1023 cost of health care isn't altogether out of reach but it is
1024 just out of reach, and as a result it might as well be
1025 altogether unavailable and that is folks who can't afford to
1026 pay the price differential that the insurance industry
1027 charges them because of the size of the groups to lump them
1028 into. If you are in a smaller group, it costs you more to

1029 get that same health care package of benefits than it does
1030 for folks who are members of larger groups. The legislation
1031 I introduced in the last Congress, the SHOP Act, the Small
1032 Business Health Option Program Act, addresses this price
1033 disparity in ways that I think will make health insurance
1034 available to more folks who can afford to kick in for the
1035 cost of care they are drawing out rather than drawing out
1036 care at the emergency room without kicking in at all, so I
1037 hope we can explore ways and means of making health care more
1038 affordable for folks just by eliminating the price
1039 differential that folks have to pay for the same benefits
1040 package.

1041 Thank you, Mr. Chairman. I yield back.

1042 [The prepared statement of Mr. Barrow follows:]

1043 ***** COMMITTEE INSERT *****

|

1044 Mr. {Pallone.} Thank you.

1045 The gentleman from Texas, Mr. Gonzalez.

1046 Mr. {Gonzalez.} Waive opening. Thank you, Mr.

1047 Chairman.

1048 [The prepared statement of Mr. Gonzalez follows:]

1049 ***** COMMITTEE INSERT *****

|
1050 Mr. {Pallone.} Thank you.

1051 I think we have covered everybody here for opening
1052 statements, so we will now go to our panel. I know you have
1053 been waiting patiently and we appreciate that. I want to
1054 welcome everyone, and let me introduce you starting on my
1055 left here, and they are all doctors, every one. Dr. Brian
1056 Smedley, who is vice president and director of the Health
1057 Policy Institute, the Joint Center for Political and Economic
1058 Studies; Dr. Michael John Kitchell, who is president-elect of
1059 the Iowa Medical Society, the McFarland Clinic; Dr. Michael
1060 Sitorius, professor and chairman of the Department of Family
1061 Medicine at the University of Nebraska Medical Center; and
1062 from my home State of New Jersey, welcome, Dr. Lavizzo-
1063 Mourey, who is president and CEO of the Robert Wood Johnson
1064 Foundation. And then we have Dr. Fitzhugh Mullan, Murdock
1065 head professor of medicine and health policy and professor of
1066 pediatrics at the George Washington University; Dr. Jeffrey
1067 Harris, president of the American College of Physicians; Dr.
1068 James Bean, who is president of the American Association of
1069 Neurological Surgeons, and Dr. Diane Rowland, who is
1070 executive director of the Kaiser Commission on Medicaid and
1071 the Uninsured. Now, I am told that you don't actually have a
1072 timer down there so you won't know when the 5 minutes are up.

1073 The only thing more dangerous is when we don't have timers up
1074 here. But please try to stick to the 5 minutes if you can
1075 and of course the statements become part of the record, and
1076 we will start with Dr. Smedley.

|
1077 ^STATEMENTS OF BRIAN D. SMEDLEY, PH.D., VICE PRESIDENT AND
1078 DIRECTOR, HEALTH POLICY INSTITUTE, JOINT CENTER FOR POLITICAL
1079 AND ECONOMIC STUDIES; MICHAEL JOHN KITCHELL, M.D., PRESIDENT-
1080 ELECT OF IOWA MEDICAL SOCIETY, MCFARLAND CLINIC PC; MICHAEL
1081 A. SITORIUS, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF
1082 FAMILY MEDICINE, UNIVERSITY OF NEBRASKA MEDICAL CENTER; RISA
1083 LAVIZZO-MOUREY, M.D., M.B.A., PRESIDENT AND CEO, ROBERT WOOD
1084 JOHNSON FOUNDATION; FITZHUGH MULLAN, M.D., MURDOCK HEAD
1085 PROFESSOR OF MEDICINE AND HEALTH POLICY, PROFESSOR OF
1086 PEDIATRICS, THE GEORGE WASHINGTON UNIVERSITY; JEFFREY P.
1087 HARRIS, M.D., F.A.C.P., PRESIDENT, AMERICAN COLLEGE OF
1088 PHYSICIANS, JAMES R. BEAN, M.D., PRESIDENT, AMERICAN
1089 ASSOCIATION OF NEUROLOGICAL SURGEONS; AND DIANE ROWLAND,
1090 SC.D., EXECUTIVE DIRECTOR, THE KAISER COMMISSION ON MEDICAID
1091 AND THE UNINSURED

|
1092 ^STATEMENT OF BRIAN D. SMEDLEY

1093 } Mr. {Smedley.} Thank you, Mr. Chairman. I appreciate
1094 the opportunity to provide testimony on racial and ethnic
1095 disparities and health care access and quality.

1096 For nearly 40 years, the Joint Center for Political and
1097 Economic Studies has served as one of the Nation's premier

1098 think tanks on a broad range of public policy concerns for
1099 African-Americans and other communities of color. We
1100 therefore welcome the opportunity to comment on strategies
1101 for addressing health care disparities.

1102 As the committee has pointed out, health care
1103 disparities are differences in access to and the quality of
1104 health care experienced by racial and ethnic minorities,
1105 immigrants, those who aren't proficient in English, those who
1106 live in rural communities and many others relative to more
1107 advantaged groups. Left unaddressed, these disparities have
1108 the potential to unravel even the best efforts to contain
1109 health care costs and improve the overall quality of care.
1110 In addition, their persistence leaves U.S. health care
1111 systems poorly prepared to address the needs of some of the
1112 fastest growing segments of the population.

1113 This morning I would like to briefly examine the causes
1114 and consequences of racial and ethnic health care disparities
1115 and offer some policy strategies for their elimination. As I
1116 hope to illustrate, these disparities are unjust and
1117 avoidable. I will therefore refer to them as inequities
1118 throughout the remainder of my testimony.

1119 Health care inequities are not new. They are a
1120 persistent relic of segregation and historically inadequate
1121 health care for communities of color. Like access to other

1122 opportunities, health care for minorities suffered from
1123 government inattention for over 100 years after the end of
1124 the Civil War. Even less than 45 years ago, minorities
1125 routinely received inequitable care in segregated settings if
1126 care was received at all. Today health care is much more
1127 broadly available but the contemporary context remains shaped
1128 by this history.

1129 I want to note at the outset that while health care
1130 access and quality disparities are unacceptable, they are not
1131 the most important factors that contribute to the widely
1132 divergent health status of America's racial and ethnic
1133 groups. Some groups, particularly African-Americans, American
1134 Indians and Alaska Natives and Native Hawaiians and Pacific
1135 Islands experience poor health relative to national averages
1136 from birth to death in the form of higher infant mortality,
1137 higher rates of disease and disability and shortened life
1138 expectancies. The large and growing body of public health
1139 research demonstrates that to address these problems, we must
1140 improve the social and economic contexts that shape health.
1141 As the World Health Organization's report on social
1142 determinates of health states, inequities in health and
1143 avoidable health inequalities arise because of the
1144 circumstances in which people grow, live, work and age and
1145 the systems put in place to deal with illness.

1146 It is clear that many Americans, disproportionately
1147 racial and ethnic minorities, face health care access and
1148 quality inequities. Some of these inequities can be
1149 explained by socioeconomic factors while others cannot. The
1150 National Healthcare Disparities Report, which is prepared and
1151 released annually by the Agency for Health Care Research and
1152 Quality, has found that African-Americans, Hispanics,
1153 American Indians and Alaska Natives fare worse than whites on
1154 a preponderance of measures of health care access and
1155 quality. For example, the report finds that minorities are
1156 less likely to receive even routine evidence-based procedures
1157 and experience greater communication barriers.

1158 Now, the NHDR provides a window to the health care
1159 experiences of a diverse patient population but it does not
1160 disentangle the influences of race, income and insurance on
1161 health care. A substantial body of evidence, as has been
1162 pointed out, demonstrates that racial and ethnic minorities
1163 receive a lower quality and intensity of health care than
1164 white patients even when they are insured at the same levels
1165 and present with the same types of health problems. Many
1166 factors contribute to these inequities and these often
1167 interact in complex ways. I would like to focus on an
1168 important underlying factor in health care inequality and
1169 that is residential segregation. Racial and ethnic

1170 minorities are more likely than whites to live in segregated,
1171 high-poverty communities, communities that have historically
1172 suffered from a lack of health care investment. Institutes
1173 that serve communities of color are more likely to experience
1174 quality problems and have fewer resources for patient care
1175 than institutions serving non-minority communities. Just as
1176 an example, a recent study of African-American and white
1177 Medicare patients found that the risk of admission to high-
1178 mortality hospitals was 35 percent higher for blacks than for
1179 whites in communities with high levels of residential
1180 segregation. Racial and ethnic segregation and inequality
1181 therefore set the stage for inequitable health care in the
1182 United States.

1183 To solve these problems, we must prioritize and invest
1184 in improving the health of communities that suffer from
1185 health care inequities. To make the largest gains, we should
1186 improve social and economic conditions for health. For
1187 example, the federal government should enforce provisions to
1188 address environmental justice in minority and low-income
1189 communities and should establish health empowerment zones in
1190 communities that disproportionately experience disparities in
1191 health status and health care. To improve health care access
1192 and quality for communities of color, the federal government
1193 should improve access to health care providers, as many on

1194 the committee have pointed out. We need to make special
1195 efforts to ensure that health care resources are better
1196 aligned with these communities' needs. We can do so by
1197 increasing the diversity of our health professional
1198 providers, supporting safety-net institutions, providing
1199 incentives for providers to serve in underserved communities,
1200 and addressing the geographic imbalance of health care
1201 resources like community health centers. We can also promote
1202 equal high-quality access to care by collecting and
1203 monitoring data on disparities and publicly reporting these
1204 data. We can also encourage the adoption of cultural and
1205 linguistic standards and encourage attention to disparities
1206 in quality improvement initiatives.

1207 Mr. Chairman, my time is short and these are but a few
1208 of the many ideas that will be put forward today, and we look
1209 forward to working with you as you craft legislation to
1210 address these issues.

1211 [The prepared statement of Mr. Smedley follows:]

1212 ***** INSERT 1 *****

|

1213 Mr. {Pallone.} Thank you, Dr. Smedley.

1214 Dr. Kitchell.

|
1215 ^STATEMENT OF MICHAEL JOHN KITCHELL

1216 } Dr. {Kitchell.} Thank you, Chairman Pallone, Ranking
1217 Member Deal and Congressman Braley for inviting me. I
1218 practice neurologist in a 167-member physician-owned multi-
1219 specialty clinic in central Iowa. We have offices in 21
1220 different sites in rural Iowa and we have about 1 million
1221 patient visits per year.

1222 Maintaining access in rural America is difficult because
1223 of physician shortages, long distances to travel and fewer
1224 services that are available. You will hear other speakers
1225 today that will talk about the shortage of physicians in
1226 certain specialties, for example, internal medicine. In
1227 Iowa, we actually have 3.7 times fewer internal medicine
1228 physicians as the State of Massachusetts, and you aren't
1229 aware, Massachusetts has recently declared a critical
1230 shortage of 12 different specialties including internal
1231 medicine. So if those shortages in Massachusetts in critical
1232 when we have 3.7 times fewer internists, I would say we are
1233 just about comatose.

1234 The medical economic survey has actually shown that
1235 rural physicians practice expenses are higher in their
1236 survey. They are higher than inner city, suburban and urban

1237 physicians. The main reasons for practice expenses being
1238 higher in rural areas is the number of patients that we see.
1239 When you have half as many physicians in rural areas, you
1240 have to see a few more patients.

1241 Rural physicians are paid less by Medicare for our work
1242 despite the fact that we work longer hours. Medicare pays
1243 rural physicians less for practice expenses despite the fact
1244 that Medicare has never done a survey of the actual practice
1245 expense differences for physicians in rural areas. This has
1246 been going on for 17 years. Medicare pays us less for e-
1247 prescribing. You know, I looked for a geographic discount on
1248 electronic prescribing equipment and I couldn't find any
1249 geographic discounts. I looked for geographic discounts on
1250 office equipment, computers and yes, even electronic medical
1251 records and, you know, I couldn't find a geographic discount
1252 on electronic medical records.

1253 Medicare also pays us less for quality, and Congressman
1254 Braley has been kind enough to sponsor a bill to eliminate
1255 the devaluation of quality. Medicare pays quality for
1256 physicians at a lower rate in rural areas. I think that that
1257 devaluation of quality is the ultimate insult to rural
1258 physicians. Some rural Medicare fees are as low as one-third
1259 of what our private insurance payers are paying us. Some
1260 health care services are delivered at a loss in rural areas

1261 because Medicare pays so little. If Medicare expanded or if
1262 Medicare would cut their payments, obviously there will be
1263 more losses, more losses of dollars, more losses of service.
1264 You can't make up on volume when the cost of the service is
1265 greater than what you are paid.

1266 Congressman Braley, Senator Grassley and Senator Harkin
1267 have all sponsored legislation to eliminate or at least
1268 reduce these geographic penalties. President Obama in
1269 October also has come out in support of geographic equity. I
1270 hope that you will also come out in support of geographic
1271 equity.

1272 A lot of what is wrong in health care though is due to
1273 the physician payment system. This physician payment system
1274 is called the resource-based relative value unit system, that
1275 is, our payment system pays for resource use. It should be
1276 no surprise then when we pay for resource use that we have
1277 the most expensive health care system in the world. When we
1278 pay for more expenses rather than pay for the most effective
1279 care, we are going to get more expensive care and we won't
1280 get as much cost-effective care.

1281 We need to pay for value, not geography. We need to pay
1282 for things that matter to the patient. We need to pay for
1283 the right tests and treatment, not just more tests and
1284 treatment. Iowa is a good example of a high value in health

1285 care. It shows that high-quality health care doesn't have to
1286 be so expensive. The Commonwealth Fund has rated Iowa's
1287 health care system as number one in children's care and
1288 number two for care of adults. The Agency for Health Care
1289 Research on Quality, Dartmouth and other researchers have
1290 consistently shown that Iowa and Midwestern States take the
1291 lead in quality and cost-effective care. I testified 6 years
1292 ago at the Senate Finance Committee on the national health
1293 policy forum and I urged that Medicare pay for value, not
1294 volume. I urged that Medicare pay for quality, not quantity.
1295 Unfortunately, over the last 6 years there hasn't been much
1296 progress made in paying for value or paying physicians for
1297 quality. The Medicare payment system for quality is called
1298 Physician Quality Reporting Initiative, or PQRI. PQRI is
1299 definitely a failure. Only 8 percent of the Nation's
1300 physicians succeeded with this program. PQRI does not reward
1301 quality. It simply rewards reporting. The lowest quality
1302 physician in this country could report correctly on three
1303 quality measures that they never did any of those measures
1304 and they would get the bonus.

1305 Mr. {Pallone.} Doctor, I hate to interrupt but you are
1306 a minute over, so if you could wrap up?

1307 Dr. {Kitchell.} Medicare's Hospital Quality Rewards
1308 program is a success because it measures larger groups and

1309 systems. So what should Medicare do to reward quality and
1310 value for physicians? Another lesson that can be learned
1311 from Iowa is about coordinated care, teamwork and
1312 accountability. Quality measures should be based on teams,
1313 groups and systems. We need to encourage all physicians to
1314 be part of the system. Middlesex County, Connecticut, is a
1315 good example of independent physicians getting together,
1316 improving quality, improving value and being accountable. We
1317 need changes in the payment system for geographic equity to
1318 reduce cost and increase quality of value.

1319 Thank you, Mr. Chairman.

1320 [The prepared statement of Dr. Kitchell follows:]

1321 ***** INSERT 2 *****

|

1322 Mr. {Pallone.} Thank you.

1323 Dr. Sitorius.

|
1324 ^STATEMENT OF MICHAEL A. SITORIUS

1325 } Dr. {Sitorius.} I would like to thank you, Mr.
1326 Chairman, for conducting this subcommittee hearing on the
1327 accessibility of health care.

1328 I am here to share information about the Bellevue
1329 Medical Center, which is currently under construction in
1330 Bellevue, Nebraska, a suburb of Omaha. The Bellevue Medical
1331 Center is an entirely different entity than anything we have
1332 seen across the country. It is going to be a full-service
1333 community hospital providing a wide array of services
1334 including emergency services 24 hours to one of the largest
1335 communities in the United States without an acute care
1336 hospital. It is majority owned by the largest public
1337 hospital system in the State. It is expected to open in
1338 April of 2010. This medical center illustrates how
1339 hospitals, doctors and communities came come together to
1340 enhance the access of health care to populations in need. I
1341 believe the Bellevue Medical Center represents the best in
1342 American health care. When we open our doors next spring, we
1343 will be an example of a public hospital system, a group of
1344 committed and talented physicians, a supportive city
1345 government and a thriving and responsive business community

1346 that came together to make health care accessible to an
1347 underserved population.

1348 Bellevue is the third largest city in Nebraska, it is
1349 about 45,000 residents, and it is home to Offutt Air Force
1350 Base and the United States Strategic Command. Approximately
1351 10,000 active-duty military personnel, 20,000 dependents and
1352 11,000 military retirees live in the Bellevue area, a very
1353 important asset to the Bellevue community. It may come as a
1354 surprise that Bellevue has not currently or has ever had a
1355 community hospital or emergency room in the city. The Offutt
1356 Air Force military hospital, Ehrling Bergguist, closed in
1357 2005 as part of the Base Closure Realignment Commission.
1358 Though clinics remain at the Ehrling Bergguist Hospital, the
1359 remaining same-day surgery and evening urgent care clinics
1360 will be closing in the fall of 2009. As a family physician,
1361 I can see firsthand the need for a hospital in Bellevue.
1362 There are approximately 180,000 people in eastern Nebraska
1363 and western Iowa who would benefit from the hospital, and
1364 will, in 2010.

1365 Currently, all the rescue squads in the Bellevue
1366 community leave that community for access to emergency care.
1367 Low-income individuals benefit from this full-service
1368 hospital as well. The UNMC Physician Group currently has a
1369 clinic in the Bellevue area which serves a significant low-

1370 income and Hispanic population which live in the near south
1371 Omaha area. This hospital will provide access to care that
1372 is currently not available to that population.

1373 Furthermore, I have a unique vantage point on the
1374 medical needs in this area. As chair of the Department of
1375 Family Medicine, we have had an affiliated family medicine
1376 residency training program with the Air Force since 1992.
1377 Unfortunately, with the closure of that base hospital in
1378 2005, it has made difficult some of the training
1379 opportunities for one-fifth of the Air Force family medicine
1380 residents in their training programs. It is then important
1381 that we combine that military training need with the needs of
1382 the population to come up with the idea for the Bellevue
1383 Medical Center. The center is a creative solution to address
1384 the health care needs of the community of which it is
1385 serving. The Bellevue Medical Center is aligned with an
1386 academic medical center, the University of Nebraska Medical
1387 Center and the Nebraska Medical Center. Faculty physicians
1388 and community physicians meet community needs. When it opens
1389 in April of 2010, it will be a full-service hospital
1390 delivering adult care, pediatric care, labor and delivery,
1391 emergency care, inpatient and outpatient surgery and
1392 intensive care. This represents a collaborative model
1393 involving public, academic community physicians and community

1394 leaders. The Bellevue Medical Center will hold strongly to
1395 the values of the existing Nebraska Medical Center for its
1396 excellence, innovation and quality patient care. In
1397 addition, it will serve as an educational mission for the
1398 medical center. It will train 20 percent of the Air Force
1399 complement of family practice resident physicians and will
1400 allow training in two different locations, the tertiary care
1401 academic medical center and the community-based Bellevue
1402 Medical Center in 2010.

1403 And in this time of economic downturn, this project also
1404 has created jobs. In addition to the hundreds of
1405 construction jobs already created, the Bellevue Medical
1406 Center will employ 600 FTEs when opened.

1407 The Bellevue Medical Center has strong community
1408 support. In fact, the community is extremely engaged and led
1409 the effort to make this Bellevue Medical Center a reality. I
1410 believe the Bellevue Medical Center can serve as a health
1411 care model for other communities. The Nation's health care
1412 system needs to encourage innovation through partnerships, in
1413 our case, an academic medical center partnered with faculty
1414 physicians, community physicians and the community. I would
1415 encourage other academic medical centers to consider to
1416 replicate what the Nebraska Medical Center has done in the
1417 Bellevue community. Moreover, the Bellevue Medical Center is

1418 also a model as it relates to care of our military service
1419 members, their families and military retirees. It is our
1420 position that our military service members, their families
1421 and retirees deserve the best quality health care possible
1422 from a nearby community hospital. The Bellevue Medical
1423 Center will be able to provide that care. This center will
1424 also care for all of the benefits provided under the Tri-Care
1425 program. The Bellevue Medical Center will accept and look
1426 forward to working with the Tri-Care patients.

1427 In conclusion, as Congress begins to tackle health care
1428 reform, access to health care must be a significant part of
1429 any solution. I am proud to say that the Bellevue Medical
1430 Center stands ready to be part of that solution to expanding
1431 access to health care. We are excited that your subcommittee
1432 has asked us to share our story with you this morning.

1433 Thank you for your attention and interest and I would be
1434 happy to answer questions when we get to that point.

1435 [The prepared statement of Dr. Sitorius follows:]

1436 ***** INSERT 3 *****

|

1437 Mr. {Pallone.} Thank you, Doctor.

1438 Dr. Lavizzo-Mourey.

|
1439 ^STATEMENT OF RISA LAVIZZO-MOUREY

1440 } Dr. {Lavizzo-Mourey.} Thank you, Chairman Pallone and
1441 Ranking Member Deal and members of the subcommittee for this
1442 opportunity to testify.

1443 As has been mentioned, it is Cover the Uninsured Week
1444 and communities all across the country are calling for fixes
1445 to our broken health care system. Expanding coverage must be
1446 a priority as Congress considers opportunities for health
1447 reform but this alone will not fix the problem. In my
1448 written testimony, I have touched on issues of health care
1449 disparities and non-financial barriers to health but I would
1450 like to focus my oral remarks on the role of nurses in
1451 ensuring the access to high-quality care and opportunities
1452 for addressing the shortage of nurses and nurse faculty.

1453 If you have ever been hospitalized or had a loved one
1454 who was hospitalized, you know that nurses make a difference.
1455 Nurses' diligence keeps bad things from happening to
1456 patients. Their actions prevent medical errors and
1457 infections. They keep patients safe from falls and from the
1458 complications of extended bed rest. They also work in
1459 community settings to prevent disease, help patients manage
1460 their diseases better and avoid unnecessary hospitalizations.

1461 As Congresswoman Capps noted recently at the White House
1462 Forum for Health Reform, there is a projected shortage of
1463 500,000 nurses by 2020. The nursing shortage results from a
1464 confluence of factors: a shortage of nurse faculty, too few
1465 nurses enrolling in nursing programs and turnover among
1466 experienced nurses. There is a vacancy rate of 7.6 percent
1467 among nursing faculty which results in far too many qualified
1468 students being turned away. Solving this problem will
1469 require action at the national level and a commitment of
1470 resources both public and private. The results of our
1471 grantees' and partners' work suggest that the following steps
1472 must be taken.

1473 First, we need to increase the number of nurses with
1474 baccalaureate degrees to create a larger pool of nurses who
1475 will qualify to pursue faculty careers. Second, we need to
1476 increase financial assistance to enable more nurses to attend
1477 graduate school and obtain teaching qualifications. Third,
1478 encourage private sector to adopt evidence-based practices
1479 including the use of technology that will improve the
1480 retention of nurses in their clinical roles. And finally, we
1481 need to support research to demonstrate the nurse's role in
1482 improving the quality of patient care and improving outcomes.
1483 It is also essential that funding for workforce development
1484 not ebb and flow with yearly changes in appropriations to

1485 Title VIII programs.

1486 I want to highlight a few specific promising programs
1487 and strategies that address the nursing shortage and the
1488 faculty shortage. First, at our foundation we found
1489 scholarships to support accelerated nursing degrees for
1490 students who already have a degree in a discipline other than
1491 nursing. These are typically students that are ineligible
1492 for federal aid programs, and I can tell you, these
1493 scholarship programs are hugely oversubscribed. Second, we
1494 are providing career development awards to outstanding junior
1495 faculty. Third, there are many State partnerships of nurses,
1496 educators, consumers, business groups, government and
1497 philanthropy that are working together on practical creative
1498 solutions like using shared curriculum, online education,
1499 simulation centers for training, easing the transition from
1500 associate to baccalaureate programs and increasing the
1501 diversity of the nursing workforce. Taken together, these
1502 programs seem to increase the number of baccalaureate-
1503 prepared nurses, provide incentives and rewards for nursing
1504 faculty to educate the next generation of nurses, shorten the
1505 pipeline for providing nursing faculty and provide a new
1506 cadre of nursing leaders.

1507 Now, as we consider the critical task of ensuring that
1508 the education system can graduate new nurses, we must also

1509 retain experienced nurses. We have a demonstration project
1510 called Transforming Care at the Bedside that shows hospitals
1511 can successfully retain nurses through organizational reforms
1512 that do not add costs. I know that my colleague, Dr. Mullan,
1513 will focus on the shortage of primary care physicians but
1514 nurse practitioners are an effective, high-quality way to
1515 fill the gap in primary care, particularly as we think about
1516 access in rural and other underserved settings.

1517 So in conclusion, as Congress addresses both the
1518 shortage of primary care physicians and the need to control
1519 spending, I encourage you think about opportunities to use
1520 nurse practitioners more widely and effectively.

1521 Thank you for this opportunity to testify today and for
1522 your attention to these issues that reach beyond ensuring
1523 health care coverage and allow us to strive for
1524 comprehensive, meaningful reform.

1525 [The prepared statement of Dr. Lavizzo-Mourey follows:]

1526 ***** INSERT 4 *****

|

1527 Mr. {Pallone.} Thank you, Doctor.

1528 Dr. Mullan.

|
1529 ^STATEMENT OF FITZHUGH MULLAN

1530 } Dr. {Mullan.} Chairman Pallone, Ranking Member Deal,
1531 members of the committee, colleagues, thank you for the
1532 opportunity to testify today. I will be talking about the
1533 clinical workforce, largely physicians but not limited to
1534 physicians. I started as a physician in the National Health
1535 Service Corps. I served for a period as the director of the
1536 National Health Service Corps, and in recent years I have
1537 worked in scholarly pursuits trying to understand the
1538 dynamics and policies related to the health workforce. So I
1539 have practiced it, I have run it and now I am studying it,
1540 and I am here to share that with you as much as I can and
1541 very expeditiously.

1542 Massachusetts has been cited as an example, and I will
1543 say to you, it is an example of my principal premise to you
1544 and that is that substantial reform and improvement in access
1545 and in health care in this country will not take place
1546 without substantial reform and improvement in the health
1547 workforce in this country, and the experience of
1548 Massachusetts has been when you provided expanded access,
1549 they did indeed come, and where they hit the first bump in
1550 the road was the absence of a good, strong primary care base,

1551 even in a State that is well endowed with physicians. So
1552 primary care is at the core of the reform of the health
1553 workforce.

1554 A few words about the shape and size of the health
1555 workforce. I offer you this graphic as a way to
1556 conceptualize what I consider the three phases of the life
1557 cycle of a physician and that would be medical school,
1558 graduate medical education and practice. Clearly, practice
1559 is a 30- to 40-year proposition and the others presumably are
1560 somewhat shorter but all three have a character and a
1561 legislative component and I suggest you consider those in
1562 that regard and we will go through them in a moment with the
1563 particular legislative potentials of each of those. In
1564 general, we do have problems in primary care. We have a
1565 smaller base compared to many other countries in terms of how
1566 we approach it. We have an inverted pyramid with a small
1567 base and a large wobbly superstructure of people engaging in
1568 specialty and subspecialty clinical roles. More important
1569 than this are the trends in primary care which for a variety
1570 of reasons ranging from reimbursement to what is in, folks
1571 are not going into primary care. That is a huge problem for
1572 the future and one that can be addressed both by investments
1573 and financially but also by statements by public bodies such
1574 as the Congress that this is important.

1575 Overall, my judgment would be in the somewhat
1576 contentious area of do we have enough doctors, I think we are
1577 in the right zone. We have a 30-year history now of
1578 increasing physician population ratio. We are at about 280
1579 per 100,000. That puts us a little bit ahead of Canada and
1580 the United Kingdom, a little bit behind Germany and France.
1581 All these countries including ourselves are going to
1582 experience problems of aging population and I will address
1583 those in a moment.

1584 Our major problem, however, is that they are poorly
1585 distributed. Physicians tend to be urban. They tend to be
1586 in well-to-do areas and they tend not to go where the most
1587 severe problems are. That has continued to be a problem as
1588 we produce more doctors. They tend to continue to locate in
1589 similar areas. So we can make far better and more prudent
1590 use of our workforce if it was better distributed both in
1591 terms of geography and specialty, and we have two American
1592 inventions that are enormous assets in both what is happening
1593 now and what should and can happen in the future, and those,
1594 as referenced by Dr. Lavizzo-Mourey and others, are physician
1595 assistants and nurse practitioners, about 70,000 of the
1596 former, 100,000 of the latter. We invented them. Now the
1597 rest of the world is running to try to catch up but they have
1598 shown very effective use and they are effective not only in

1599 the primary care area but in the specialty area. A way to
1600 attenuate our need for more specialists is more collaborative
1601 work with non-physician clinicians including particularly
1602 nurse practitioner and physician assistants. We also have in
1603 place two very important programs that affect workforce and
1604 that is the Nation Health Service Corps as an incentive
1605 program and community health centers as a deployment
1606 mechanism to put folks to work. Those need to be invested in
1607 and continue to be recapitalized.

1608 Now, let us quickly go through this continuum. In
1609 medical school we are seeing expansion. New medical schools
1610 are coming online. Old schools are expanding their capacity.
1611 This is good. We have in addition two very important
1612 programs that impact medical education. The first is Title
1613 VII in the jurisdiction of this committee. It is an old
1614 program. It could use reconceptualizing and certainly
1615 reinvigorating but it is where the federal government offers
1616 or can offer incentives to medical schools and medical
1617 students for different kinds of careers and there is a lot
1618 that can be said about that important area of investment.
1619 And of course, the National Health Service Corps, which
1620 happily is receiving more attention. There are about 3,500
1621 people in the service in the field today. About half of
1622 those are physicians. You are talking 1,700 physicians,

1623 800,000 physicians in America. This is a very, very small
1624 but important program. It needs to get on the map in a more
1625 major way.

1626 Graduate medical education, a very important area, and
1627 primarily the jurisdiction of this committee because it is \$8
1628 billion, \$8.5 billion in Medicare funds that fund the GME
1629 largely. It is a huge program without, as I have
1630 characterized it, a brain. It is formulaic. It is not
1631 currently available to help with workforce redistribution. A
1632 great deal could be done with that. A great deal of
1633 attention needs to be paid to that. Modest activities would
1634 include incentivizing community-based and ambulatory
1635 training. More major would be realigning Medicare GME with
1636 national workforce needs with a better, more formal
1637 allocation system.

1638 And finally in practice, a lot could be done if you
1639 train them and put them out. In an environment that devalues
1640 primary care, they will find other ways to do other things
1641 and charge the system in other ways. So practice has to be
1642 realigned. We need payment reform. We need practice
1643 organization reform, primary care medical homes, and finally,
1644 health information systems which happily are getting
1645 attention will make all providers, particularly primary care,
1646 this information much more effectively.

1647 Finally, two ideas that I think need attention. One is,
1648 we function in an information-poor environment in terms of
1649 workforce planning. Data is not good. We need a national
1650 center for health workforce studies that would on a regular
1651 basis work on census issues, on analytic issues and on
1652 projection issues. And finally, a national health workforce
1653 commission, a deliberative body perhaps on the order of
1654 MedPAC that advises the Congress, the Administration and the
1655 American people on the issues of workforce, a very important,
1656 a very difficult, complex area. We need brains at work on
1657 that day in and day out with the sanction of the Congress
1658 that would help us think through these dilemmas.

1659 So I thank you for your time. I would be happy to
1660 engage in discussion and participate with the committee as
1661 you consider reform in this area. Thank you, Mr. Chairman.

1662 [The prepared statement of Dr. Mullan follows:]

1663 ***** INSERT 5 *****

|
1664 Mr. {Pallone.} Thank you, Dr. Mullan.
1665 Dr. Harris.

|
1666 ^STATEMENT OF JEFFREY P. HARRIS

1667 } Dr. {Harris.} Thank you, Chairman Pallone and Ranking
1668 Member Deal, for allowing me to share the American College of
1669 Physicians' views on primary care workforce and how it
1670 affects access.

1671 I am Jeff Harris, president of the ACP. Until recently,
1672 I practiced in a rural community with a population of 40,000
1673 in Virginia. The office in which I practice focused on the
1674 delivery of primary care and nephrology. This year I have
1675 had the good fortune to be president of the American College
1676 of Physicians, representing 126,000 internal medicine
1677 physicians and medical students. The United States is
1678 experiencing a primary care shortage in this country, the
1679 likes of which we have not seen. The demand for primary care
1680 in the United States will grow exponentially as the Nation's
1681 supply of primary care dwindles.

1682 The reasons behind this decline in the supply of primary
1683 care physicians are multifaceted and complex. They include
1684 the rapid rise in medical education debt, a decrease in
1685 income potential for primary care physicians, failed payment
1686 policies and increased burdens associated with the practice
1687 of primary care. Many regions of the country already are

1688 experiencing primary care shortages. The Institute of
1689 Medicine reports that it would take about 16,000 additional
1690 primary care physicians to meet the needs in currently
1691 underserved areas. Two recent studies found that the
1692 shortage of primary care physicians for adults will grow to
1693 over 40,000, even after taking into account the important
1694 contributions of nurses, nurse practitioners and physician
1695 assistants as part of the primary care team. Approximately
1696 21 percent of physicians who were board certified in the
1697 1990s have left internal medicine compared to 5 percent who
1698 have departed from internal medicine subspecialties.

1699 Equally alarming is the fact that the pipeline of
1700 incoming primary care physicians is also drying up. In 2007,
1701 only 23 percent of third-year internal medicine residents
1702 intended to pursue careers in general internal medicine.
1703 This was down from 54 percent in 1998. Even more troubling,
1704 a recent survey found that only 2 percent of medical students
1705 plan to go into general internal medicine. ACP strongly
1706 supports the need to ensure all Americans have access to
1707 affordable health coverage. As more people are covered,
1708 though, the primary care workforce needs to grow to take on
1709 more patients. Primary care physicians are the first line of
1710 contact for individuals newly entering the health care
1711 system. If we do not increase the primary care workforce, it

1712 will become impossible in many communities for people who do
1713 not currently have a relationship with a primary care
1714 physician to find an internist, family physician or
1715 pediatrician who is taking new patients. In Massachusetts,
1716 where health insurance coverage was recently expanded and
1717 nearly 95 percent of the State's residents have coverage, the
1718 wait to see primary care physicians in Massachusetts has
1719 reportedly grown to as long as 100 days. Yet Massachusetts
1720 has a higher physician-to-patient ratio than most other
1721 States.

1722 The cost of providing coverage to more than 46 million
1723 uninsured Americans will be much higher and the outcomes of
1724 care much poorer without more primary care physicians. More
1725 than 100 studies referenced in the ACP's recent paper, *How is*
1726 *the Shortage of Primary Care Physicians Affecting the Quality*
1727 *and Cost of Medical Care*, demonstrates that primary care is
1728 consistently associated with better outcomes and a lower cost
1729 of care. For instance, one study found that an increase of
1730 just one primary care physician per 10,000 population in a
1731 State was associated with a rise in the State's quality rank
1732 and a reduction in overall spending by \$684 per Medicare
1733 beneficiary.

1734 The United States needs a comprehensive approach to
1735 ensure access to primary care. We should start with a

1736 national health care workforce process to set specific goals
1737 for educating and training a supply of health professionals
1738 including primary care to meet the Nation's health care
1739 needs. In the United States, the numbers and types of health
1740 care professionals being trained are largely determined by
1741 the availability of training programs, the number of
1742 applicants and inpatient service needs of academic medical
1743 centers. But institutional service needs are poor indicators
1744 of national health workforce requirements, particularly as
1745 patient care has continued to shift from inpatient to
1746 outpatient settings.

1747 The Institution of Medicine has recommended ``a
1748 comprehensive national strategy to assess and address current
1749 and projected gaps in the number, professional mix,
1750 geographical distribution and diversity'' of the health care
1751 workforce. Secondly, we need to fund programs to cover the
1752 cost of medical education for students who agree to pursue
1753 careers in primary care and subsequently practice in areas of
1754 the Nation with greatest needs. Third, Medicare payment
1755 policies need to be reformed. The career choices of medical
1756 students and young physicians should be largely unaffected by
1757 considerations of differences in earnings expectations, yet
1758 Medicare payment policies systematically undervalue the
1759 comprehensive, longitudinal, preventive and coordinated care

1760 that is the hallmark of primary care. Currently the average
1761 primary care physician earns approximately 55 percent of the
1762 average earnings for all other non-primary care physician
1763 specialties. Studies show that this compensation gap is
1764 among the most significant reasons for the growing shortage
1765 of primary care physicians. To eliminate this differential
1766 as a critical factor in medical student and resident choice
1767 of specialty, the average net compensation for primary care
1768 physicians would need to be raised by Medicare and other
1769 payers to be competitive with other specialties. We
1770 recommend that Congress institute a process that would result
1771 in such targeted annual increase in Medicare fee schedule
1772 payments to make primary care competitive with other
1773 specialties over a five-year period beginning next year. The
1774 funding for such payments should take into account primary
1775 care's contribution to reducing overall Medicare cost
1776 associated with preventable hospital, emergency room and
1777 intensive care visits, many of which are reimbursed under
1778 Medicare Part A. Although it may appear to some that our
1779 call to increase Medicare payments to primary care is self-
1780 serving, the fact is that almost half of the ACP's membership
1781 practices in subspecialties, not general internal medicine,
1782 yet they share our belief that having a sufficient primary
1783 care workforce is essential if patients are to have access to

1784 high-quality, effective and affordable care.

1785 Finally, we need new payment models that align
1786 incentives for accountable, coordinated patient-centered care
1787 including continued expansion of the patient-centered medical
1788 home. The Commonwealth Fund's Commission on High-Performing
1789 Health Care Systems recently issued a report--

1790 Mr. {Pallone.} Dr. Harris, I didn't stop you because I
1791 was interested but you are 3 minutes over, so you have to
1792 wrap up.

1793 Dr. {Harris.} I apologize.

1794 Mr. {Pallone.} That is all right.

1795 Dr. {Harris.} One last paragraph. In conclusion, the
1796 United States faces a critical shortage of primary care
1797 physicians for adults. We believe that it is imperative for
1798 all Americans to be provided with access to affordable
1799 coverage. We also know that coverage alone will not ensure
1800 that patients have access to high-quality and affordable care
1801 if there are not primary care physicians available to meet
1802 those needs.

1803 Thank you for your patience.

1804 [The prepared statement of Dr. Harris follows:]

1805 ***** INSERT 6 *****

|

1806 Mr. {Pallone.} Thank you.

1807 Dr. Bean.

|
1808 ^STATEMENT OF JAMES R. BEAN

1809 } Dr. {Bean.} Thank you, Chairman Pallone and Ranking
1810 Member Deal and members of the Health Subcommittee for the
1811 opportunity to address you about patient access to medical
1812 care. My name is Jim Bean. I practice neurosurgery in
1813 Lexington, Kentucky, for the past 29 years. I serve
1814 currently as president of the American Association of
1815 Neurological Surgeons, and this is a member organization of
1816 Doctors for Medical Liability Reform, the Health Coalition on
1817 Liability and Access, and the Alliance of Specialty Medicine.

1818 Access to effective medical care depends on a number of
1819 factors and we have talked about them, but one that is too
1820 often neglected is a barrier to access that is created by a
1821 malfunctioning medical liability system. I think it is safe
1822 to say there is near-universal agreement among physicians,
1823 patients and policymakers that our medical liability system
1824 is broken. Defining how is the issue. In 2005, Senators
1825 Hillary Clinton and Barack Obama acknowledged this when they
1826 cosponsored medical liability legislation to deal with the
1827 mounting access-to-care crisis. A 2008 white paper, Call to
1828 Action, released by Senate Finance Committee Chair Max
1829 Baucus, also acknowledges that the current legal environment

1830 leads to the practice of defensive medicine and calls for
1831 alternatives to civil litigation so that the administrative
1832 costs associated with litigation, which account for 60
1833 percent of malpractice premiums, can be reduced. Those at
1834 the forefront of health care reform understand that it will
1835 do little good to achieve universal insurance coverage if the
1836 doctors who actually supply critical aspects of care are
1837 either driven from practice or retire early or simply shun
1838 the lifesaving procedures that need to be done because of
1839 uncontrolled risk.

1840 The problem of access to care is especially critical for
1841 high-risk specialties. We have been talking a lot about
1842 primary care but we should not forget that the specialty care
1843 has to be rendered in a safe system. Specialties such as
1844 neurosurgery, obstetrics, orthopedics, general surgery,
1845 emergency medicine and others, these specialties have been
1846 hit particularly hard by lawsuits and rising insurance
1847 premiums and they are the same ones who provide critical
1848 emergency services, and when they leave, they leave enormous
1849 gaps. The crisis persists despite a clear record of
1850 successful reform in some States. Mississippi and West
1851 Virginia both faced critical loss of medical services because
1852 of a doctor exodus because of skyrocketing liability costs.
1853 Mississippi lost a substantial number of obstetricians. Both

1854 States, West Virginia and Mississippi, lost enough
1855 neurosurgeons to endanger their emergency care system.
1856 Liability State reforms dramatically reversed the trend and
1857 doctors have begun to return. All States should have the
1858 same advantage. Perhaps the most dramatic example is Texas.
1859 We have heard about it. Before reform in 2003 doctors fled
1860 the State. Texas ranked 48th out of 50 States in physician
1861 manpower, and since medical liability reform, 69 underserved
1862 counties have seen a net gain in emergency physicians and a
1863 number of other specialists. Access to care was clearly
1864 improved.

1865 While we strongly believe that comprehensive reforms
1866 passed in Texas should be applied nationwide, other proposed
1867 reforms may help as well. They include early offers,
1868 specialized health courts and a presumptive defense by using
1869 evidence-based medicine. The President endorsed such an
1870 approach in a New England Journal of Medicine article
1871 printed online. It was entitled Modern Health Care for All
1872 Americans, and it was published during the presidential
1873 campaign on September 24, 2008. I have a copy if you would
1874 like. He wrote that he would be open to additional measures
1875 to curb malpractice suits and reduce the cost of malpractice
1876 insurance and he further wrote, ``I will also support
1877 legislation dictating that if you practice care in line with

1878 your medical society's recommendations, you cannot be sued.''

1879 We strongly support the President's announced position and

1880 look forward to its implementation as policy.

1881 Our President and this Congress are dedicated to

1882 reforming our health care system and ensuring access to care,

1883 but access to quality care must come first and ensuring

1884 patient access to care means acting out to fix a critically

1885 ill medically liability system.

1886 Mr. Chairman, thank you.

1887 [The prepared statement of Dr. Bean follows:]

1888 ***** INSERT 7 *****

|

1889 Mr. {Pallone.} Thank you, Dr. Bean.

1890 Dr. Rowland.

|
1891 ^STATEMENT OF DIANE ROWLAND

1892 } Ms. {Rowland.} Thank you, Chairman Pallone and Ranking
1893 Member Deal and members of the committee, for the opportunity
1894 today to participate in this hearing on making health care
1895 work for American families. My testimony today will address
1896 the role public programs have played in improving access and
1897 helping to reduce health care disparities. Indeed, health
1898 care coverage matters. It may not be enough to assure
1899 access, but without it, access to care suffers and
1900 disparities rise.

1901 Together today, Medicare and Medicaid provide coverage
1902 to over a quarter of our population, 80 million Americans,
1903 our oldest, our poorest, our most disabled and among our
1904 sickest residents. Both programs for over 40 years have been
1905 central to our Nation's efforts to improve access to care and
1906 the health care of the American people. Medicare has helped
1907 to provide access to care for the elderly by easing the
1908 financial burden for care and opening up access to the broad
1909 range of medical services and new technology that has helped
1910 to both extend life and promote better care. Medicare has
1911 helped not only to improve access to medical care but also to
1912 reduce racial barriers to care, both through the enforcement

1913 of the civil rights legislation that led to the desegregation
1914 of health care facilities and by providing equal benefits to
1915 all beneficiaries without regard to health status, income,
1916 racial or ethnic identity or State of residence.

1917 Medicaid is the workhorse today of the U.S. health care
1918 system, providing coverage for almost 60 million Americans
1919 left out of private health insurance and with very special
1920 health care needs. Medicaid coverage of the low-income
1921 population provides access to a comprehensive scope of
1922 benefits with limited cost sharing that is geared to meet the
1923 health needs and limited financial resources of Medicaid's
1924 beneficiaries who tend to be both sicker and poorer than the
1925 privately insured low-income population. Medicaid also helps
1926 to address racial and ethnic disparities and access to care.
1927 Because minority Americans are more likely than whites to be
1928 low income and without access to job-based coverage, Medicaid
1929 provides an important safety net, today covering one in four
1930 non-elderly African-Americans and Latinos. In fact, minority
1931 populations compose over half of the Medicaid beneficiaries.
1932 The comprehensive scope of Medicaid benefits is critical,
1933 given the low incomes and complex health needs of the
1934 population Medicaid services including the chronically ill
1935 and people with severe disabilities. When the health needs
1936 of the beneficiaries on Medicaid are taken into account,

1937 Medicaid is in fact a low-cost program. Both adult and child
1938 per capita spending are lower in Medicaid than under private
1939 health insurance. Medicaid enrollees, however, tend to fare
1940 as well as the privately insured on important measures of
1941 access to primary care. Uninsured children have
1942 significantly higher rates of no usual source of care.
1943 Compared to only 4 percent of publicly insured children and 3
1944 percent of privately insured children, one third-of uninsured
1945 children have no usual source of care. There have been great
1946 gains in reducing the share of low-income children who are
1947 uninsured through the expansion of Medicaid and CHIP
1948 demonstrating that public programs can provide a solid
1949 platform from which to expand coverage.

1950 As the Nation moves forward to consideration of how to
1951 provide coverage to the over 45 million uninsured Americans
1952 today, Medicaid's role for the low-income population provides
1953 a strong platform on which reform efforts can be build as
1954 evidenced by the recent experience with children's coverage.
1955 One must recall that the uninsured population is
1956 predominantly low income, two-thirds with incomes below 200
1957 percent of poverty, or roughly \$44,000 for a family of four a
1958 year. Medicaid provides a strong and tested foundation upon
1959 which to build these health reform efforts but it could play
1960 indeed a stronger role if coverage of the low-income

1961 population was improved through expanded eligibility and
1962 reduction of enrollment barriers through addressing payment
1963 rates and administrative burden to help boost provider
1964 participation and promote greater access to primary care
1965 especially and through a stabilization of financing so that
1966 the periodic cuts in the program that affect reimbursement to
1967 providers and coverage for beneficiaries do not need to
1968 occur.

1969 In summary, the Medicaid program has an established
1970 track record in providing the scope of benefits and range of
1971 services to meet the needs of low-income population including
1972 those with chronic illness and severely disabling conditions.
1973 Drawing on Medicaid's experience in already substantial
1974 coverage of the low-income population offers an appropriate
1975 starting point for extending coverage to the low-income
1976 uninsured population through health care reform. While
1977 health insurance coverage is essential to open the door to
1978 the health care system for these individuals, broader
1979 measures as you have heard discussed today need to also be
1980 put in place as a complement to assure that the coverage card
1981 is not an empty promise. Thank you.

1982 [The prepared statement of Ms. Rowland follows:]

1983 ***** INSERT 8 *****

|
1984 Mr. {Pallone.} Thank you, Dr. Rowland, and thank all of
1985 you. I know it is a large panel, but you covered a lot of
1986 very important areas and we appreciate it. We now have
1987 questions from the members and I will start with myself for 5
1988 minutes.

1989 I am going to start with Dr. Mullan and I am going to
1990 throw a few things at you here. I don't know if you will
1991 have time to answer them all but I am very concerned about
1992 the financing of medical education, you know, the whole idea
1993 of Medicare financing GMEs. If you were to suggest to me
1994 that we probably should have an alternative financing
1995 mechanism and not maybe even use Medicare, I would like to
1996 hear that. But even more important, my concern is about, you
1997 said 30 percent of the doctors are educated abroad. To me,
1998 that makes no sense and I don't think any effort is being
1999 made to reverse that. If anything, it seems to me that we
2000 will probably see a situation where more of our physicians
2001 are educated abroad, and that makes no sense to me. You
2002 know, I talk about how I attend events in my district with
2003 medical doctors who are raising money for Caribbean medical
2004 schools rather than for UMDNJ in New Jersey. There were
2005 reports in the media a few months ago about foreign medical
2006 schools raising money and buying essentially residencies at

2007 hospitals in the New York metropolitan areas so that their
2008 students would have preference for residencies over graduates
2009 of American medical schools. What does this all mean in
2010 terms of the quality of physicians that so many are educated
2011 abroad, be they Americans that go abroad or immigrants? I
2012 mean, where are we going? Some of these schools, they seem
2013 to be opening more and more overseas. A lot of them are
2014 private, not even government run. I don't know what kind of
2015 controls they have. Should we reverse this? I am not even
2016 talking about the impact on other countries, potential brain
2017 drain on other countries. That concerns me less. Maybe I
2018 should be concerned about it but I am not so much. Would you
2019 address that? Because I hear about it every day at home. I
2020 know it is a lot to ask you but--

2021 Dr. {Mullan.} Well, I will try to give the 2-minute
2022 synopsis on international medical graduates and how we have
2023 gotten to where we have gotten and what we can do about it.
2024 Very quickly, we have chronically undertrained. We have not
2025 trained sufficient physicians in our medical schools, and
2026 over the years we have put a lot of investment from the
2027 Congress in particular and from State governments into
2028 medical education at the medical school level in the 1960s
2029 and 1970s and this had a very good response. We doubled the
2030 output of medical schools between 1965 and 1980. At that

2031 point everybody said whoa, we are going to overshoot, and
2032 funding was throttled back. Schools remain where they were.
2033 So between 1980 and 2005, we lost one medical school, a net
2034 loss of one, and the graduating class, 16,000, 16,500, every
2035 year was the same. Meanwhile over time, the residency
2036 opportunities grew, reflecting somewhat the needs of the
2037 country, and the opportunity for international graduates who
2038 took exams like the U.S. exams, today they take exams that
2039 are exactly the same to come and fill residency positions and
2040 then remain in practice, grew. So that today about 27
2041 percent of our residents and 25 percent of our doctors in
2042 practice are graduates of international schools. A minority
2043 of these, about 20 percent today, come from schools in the
2044 Caribbean, which are essentially designed for U.S. students
2045 to go abroad and come back as international medical
2046 graduates. That is because the need for medical education
2047 was not being made onshore. We didn't have enough
2048 placements.

2049 Mr. {Pallone.} But Doctor, should we be reversing this?
2050 I mean, my fear is the quality is good. Is this a way for us
2051 to save money so we should say great, let us have everybody
2052 educated abroad because the cost is less and let that burden
2053 be passed onto someone else? Does it matter? Are we doing
2054 anything to change it?

2055 Dr. {Mullan.} The answer is yes, we should be reversing
2056 it. That is good domestic policy. It is good foreign policy
2057 both. It gives more opportunity to domestic students if we
2058 have opportunities for them to train onshore and it
2059 diminishes the brain drain, which is bad foreign policy
2060 around the world. Many governments are resenting the fact
2061 that we are pulling their doctors here. The way it is
2062 happening and it is happening in a somewhat spontaneous
2063 fashion, is that medical schools are now growing again,
2064 increasing the opportunities. It is estimated that the
2065 medical school positions over the next 3 or 4 years will grow
2066 by 25 percent, and what will happen by all estimates is, that
2067 as more U.S. graduates come out, they will be selected for
2068 residency positions and de facto or in passing, the
2069 international medical graduates will have less opportunities.
2070 They will be less drawn from abroad. The problem--

2071 Mr. {Pallone.} But is that true? I mean, was this an
2072 aberration that I read in the New York Times where these
2073 foreign medical schools are now essentially buying
2074 residencies?

2075 Dr. {Mullan.} The foreign medical schools you refer to
2076 are the Caribbean commercial schools that are training
2077 largely U.S. students abroad and they did conclude--one of
2078 them concluded a large agreement with the New York Health and

2079 Hospitals Corporation for medical student places on their
2080 wards. It is unclear what will happen. U.S. New York-based
2081 schools that have placed their students there are in
2082 competition for those. Traditionally they have not paid for
2083 them. And it will be interesting to see how that plays out.
2084 But I think the point is, if the opportunities for practice
2085 in the United States for international medical graduates
2086 diminish because more and more of our positions are being
2087 filled by our own graduates, that business will diminish and
2088 we will not be so reliant on foreign graduates, whether they
2089 are U.S. citizens to begin with or international citizens.

2090 Mr. {Pallone.} So you think we are reversing this
2091 policy and we shouldn't worry much about it?

2092 Dr. {Mullan.} I think we should remain concerned about
2093 it. I think we are in a period where it is going to
2094 diminish. Now, we should understand that the number of
2095 residency positions in the country has remained relatively
2096 fixed. In round numbers, about 100,000 people are in
2097 residency every year, about 24,000, 25,000 new people in a
2098 residency each year. If we increase GME funding, graduate
2099 medical education Medicare funding, we will increase the
2100 opportunities and that will again begin to draw on the rest
2101 of the world. So right now where the physicians are capped
2102 under Medicare, that is Medicare reimbursement is capped, we

2103 are not creating more residency positions so the increased
2104 number of U.S. medical school graduates will go into a fixed
2105 number of positions, and by doing that it will diminish the
2106 number of international graduates that we bring into our
2107 country.

2108 Mr. {Pallone.} Thank you.

2109 Mr. Deal.

2110 Mr. {Deal.} Thank you.

2111 I would like to follow up on that too. I had a
2112 constituent that I asked him what his doctor told him. He
2113 said I don't know, I didn't understand a word he said, and
2114 that is a continuing problem. I didn't realize the
2115 percentages were as great until I read your testimony. With
2116 regard to the New York situation that you talked about, if we
2117 are funding graduate medical education through Medicare and
2118 the hospitals are now entering into private negotiated
2119 purchases of those slots, are we in effect funding slots
2120 through public funding that are now being in effect sold to
2121 foreign medical colleges?

2122 Dr. {Mullan.} That is a good question. I think the
2123 answer is no, because as I understand the agreement in New
2124 York, it is for the training of medical students, not for
2125 graduate medical education. The residency slots which
2126 Medicare funds remain the same. They are filled by both U.S.

2127 graduates and international medical graduates. Remember, I
2128 said we graduated about 16,000. If you add in osteopathic
2129 medical schools, U.S. based, we graduate about 18,000 every
2130 year. We offer 24,000 internship positions, post-graduate
2131 year one. So the difference between the 18,000 we graduate
2132 and the 24,000 that are offered are filled by international
2133 graduates, U.S. international graduates and non-U.S.
2134 international graduates. As the U.S. graduate numbers rise
2135 with the 24,000 positions to be filled, the international
2136 medical graduate numbers will diminish.

2137 Mr. {Deal.} Let me go to Dr. Harris because on a
2138 related subject to those residency slots, you make the point
2139 that we do not have enough residents in their post-graduate
2140 education going into the primary care internal medicine
2141 slots. How do we correct that? Is that something that the
2142 funding should be channeled more in the direction of those
2143 residency slots rather than the others, or how would you
2144 suggest we fix that?

2145 Dr. {Harris.} Well, we do recommend that there be
2146 focused GME funding on expanding the number of primary care
2147 spots. We feel that you need to be attentive to that. But
2148 the answer comes when you interview young people and ask them
2149 why are you not choosing primary care for a career, and the
2150 answers are three. One, it gets back to the question about

2151 medical education. You can argue that fundamentally there is
2152 a design flaw with medical education in that most medical
2153 schools in this country are centered around tertiary care
2154 centers where most ill people in the States are sent for
2155 their care while the most exotic illnesses are sent for very
2156 focused care. It is intellectually wonderfully satisfying,
2157 it is a wonderful place to spend 4 years, but there is
2158 precious little exposure to what the majority of health care
2159 is in this country, namely outpatient ambulatory care. So
2160 one of the things you need to do is increase that exposure to
2161 show young people that following patients longitudinally,
2162 knowing them for years, if not decades, is a pleasure. The
2163 second thing has to do with the pace and that gets back to
2164 the notion of this medical center home or funding for bundled
2165 care that allows the expansion of the team that gives
2166 physicians time with their patients. Remember, 20 percent of
2167 the Medicare population in this country has five or more
2168 chronic illnesses.

2169 Mr. {Deal.} Let me stop you because my time is running
2170 out. I understand that. I think your point is well made
2171 that the traditional residency is in a hospital environment
2172 whereas the primary care whereas the primary care physicians
2173 that we need to be attracting, their practice is not going to
2174 be necessarily in that hospital environment. We need to have

2175 a different environment in which for them to complete that
2176 exposure. Is that what you are saying?

2177 Dr. {Harris.} We need to increase their exposure to
2178 ambulatory medicine during their training.

2179 Mr. {Deal.} But doesn't that have to be done under the
2180 auspices of a hospital that is providing the residency
2181 program?

2182 Dr. {Harris.} Yes.

2183 Mr. {Deal.} Okay. Let me go back to Dr. Mullan just a
2184 second.

2185 We know that NIH funding has been significantly boosted
2186 as a result of the stimulus input. You made a statement in
2187 your written testimony talking about the rise in NIH funding
2188 from \$2.4 billion in 1970 to \$16.3 billion in 2004, and you
2189 say creating a robust culture of research at medical schools
2190 that dominates medical school finances, faculty values and
2191 school culture. Now, with this huge influx of new money into
2192 NIH, is that going to exacerbate this problem about the focus
2193 of medical schools and focus it away from increasing primary
2194 care training or is it going to help it? Which way it is, or
2195 neither?

2196 Dr. {Mullan.} Good question. The stimulus money is
2197 focused in very practical ways and I think would probably be
2198 more practice-friendly perhaps than traditional NIH funding

2199 but the point is well taken, and I am not here to talk
2200 against NIH funding. I am here to talk for balance and we
2201 need to think if our medical schools are being endowed with
2202 enormous research money, creating a culture that values
2203 research and specialism when the problems in the country are
2204 generalism, we need to think about how to rebalance that and
2205 medical schools and funding for generalist research is
2206 important as well.

2207 Mr. {Pallone.} Ms. Christensen.

2208 Ms. {Christensen.} Thank you, Mr. Chairman. I didn't
2209 expect you to come to me that quickly.

2210 I thank all of the panelists as I said, for not only
2211 your testimony today but for the work that you have been
2212 doing over the years.

2213 Dr. Smedley, and I will probably also ask Dr. Rowland to
2214 answer, I am an advocate of building on the public programs
2215 to expand coverage but I have a concern that as we reform the
2216 system that we don't perpetuate a two-tiered system of care.
2217 There have been several studies that I have seen that have
2218 shown that despite the increased access that Medicaid
2219 patients have to services, they don't have as good outcomes.
2220 They have about the same outcomes as the uninsured. So why
2221 do you think this is and how can we fix the problem? And is
2222 there a role for the public plan that we are talking about in

2223 all of this? Dr. Smedley?

2224 Mr. {Smedley.} Sure. First, I agree with Dr. Rowland's
2225 statement that Medicaid has been vitally important for low-
2226 income communities and communities of color. I have no doubt
2227 that without Medicaid, many more people would have suffered
2228 unnecessarily and we would have had many more premature
2229 deaths. By the same token, we know there are some things
2230 that need to be fixed and so it is important that we try to
2231 address the fact that we have tiered health care insurance
2232 systems, and so to the extent that people of color are
2233 disproportionately in lower-tier systems, this in itself can
2234 be one of the many causes of health care inequality and it is
2235 important that we take steps to strength Medicaid so that it
2236 is not stigmatizing to be a Medicaid patient. I was sharing
2237 with you earlier a story. I was surprised to walk into a
2238 county health clinic in one of our northeastern States. I
2239 walked into a waiting room that was approximately 20 feet by
2240 30 feet, a very small waiting room where you could your name
2241 if you were called, but yet along one of the walls there was
2242 a sign that said ``Medicaid patients only.'' This was
2243 surprising to me because it further stigmatizes Medicaid
2244 patients and so to the extent that Congress can take steps to
2245 ensure that all of our public plans are comparable to private
2246 plans in terms of coverage, quality, quality incentives and

2247 performance incentives, I think this will go a long way
2248 toward reducing that inequality.

2249 Ms. {Christensen.} Dr. Rowland, we want to make sure
2250 that the card isn't an empty promise. It just seems to me
2251 that when you have a Medicaid card and another card, you
2252 know, it just opens the door for bias.

2253 Ms. {Rowland.} I think there are two things to note
2254 here. One is that many of our low-income population live in
2255 medically underserved areas so much of the discussion we have
2256 had today about bringing more resources into that area is
2257 important. I think the second thing to note, however, is
2258 that we can do more to make Medicaid payment rates more
2259 equalized with the rest of the health care system and that
2260 unfortunately as we gave States greater flexibility over
2261 their programs, many of them have used that flexibility when
2262 they need to cut costs to reduce payment rates, although we
2263 do see States improve those payment rates whenever their
2264 resources are more abundant. So over the last few years
2265 before this economic downturn, many States moved to up their
2266 payment rates. I think that the most important thing is to
2267 make sure that the card provides people with access to
2268 physician services and to primary care service and I think we
2269 should note that within the Medicaid program over the last
2270 few years the advance of managed care and the use of primary

2271 care networks has helped to really secure a better access, so
2272 I do worry that in some cases the providers willing to
2273 participate in those networks are not the same as the
2274 providers willing to provide care to the privately insured.

2275 Ms. {Christensen.} Thank you.

2276 Dr. Lavizzo-Mourey, thank you for the work that Robert
2277 Wood Johnson has done, and I was really interested in the
2278 family nurse partnership program as well as the others, but
2279 we hear an argument and we asked the CBO director, several of
2280 us did over and over again about savings that would be
2281 realized by prevention and you talk about a savings that you
2282 see in the family nurse partnership program. Their argument
2283 is that we will spend more money on prevention and so we
2284 won't realize any savings and I find this a major obstacle to
2285 getting done what we need to get done and making the
2286 investment. How would you respond to that?

2287 Dr. {Lavizzo-Mourey.} Thank you for this question.
2288 When people talk about prevention, they often lump a number
2289 of issues together that really should be separated. First,
2290 you referenced the nurse family partnership program. That is
2291 a program, for those who don't know, that invests in the
2292 relationship between nurses and moms-to-be or young mothers
2293 that teaches them how to navigate the health care system but
2294 also how to provide better health for themselves and their

2295 babies so it is an investment in health that happens in the
2296 community. The benefits that accrue from that investment
2297 happen over a number of years, not 2 or 3 but really over 10
2298 to 15 years. We continue to see savings up until the child
2299 is in their adolescence. So once has to look for the savings
2300 over a long enough period of time, first of all, in order to
2301 really understand whether there are savings.

2302 Secondly, we often talk about prevention and we are
2303 really referring to clinical services, screening tests and
2304 the like, and there frankly the results are mixed on whether
2305 it is going to provide savings. However, we do know it
2306 almost always improves health and produces a better value,
2307 but one has to also separate from that prevention that occurs
2308 at the community level, community-based investments such as
2309 reducing obesity, improving physical activity, reduction of
2310 tobacco use. These have been shown time and time again in
2311 large public health studies to reduce the overall costs of
2312 care because they improve the health, and we really need to
2313 focus those three separately if we are going to answer the
2314 question of whether prevention saves money.

2315 Mr. {Pallone.} The gentleman from Illinois, Mr.
2316 Shimkus.

2317 Mr. {Shimkus.} Thank you. I am going to try to be
2318 quick. It is a huge panel. I appreciate you all coming and

2319 I apologize for being in and out like we all have to do when
2320 there is business. Let me ask a question, and if you can
2321 answer briefly and I will try to get the whole panel. It
2322 depends on how quick you answer. You know, Senator Baucus on
2323 the other side's basic premise is Medicaid for all, cover the
2324 uninsured. Would you support that, Dr. Smedley? We are
2325 hearing some bad comments on Medicaid here.

2326 Mr. {Smedley.} I believe it was Medicare for all, if I
2327 am not mistaken, which--

2328 Mr. {Shimkus.} Okay. Well, let us assume that we want
2329 to cover the uninsured through Medicaid. Would you support
2330 that?

2331 Mr. {Smedley.} Well, it is important that we ensure
2332 that everyone has comprehensive care and that--

2333 Mr. {Shimkus.} So would you support current State-run
2334 Medicaid system insuring the uninsured today?

2335 Mr. {Smedley.} I would support as broad a pool as
2336 possible.

2337 Mr. {Shimkus.} So would you support State Medicaid
2338 programs covering the uninsured of each State?

2339 Mr. {Smedley.} That is an option that can work in many
2340 States. I am sorry I cannot give you a definitive answer.

2341 Mr. {Shimkus.} Dr. Kitchell?

2342 Dr. {Kitchell.} Yes, I think that Medicaid should be

2343 expanded but I also think that we should maintain private
2344 insurance for patients who need it.

2345 Mr. {Shimkus.} Okay. Thank you.

2346 Dr. {Kitchell.} As we--

2347 Mr. {Shimkus.} That is good. I really want to go quick
2348 and I don't want to be disrespectful.

2349 Dr. Sitorius?

2350 Dr. {Sitorius.} I am going to second Dr. Smedley. In
2351 some States it will work, in others it may not.

2352 Mr. {Shimkus.} Okay.

2353 Dr. {Sitorius.} I am not answering your question. I
2354 understand that.

2355 Mr. {Shimkus.} All right. That is good to know when
2356 you are on the record because that makes a statement about
2357 the current Medicaid system.

2358 Ma'am, I don't want to butcher your name. I am sorry.

2359 Dr. {Lavizzo-Mourey.} Lavizzo-Mourey. It is a
2360 mouthful, I know. Our foundation does not advocate for
2361 specific plans but we do have principles that suggest that
2362 there are a broad array of ways to, as Dr. Smedley says,
2363 ensure that we can increase the number of--

2364 Mr. {Shimkus.} Okay, but my focus is on Medicaid system
2365 in States as we know today. Covering the uninsured through
2366 Medicaid system in States, is that a way to insure the

2367 uninsured?

2368 Dr. {Lavizzo-Mourey.} It is one way among others.

2369 Mr. {Shimkus.} So you are not going to answer either.

2370 Sir, I don't see your nametag. I apologize.

2371 Dr. {Mullan.} Mullan. I would agree it is one of a

2372 number of options. It would not be my preferred option.

2373 Mr. {Shimkus.} Great.

2374 Dr. Harris?

2375 Dr. {Harris.} Congressman, in our paper we felt that--

2376 Mr. {Shimkus.} Quicker, please.

2377 Dr. {Harris.} --consideration should be given up to 200

2378 percent of the federal poverty limit for covering people.

2379 That would capture a sizable number of these people.

2380 Mr. {Shimkus.} So you are saying yes for 200 percent of

2381 poverty?

2382 Dr. {Harris.} As part of this overall pool of people.

2383 That will in no way capture all of the uninsured.

2384 Dr. {Bean.} No. The benefits are wide but the pay is

2385 so low, you won't get participation.

2386 Mr. {Shimkus.} Dr. Rowland?

2387 Ms. {Rowland.} For the low-income population, two-third

2388 of the uninsured, expanding Medicare would make a lot of

2389 sense.

2390 Mr. {Shimkus.} For the uninsured?

2391 Ms. {Rowland.} Yes.

2392 Mr. {Shimkus.} Okay. Let me go with this question.

2393 Would you trade your current insurance policy for a Medicaid
2394 policy, Dr. Smedley?

2395 Mr. {Smedley.} No.

2396 Mr. {Shimkus.} Just go down the table. Dr. Kitchell?

2397 Dr. {Kitchell.} As I said, some private insurance--

2398 Mr. {Shimkus.} Would you trade yours for a Medicaid
2399 policy?

2400 Dr. {Kitchell.} No.

2401 Dr. {Sitorius.} No.

2402 Dr. {Lavizzo-Mourey.} My plan has things that Medicaid
2403 does not have in it.

2404 Mr. {Shimkus.} So that is a no?

2405 Dr. {Lavizzo-Mourey.} That is a no.

2406 Mr. {Shimkus.} Thank you.

2407 Dr. {Mullan.} No.

2408 Dr. {Harris.} No.

2409 Dr. {Bean.} No.

2410 Ms. {Rowland.} Yes.

2411 Mr. {Shimkus.} Thank you. We may give you that
2412 opportunity to do that.

2413 Ms. {Rowland.} Medicaid has low cost sharing and
2414 comprehensive benefits and covers a lot of services that

2415 private insurance doesn't.

2416 Mr. {Shimkus.} Obviously with the doctor's question
2417 about, or your question about someone going into a clinic,
2418 being casted as Medicaid only this line versus other lines,
2419 that is why I asked that question. It is really a follow-up.

2420 I am really involved, this is my district. I have about
2421 14 community health clinics. They service--Illinois services
2422 1.3 million Medicaid, uninsured, Medicare and for-pay folks.
2423 It has been very successful. When I first got elected to
2424 Congress, I had zero in my district. Now, the benefits of
2425 community health clinics are what? The people who practice
2426 there are protected by the Federal Tort Claims Act. It has
2427 allowed them to provide health care to the uninsured. Do you
2428 think that some model, talking about what happened with
2429 Texas, what happened in Illinois, although our legislation is
2430 being reviewed by the Supreme Court--we had medical liability
2431 reform for my neurologist. There was a time when we did not
2432 have a single neurologist south of Springfield because of
2433 medical liability. Would moving on a Federal Tort Claims Act
2434 provision on medical liability be helpful in access to care
2435 and keeping costs down? Dr. Smedley?

2436 Mr. {Smedley.} I don't know if the evidence speaks to
2437 that. Community health centers are successful not solely
2438 because of tort issues but because of--

2439 Mr. {Shimkus.} So you are saying that the fact that
2440 they don't have liability costs because they are protected,
2441 that doesn't affect the way they charge individuals?

2442 Mr. {Smedley.} No, they are--community health centers
2443 have done a marvelous job targeting the needs of low-income
2444 and underserved communities. I believe that is the primary
2445 reason that they are successful.

2446 Mr. {Shimkus.} I would beg to differ.

2447 Dr. Kitchell?

2448 Dr. {Kitchell.} Yes, I think community health centers
2449 are a good idea. We have actually--

2450 Mr. {Shimkus.} I am talking about the Federal Tort
2451 Claims Act protection on community health centers.

2452 Dr. {Kitchell.} That would help, yes.

2453 Dr. {Sitorius.} Yes.

2454 Dr. {Lavizzo-Mourey.} I practice in a community health
2455 center. I have to agree with Dr. Smedley that the reasons
2456 that they are successful have much more to do with other
2457 issues.

2458 Mr. {Shimkus.} Do you pay any liability insurance when
2459 you practice in the community health center?

2460 Dr. {Lavizzo-Mourey.} No, I do not.

2461 Mr. {Shimkus.} Okay. Thank you.

2462 Dr. {Mullan.} Health centers are distinctly successful

2463 for other causes. Is the tort protection afforded to
2464 provides there useful? Yes.

2465 Mr. {Shimkus.} Dr. Harris?

2466 Dr. {Harris.} I simply agree with Dr. Mullan.

2467 Dr. {Bean.} Yes, it would help.

2468 Ms. {Rowland.} I agree with Dr. Mullan.

2469 Mr. {Shimkus.} Thank you, Mr. Chairman. I think tort
2470 issues should be part of this health care debate. I yield
2471 back.

2472 Mr. {Pallone.} Thank you.

2473 Mr. Braley.

2474 Mr. {Braley.} Dr. Kitchell, I want to follow up on some
2475 of the points you raised in your opening statement,
2476 especially dealing with geographic reimbursement inequities.
2477 You mentioned the Geographic Practice Cost Index, also
2478 commonly referred to as GPCI, reduced fees for physicians
2479 because of where they live. In your best estimate, what is
2480 the differential in Medicare fees between the highest GPCI
2481 areas and the lowest GPCI areas?

2482 Dr. {Kitchell.} The differential is 34 percent between
2483 North Dakota, Arkansas, and then the highest area is in
2484 California.

2485 Mr. {Braley.} And then to follow up on your point, when
2486 you are out looking to replace equipment and looking for

2487 durable medical equipment that you use in your practice, have
2488 you found a similar inequity of what the cost of that
2489 equipment is based upon geographic differences?

2490 Dr. {Kitchell.} No. In fact, about 2 years ago when we
2491 decided to buy an electronic medical record, that cost of \$21
2492 million for our clinic is exactly the same as anywhere in the
2493 country.

2494 Mr. {Braley.} Can you explain in further detail how it
2495 is that these reimbursement inequities built upon a flawed
2496 GPCI formula impact access to care in rural areas?

2497 Dr. {Kitchell.} Well, there are some services that are
2498 not even paid as much as the cost of delivering those
2499 services. Let me give you an example of a cardiac
2500 defibrillator implant. The Medicare reimbursement for that
2501 is actually less than the cost of the device. So the payment
2502 for the labor, the payment for the rent, the payment for all
2503 the other services that that patient needs, Medicare pays
2504 less than the cost of that machine.

2505 Mr. {Braley.} Now, one of the solutions that has been
2506 proposed is putting a floor on GPCI inequities and we know
2507 that by enacting a 1.0 floor on work GPICs we reduce the
2508 inequity even though there is still this 8 percent
2509 differential you mentioned in your testimony. Do you feel
2510 that a 1.0 floor on practice expense GPICs would also

2511 decrease rural health care disparities?

2512 Dr. {Kitchell.} Yes, that would be our best solution.

2513 Mr. {Braley.} Earlier this year I spoke in this
2514 committee about the need for a reimbursement system that
2515 rewards quality. Can you explain how a model system might
2516 look to provide quality-based reimbursements to physicians?

2517 Dr. {Kitchell.} Yes. As I said, the PQRI program is
2518 flawed. The hospital system is doing a good job of rewarding
2519 quality. Quality needs to be rewarded for teams, groups and
2520 systems. Quality is team-based care. The medical home
2521 model, the bundled systems, the shared savings, they rely
2522 upon physicians working together with non-physicians in teams
2523 so we should be encouraging, we should be incenting
2524 physicians to be part of teams, groups and systems, and as I
2525 mentioned, the Middlesex, Connecticut, example is a great
2526 example where independent physician practices have gotten
2527 together in an accountable care organization and they have
2528 increased their quality and reduced the costs of care. I
2529 think this is a key point for Americans is to understand that
2530 by working together, physicians and non-physicians working
2531 together, we can improve quality and we can reduce costs.

2532 Mr. {Braley.} All right. Dr. Bean, I am going to
2533 follow up a little bit on your testimony because one thing
2534 that was noticeably absent from your testimony was a

2535 discussion of preventable medical errors and there has been a
2536 lot of testimony from the panel about the importance of an
2537 Institute of Medicine finding relating to access to health
2538 care but no one has mentioned the seminal Institute of
2539 Medicine study in 2000 and the follow-up study identifying
2540 the acute problem of preventable medical errors and the costs
2541 they impose on the system. So do you agree that the most
2542 effective way to reduce malpractice costs in this country is
2543 by reducing or eliminating preventable medical errors?

2544 Dr. {Bean.} I am afraid I don't agree that is going to
2545 eliminate the malpractice crisis in the areas where
2546 malpractice is used or abused. I will agree with you that
2547 the focus on preventing medical errors is not only laudable
2548 but highly necessary.

2549 Mr. {Bralley.} Well, can you explain why the existing
2550 framework for health quality oversight that is in place in
2551 this country primary through the Joint Commission on
2552 Accreditation of Health Care Organizations that is hospital
2553 specific has failed to make a measurable decrease in
2554 preventable medical errors despite the fact that their
2555 sentinel-event program has been in place for over a decade,
2556 and if you take the IOM numbers of 44,000 to 98,000
2557 preventable medical errors resulting in deaths in hospitals
2558 every year and compare that to the sentinel-event statistics

2559 from JACO which show that on average only 300 sentinel-event
2560 reports are filed per year, don't you agree that there is a
2561 gross example of underreporting of the problem and a failure
2562 on the part of the community to address it?

2563 Dr. {Bean.} No, not at all. First of all, if you look
2564 back at the studies that were done where the 44,000 to 98,000
2565 figures were drawn from, these were extracted from hospital
2566 charts in about 1982 or 1983. That is almost 30 years ago.
2567 So there has been a substantial change in hospital practices
2568 and events since then. When that extraction was done, they
2569 were extrapolated from acute charts and assumed that this was
2570 happened around the country and the medical errors and
2571 negligence were equated and that is not necessarily so at
2572 all. There are things that do happen that are not negligence
2573 so saying that the medical liability system is going to
2574 handle--is necessary to prevent all that is wrong. I think
2575 that the proper way to do it is what we are doing. We are
2576 looking at quality events, and in fact if the reporting is
2577 low, maybe that review should be done again to see if that is
2578 the reason. Maybe there has been a change over the past 30
2579 years.

2580 Mr. {Braley.} Do you think there are only 300
2581 preventable medical errors a year happening in hospitals in
2582 this country? Is that your testimony?

2583 Dr. {Bean.} No, I think that, number one, if you are
2584 asking hospitals to report things or doctors to report things
2585 in the face of a medical liability system where they can be
2586 sued for millions of dollars, your incentive to be open is
2587 blunted considerably. Change the liability system. Make it
2588 possible like airlines to report things without being so open
2589 to suits that can run you out of practice, and we can have a
2590 better system for finding and correcting errors.

2591 Mr. {Braley.} Thank you, Mr. Chairman. I would just
2592 like to point out that the reporting system I am referring to
2593 at JACO is a closed system that is not open to the public.

2594 Mr. {Pallone.} Thank you.

2595 The gentleman from Texas, Mr. Burgess.

2596 Mr. {Burgess.} Thank you, Mr. Chairman, and that is an
2597 excellent point, Dr. Bean, and I am so glad you made it
2598 because the IOM study was in fact published 10 years ago and
2599 it was from data collected 20 and 30 years ago. It is high
2600 time, Mr. Chairman, we asked the Institute of Medicine to
2601 update that study. The sentinel reporting techniques have
2602 been around for 10 years. Maybe we should look again and see
2603 whether we have made any progress. I suspect we have,
2604 because even then the data from 1982 and 1983 and the data
2605 from 1992 showed significant improvement between that 10-year
2606 span and that was not accounted for in the publication, To

2607 Err is Human.

2608 Since Mr. Shimkus took my questions, Dr. Rowland, let me
2609 just ask you, you described a Medicaid program that I just
2610 scarcely recognized. In my practice, it wasn't a workhorse,
2611 it was more like a Trojan horse and all the people got inside
2612 and then you were in trouble. But let us think about it for
2613 just a minute. You were the only one who answered
2614 affirmatively to changing what you had now for what would be
2615 available in the Medicaid system. I offered an amendment
2616 during our SCHIP debate and I may well offer it as stand-
2617 alone legislation that would allow members of Congress the
2618 option of entering the Medicaid system so perhaps they could
2619 see for themselves firsthand what patients encounter. Would
2620 that be a good idea?

2621 Ms. {Rowland.} Well, first of all, I think, sir, that
2622 you come from the State of Texas and that Medicaid programs
2623 are different in different States and so one of the issues
2624 that needs to be addressed if one is going to build on the
2625 Medicaid foundation is to perhaps make the program more
2626 standard.

2627 Mr. {Burgess.} But we had no other member from Texas on
2628 the panel here today but everyone declined the opportunity
2629 for taking an adventure into the Medicaid system. I just
2630 offer that for what it is worth. Do you think I will get

2631 many cosponsors on that legislation for Members of Congress?

2632 Ms. {Rowland.} I actually doubt it.

2633 Mr. {Burgess.} Yes, I do too.

2634 Ms. {Rowland.} But I think that it does point out that
2635 the program does need improvement as a building--

2636 Mr. {Burgess.} There is no question that the program
2637 needs improvement and I did take Medicaid patients in my
2638 obstetrics practice, and the biggest problem I had was
2639 finding a specialist to whom to refer a patient when she had
2640 a problem that was beyond my scope and capabilities, and that
2641 I think really speaks to the problem that many primary care
2642 doctors have when they open their doors to Medicaid patients.
2643 If they get a complicated abscess, if they get a complicated
2644 cardiology patient, they literally have no place to send that
2645 patient, and as a consequence they may be practicing well
2646 over their heads, and that is a patient safety issue that
2647 really should not go unaddressed.

2648 Dr. Bean, I want to thank you too for your comments
2649 about the medical liability system. Texas has I think done
2650 an excellent job. I can't take any credit for it. I have
2651 introduced the Texas legislation in Congress. The bill
2652 number is 1468, for anyone keeping scoring at home. This
2653 bill actually scores as a savings by the Congressional Budget
2654 Office. It is \$3.8 billion over 4 years. It is not a huge

2655 savings. We spend trillions of dollars at the drop of a hat
2656 now. But still, \$3.4 billion to \$3.8 billion means something
2657 to someone somewhere and I just offer this, Mr. Chairman, as
2658 a gift to help balance the budget wherever it might be
2659 helpful. I will be glad to make my modest little Texas
2660 medical liability bill available so that other States can in
2661 fact enjoy some of the things that have happened in Texas.

2662 Dr. Kitchell, in my remaining time, I couldn't help but
2663 notice that your notes were handwritten so I assume you
2664 haven't purchased that \$21 million record system that is
2665 available to you?

2666 Dr. {Kitchell.} We are in the process of phasing it in,
2667 yes.

2668 Mr. {Burgess.} I understand why because even from
2669 across the street, I can tell that your partners cannot read
2670 your handwriting. Let me just ask you a couple of questions
2671 because you have some great testimony about the PQRI which I
2672 thought was a mistake when our side pushed it at the end of
2673 2006. You say it doesn't actually reward quality it rewards
2674 reporting. There was a great article in the Journal of the
2675 American Medical Association a little less than a year ago.
2676 I unfortunately don't remember the author. It was tongue in
2677 cheek. It recommended that we diagnose liberally, don't be
2678 stingy with your diagnoses. If you make more people in your

2679 patient panel class 2 diabetics, your hemoglobin A1Cs are
2680 going to look a lot better and as a consequence you are going
2681 to get a better--your payment is going to improve. You
2682 reward, you incent the wrong type of behavior when you go
2683 down the PQRI road but I do wonder, and you have the
2684 statement that there are methodological problems, are these
2685 fatal flaws or could these be corrected? And of course, one
2686 of the biggest problems with PQRI is, we didn't pay a darn
2687 thing for anyone to gather the data. It was more expensive
2688 to try to participate than any bonus that you would get at
2689 the out end on PQRI but are the problems inherent in PQRI,
2690 are they so fatal that the program cannot be salvaged and we
2691 just need to move to a different scheme?

2692 Dr. {Kitchell.} Let me just preface this slightly. The
2693 American Medical Association physician consortium for
2694 performance improvement is developing measures of quality so
2695 we cannot only measure, we can reward quality. The AMA
2696 should take a lot of credit for developing this. They have
2697 taken the lead in measuring and rewarding quality. The PQRI
2698 program has chosen to use individual measures. The
2699 consortium is now working on more team and system measures.
2700 That is where I think we need to go. The problem with the
2701 individual measures as a physician, we don't want to be
2702 profiled. We don't want to be tiered. We don't want to be

2703 rated individuals because our patients vary. Sometimes three
2704 physicians are seeing one patient so who gets the credit, who
2705 gets the blame. That is an attribution problem. So these
2706 individual measures continue to promote fragmentation of care
2707 rather than coordination of care by teams and systems. We
2708 need to think about how we deliver care and we will do better
2709 with raising quality, giving patients safety, improving the
2710 value of their care if we measure by teams, groups and
2711 systems. So my proposal would be to change the focus of PQRI
2712 to get away from reporting. Let us do measures. And we have
2713 some composite measures now and some groups, accountable care
2714 organizations are willing to be accountable for quality and
2715 for cost. It is time we allowed those groups of physicians
2716 who are willing to be accountable for quality and willing to
2717 be accountable for their costs to let them do that.

2718 Mr. {Burgess.} Are these along the lines of the
2719 physician group practice demonstration model that CMS has
2720 been doing?

2721 Dr. {Kitchell.} Yes.

2722 Mr. {Burgess.} And I would--

2723 Mr. {Pallone.} Dr. Burgess, just one more and then--

2724 Mr. {Burgess.} I would very much favor us considering
2725 in the Medicare system, which is a federal program, if a
2726 group practice is under that accountable model, to allow

2727 them, allow that group for their Medicare patients coverage
2728 under the Federal Tort Claims Act and I think we can go a
2729 long way towards pushing what is I think a very effective
2730 policy and getting doctors to buy in, and I will yield back
2731 the balance of my time.

2732 Dr. {Kitchell.} Can I just--

2733 Mr. {Pallone.} You can answer.

2734 Dr. {Kitchell.} One last comment, and just so you
2735 understand, the physician group practice demonstration
2736 project also included independent physicians. They were not
2737 a group, a formal group. They were independent practicing
2738 physicians and they got together in groups.

2739 Mr. {Pallone.} Thank you.

2740 The gentleman from New York, Mr. Weiner.

2741 Mr. {Weiner.} Thank you, Mr. Chairman.

2742 Some of my colleagues on the other side have been
2743 engaged in a furious process of erecting straw men and then
2744 burning them down. So let me just clarify a couple of things
2745 with your help. First of all, my understanding is, the
2746 proposal by some is Medicare for all, the idea being that it
2747 is a model that people are somewhat comfortable with. It is
2748 in some interpretations this problem with this debate is that
2749 some people have gotten stirred about the idea of socialized
2750 medicine, forgetting that in fact what the social compact in

2751 Medicare has been with the exception of problems with cost
2752 reduction and things that need to be fixed, it has been a
2753 success that people appreciate. The other false choice that
2754 has been offered to us is the idea that not whether Members
2755 of Congress should be offered Medicaid but whether Medicaid
2756 citizens should be offered what Members of Congress have.
2757 That is the choice that we confront. What we are trying to
2758 do is trying to take programs that are obviously deficient
2759 and replace them with models that work better. So perhaps my
2760 colleague from Texas should offer legislation offering anyone
2761 on Medicaid the same plan that Members of Congress have.
2762 That would truly be a constructive step forward. It is the
2763 premise of our entire discussion that the Medicaid system
2764 doesn't work very well and it doesn't treat people as well it
2765 should or treat physicians the way it should or reimburse
2766 States the way it should. That is a given, and to set the
2767 straw man up that, oh, well, we have to have Medicaid for
2768 everyone, wouldn't that be a terrible thing, yes, it probably
2769 would not be anyone's desired outcome and I don't think any
2770 of the collective wisdom of the panelists would suggest that
2771 that is the seminal question despite the somewhat overly yes,
2772 no, get your answer ready kind of inquisition.

2773 Let me just now ask a question, if I could. It strikes
2774 me that Medicaid is a pretty good deal for hospitals and

2775 physicians when compared to no insurance. We actually have
2776 an experience in New York City that when there is a Medicaid
2777 patient coming in the door, a lot of the hospitals in New
2778 York are gleeful. At least they have someone with some kind
2779 of coverage, some kind of predictable repayment, some kind of
2780 a process that they know that they are going to get
2781 compensated. So yes, Medicaid looks pretty problematic to a
2782 lot of physicians except when compared to what a lot of
2783 people have, which is no coverage at all. But I want to ask
2784 a question about the impetus to get more physicians to go
2785 into primary care. It seems to me that the market is not
2786 functioning efficiently, that while there is a demand for
2787 more of those, while there are more hospitals that are
2788 looking and more of our system seems to want it, it doesn't
2789 seem like the incentives are getting built in properly. As
2790 we figure out how to contract the incentives differently in
2791 the context of a national health care plan, should we be
2792 saying we will pay you more? Should we be saying we will pay
2793 more of your medical education if you go into primary care?
2794 Should we say we are going to penalize you if you decide to
2795 be a dermatologist? I mean, what would be the model if we
2796 are going to start from scratch which to some degree we are.
2797 What would be the model that would be--and Dr. Mullan, you
2798 were the one who I heard speak most articulately about it.

2799 What do you think that we should be doing to structure it so
2800 that being a primary care physician seems like a better deal?

2801 Dr. {Mullan.} I think the important thing to know is
2802 unfortunately there is not a single prescription, a single
2803 diagnosis and single prescription here, and it is along this
2804 continuum. I think there are things that need to be done in
2805 the pipeline. There are things that need to be done in
2806 practice. And as you rightly observed, the market is not
2807 working. The market is not calibrated in practice to support
2808 people very well in primary care and that is a financial
2809 matter in terms of reimbursement. It is also a structure
2810 model in terms of the hamster on the maze or hamster on the
2811 runner-type environment that has been created by the need to
2812 churn out as many patients as possible simply to pay the
2813 rent. So the restructuring of primary care with incentives
2814 from federal payers as well as others will be hugely
2815 important to creating a primary care environment which is
2816 attractive to make the market better. But if you don't have
2817 the pipeline geared to do that, you will have ill-prepared
2818 people coming and therefore the investments, Title VII, how
2819 do we--what do we do about the medical school environment,
2820 the culture to make it more friendly to primary care,
2821 community medicine, ambulatory care and the like, and with
2822 graduate medical education how do we get more people training

2823 in those areas with very heavy federal investment in that
2824 area.

2825 Mr. {Weiner.} Can I squeeze in more one question? Is
2826 there a whole different tier of health care that we maybe
2827 need to create on the preventive side, on the diagnostic
2828 side, on the nutritional side, on the testing side? I mean,
2829 should we not think about maybe having kind of clinics or
2830 mobile things or something that go out and find people before
2831 they would go and--who might be disinclined to go into a
2832 doctor's office or a hospital? You know, we have a whole
2833 collection of senior centers, for example, in New York City
2834 that seem like a perfect place to kind of capture people, you
2835 know, in a non-medical--I don't know exactly what I am
2836 describing. I guess it is something before even primary
2837 care, you know, to kind of be a gateway thing that would--you
2838 know, we seem to all worship at the altar of getting people
2839 early, doing more diagnostic, nutrition, all these different
2840 things, but should we maybe just think about a non--I know it
2841 is tough asking, you know, a panel of doctors, but should we
2842 be thinking about maybe an extra medical type of structure
2843 that grabs people in a way that maybe gets them to do the
2844 things that might keep them out of even primary care? I
2845 don't know who is best equipped to answer that.

2846 Dr. {Lavizzo-Mourey.} I will make a couple of points

2847 and I am sure my colleagues will as well. One of the things
2848 that we know about improving the health of people is that if
2849 you can take interventions to where they live and work and
2850 learn, you can do a much better job of improving their
2851 overall health. We have learned through this school-based
2852 health clinics. We know it through community-based
2853 investments in prevention, some of which I have referenced
2854 before, investments in increasing people's physical activity,
2855 reducing obesity and so on. So I would agree with you that
2856 there is an investment that needs to be made in going to
2857 where people actually spend the bulk of their time, which is
2858 not in a doctor's office or a health care setting.

2859 The other point I would like to just make is that we
2860 have talked a lot about reimbursement and adjusting that. We
2861 haven't really talked about the ways in which medical
2862 practice has changed and needing to keep up reimbursement
2863 system that mirrors that. Patients want to get care, not
2864 visits. They want to get phone calls, e-mails and other ways
2865 to allow them to manage their own care outside of a doctor's
2866 office. We don't really have a reimbursement system that
2867 encourages and incents that.

2868 Mr. {Weiner.} Thank you.

2869 Mr. {Pallone.} The gentleman from Georgia, Mr. Gingrey.

2870 Mr. {Gingrey.} Mr. Chairman, I thank you. I just want

2871 to say before I get into the questions that this straw man
2872 scenario that my friend from New York said we Republicans
2873 have adopted has been taken to perfection by the Democratic
2874 majority including President Obama, and I think it is
2875 probably time for both sides to stop doing that as we work in
2876 a bipartisan fashion to try to solve this health care reform
2877 issue. It is hugely important, and I think we can do it. I
2878 sincerely believe that we can do it.

2879 With that, let me turn to Dr. Bean actually. Dr. Bean,
2880 in your testimony you noted in his health care reform white
2881 paper, Senator Baucus acknowledged that the current legal
2882 environment leads to the practice of defensive medicine.
2883 That was his quote. I would like for you to elaborate on
2884 what constitutes defensive medicine and discuss the costs
2885 associated with this practice. If you remember, during the
2886 debate between former President Bush and candidate Senator
2887 John Kerry, in one of the debates that was brought up, and
2888 Senator Kerry said well, you know, the actual premium cost of
2889 malpractice insurance is although high for the individual
2890 doctor, not a significant number, but that is not the real
2891 cost and I wish you would explain to my fellow colleagues on
2892 the committee and those in the room what the real costs are
2893 in regard to that.

2894 Dr. {Bean.} Mark McClellan did a study back in the

2895 1990s, I think it was. The Health and Human Services used
2896 that as a basis of a 2003 study and found that the excessive
2897 tests prescribed to be certain and protect yourself from
2898 liability would cost at that time somewhere between about \$45
2899 to \$129 billion. Now, that updated--

2900 Mr. {Gingrey.} Per year?

2901 Dr. {Bean.} Per year in the health care system. That
2902 updated today would be about \$170 billion, and the study is
2903 debated but I think it is difficult truly to tell what is in
2904 the back of a doctor's mind. There is the diagnostic thing
2905 but there is the fear that is lingering in the back that if
2906 you don't cover everything, you are subject to unmerciful
2907 liability, unprotected liability. If this were taken care
2908 of, I think there would be a substantial reduction. The
2909 other issue about the premium, it is quoted to be a half
2910 percent of medical costs. Of course it is trivial because it
2911 is just a small proportion of doctors with population
2912 sustaining it. It is that bigger cost, if it is a cost issue
2913 that can be saved.

2914 Mr. {Gingrey.} Dr. Bean, thank you, and I am going to
2915 turn now to Dr. Harris because I actually back in 2005 when I
2916 introduced liability reform, tort reform here in the House, I
2917 got a letter from American College of Physicians and it said
2918 of course supporting my position on medical liability reform

2919 legislation. The American College of Physicians stated that
2920 there is ``strong evidence that the health care liability
2921 crisis resulted in many patients not receiving or delaying
2922 much-needed medical care.'' Dr. Harris, could you please
2923 explain to us how the medical liability crisis has negatively
2924 impacted access to needed medical care for millions of
2925 Americans?

2926 Dr. {Harris.} Well, I think that gets to the point that
2927 Dr. Bean was making and whether there is an element of
2928 apprehension about doing things by virtue of the threat of
2929 malpractice. I mean, it is our belief that liability reform
2930 should be part of this large effort to reform the health care
2931 system in this country, and as you know, we favor putting a
2932 cap on non-economic damages but we also think that in the
2933 middle of all this there needs to be some thought and look at
2934 the potential for other options. As you are all aware, the
2935 testing of expert courts is one that has been considered, but
2936 before making such a momentous step, we would applaud looking
2937 broadly to see what are the other options.

2938 Mr. {Gingrey.} Thank you, Dr. Harris.

2939 And in my remaining time--Mr. Chairman, remember I did
2940 waive my opening statement--Dr. Rowland, in your testimony
2941 you talked about the Medicaid program and that you
2942 recommended maybe Medicaid as a platform for extending

2943 coverage to the 45 million or so uninsured and maybe not
2944 quite that many who are underinsured. You know, when I
2945 practiced, I can tell you that there is a bias against
2946 Medicaid recipients. Of course, some doctors won't even
2947 accept Medicaid because of the low payment, but even though
2948 that do, I think that there probably is a stigma, and
2949 certainly if we use the best Medicaid program in the country,
2950 of course, all 50 are different but if you took the best as
2951 the model to offer to those who are uninsured, how do you get
2952 beyond that stigma? Maybe in the brief time, I guess I have
2953 at least another minute, for you to respond to that question?

2954 Ms. {Rowland.} Thank you. What we have seen in the
2955 implementation of the CHIP program as a companion to Medicaid
2956 and many States restructured, renamed their Medicaid program
2957 and tried to eliminate some of the stigma attached with it
2958 being a heritage program from the welfare days and have found
2959 that in Connecticut, for example, the HUSKY program was very
2960 popularly received and people didn't distinguish it. When we
2961 do surveys of the individuals who have uninsured children and
2962 ask them about access to public programs, they say they would
2963 enroll if they were eligible. They aren't always aware that
2964 they are eligible and perceive these programs to be a good
2965 program. I think the other point though that one has to make
2966 is that when we look at all the survey research over the

2967 years, Medicaid and private insurance do relatively the same
2968 in terms of access to care and access to care measures for
2969 the populations they serve always far better obviously than
2970 being uninsured. So while we have a provider participation
2971 issue and that could be corrected obviously by improving the
2972 way in which providers are paid and we have a primary care
2973 delivery system now that is being used in many States to
2974 promote better care, it is important to really look at the
2975 overall structure and eliminate some of these State-by-State
2976 variations so that it is a better base program for those low-
2977 income individuals for whom private insurance with high
2978 deductibles and large amounts of cost sharing may not be
2979 adequate, but especially for the population that Medicaid now
2980 serves, those with severe disabilities and chronic illness
2981 where the scope of benefits for Medicaid is equally important
2982 to the fact that it has low levels of cost sharing. So I
2983 think you really need to look at the population being served.
2984 And finally, I would say you also need to recognize that
2985 Medicaid is far more than a health insurance program and that
2986 the majority of its dollars are spent on long-term care and
2987 assistance to the elderly and people with disabilities that
2988 go well beyond what we are talking about in terms of the
2989 federal health insurance benefit plan or any other private
2990 health insurance plan.

2991 Mr. {Gingrey.} Dr. Rowland, thank you, and Mr.
2992 Chairman, thank you for your indulgence.

2993 Mr. {Pallone.} Thank you.

2994 Ms. Capps.

2995 Ms. {Capps.} First of all, let me thank the panel for
2996 your persistence and endurance, I guess, with this long
2997 morning, and I was called many other places but I couldn't
2998 miss coming back to address your statement, Dr. Lavizzo-
2999 Mourey. Thank you for highlighting the role of nurses and
3000 our nursing shortage. It is not the only topic on the table
3001 but it is often not on the table so I want to thank you for
3002 being here and to present that large element in health care.
3003 In your written testimony you mentioned the need to increase
3004 the number of nurses with baccalaureate degrees to create
3005 larger pools of nurses who would qualify among other things
3006 for careers in teaching. What efforts do we need to do? I
3007 would like to really zero in on this, and then one other
3008 topic, school-based health clinics that I know you are very
3009 good at as well to bring to our attention and get on the
3010 record here. What efforts need to occur at the federal level
3011 to increase the proportion of nurses with this level of
3012 education?

3013 Dr. {Lavizzo-Mourey.} One of the key issues is funding
3014 for scholarships and other financial aid programs for nurses

3015 at the baccalaureate level and for nurses who are
3016 transitioning from associate to baccalaureate. We know that
3017 these programs over the last 20 years have decreased and in
3018 the past have been a major source of financial support for
3019 nurses and I would encourage every effort to be made to
3020 enhance those.

3021 Ms. {Capps.} Thank you, and it is so clear that given
3022 the cost-of-living increases, we have less money from federal
3023 dollars in nursing education today than we did in the 1970s,
3024 and with our shortage, this is something I hope we can do our
3025 part in remedying. Of course, recruitment and financial aid
3026 is one piece of it. Retention is another. You mentioned, I
3027 would love to have you explain a little bit more for all of
3028 us, the need to retain newly licensed nurses at the bedside
3029 and particularly the work of the Robert Wood Johnson
3030 Foundation in the area that you are calling Transforming Care
3031 at the Bedside project. Briefly describe this because I
3032 still want to get to school-based health clinics so that we
3033 can understand that this is a very important example and
3034 there are other examples as well as to how we can keep nurses
3035 engaged in the delivery of health care.

3036 Dr. {Lavizzo-Mourey.} One of the things we recognize is
3037 that the pipeline for nurses entering the field is being
3038 eroded by the number of nurses that are leaving the field and

3039 these are often among the most experienced clinicians and
3040 they have demonstrated, particularly when they are trained at
3041 the baccalaureate or above level, that it decreases medical
3042 errors, poor outcomes and the like. So efforts that will
3043 enhance the retention of experienced nurses will directly
3044 impact the shortage.

3045 The program that you mentioned, Transforming Care at the
3046 Bedside, really focuses on trying to develop a cadre of
3047 nurses who understand the needs at the bedside and can make
3048 changes at the nursing level but then also disseminate those
3049 changes throughout the hospital and to other hospitals that
3050 empower nurses to do the best for patients, improve the
3051 patient centeredness and in the process improve the quality
3052 of care. So it really speaks to the issues that nurses often
3053 give for leaving the profession or leaving a particular
3054 institution that are non-financial, that is, not being able
3055 to deliver the quality of care that they feel they were
3056 trained to deliver. That is really the core issue that
3057 Transforming Care at the Bedside addresses.

3058 Ms. {Capps.} It is very important, thank you, that we
3059 have this ingredient really strong front and center in our
3060 efforts to reform health care delivery. One other thing, you
3061 mentioned the work of the Robert Wood Johnson Foundation in
3062 addressing health care needs of our Nation's children by

3063 investing in school-based centers across the country. I have
3064 long felt this. It is not just a bias because I have been a
3065 school nurse for so many years. Families trust their
3066 neighborhood schools. They will come there, not just the
3067 schoolchildren but the whole family. That is a good place to
3068 delivery care and we should be thinking about this as a cost-
3069 effective means and I would like to have you address it,
3070 because one of the problems is and I know this very
3071 personally is the shortage of school nurses and others.
3072 Nurse practitioners can deliver great care within the school
3073 setting but that is exactly where we are short supply.

3074 Dr. {Lavizzo-Mourey.} Your points are very well taken.
3075 There are 1,500 school-based clinics around the country and
3076 they have demonstrated that by providing care in the local
3077 environment, the school is a local environment, it is a
3078 trusted area that is close to where people need to get care,
3079 you can improve mental health services, you can improve
3080 primary care services and other services that the children
3081 and, as you mentioned, their families would not otherwise
3082 receive. So these are cost-effective ways of delivering care
3083 in the community that addresses, I think, some of the issues
3084 that Dr. Smedley was mentioning. People need to be able to
3085 get care close to where they live.

3086 Ms. {Capps.} Thank you, and I only wish I had time to

3087 ask some of the others on the panel for your thoughts because
3088 it seemed like I picked the one person who talked about
3089 nurses but I think there might be other agreements among the
3090 panel members that these are areas that we should rightly
3091 pursue. Thank you very much.

3092 Mr. {Pallone.} Thank you.

3093 The gentleman from Maryland, Mr. Sarbanes.

3094 Mr. {Sarbanes.} Thank you, Mr. Chairman. Thanks to the
3095 panel. Congresswoman Capps, you needn't have worried that
3096 the topic won't be continued because I am going to ask you
3097 the same questions, particularly about school-based health
3098 clinics. It is great that we have 1,500 school-based clinics
3099 across the country but that is a complete drop in the bucket
3100 in terms of what we could use them for, and Representative
3101 Weiner introduced this concept of sort of creating a
3102 different kind of infrastructure for delivering certain kinds
3103 of care. I am very interested, and the school-based health
3104 clinic falls right within this, in the concept of placed-
3105 based health care, and I think you addressed this, but let us
3106 go where people are. I mean, we can walk down the hall here
3107 and there is a clinic. There is a nursing station suite that
3108 we can stop into and it makes perfect sense to have those
3109 resources on site where you can capture certain populations.
3110 It is so obvious to me and clearly other members of the

3111 committee as well and members here in Congress that our
3112 schools represent a huge opportunity to do this. I practiced
3113 health care law for 18 years but for 8 of those years I was
3114 part time as a health care attorney and part time working 20
3115 hours for the State superintendent of schools so I was in
3116 schools, and of course what I kept seeing was the impediments
3117 to education that were represented by the health status of so
3118 many of the students and the need they had to get these
3119 services.

3120 So I would like any others who would like to join this
3121 conversation to talk about this concept of place-based health
3122 care, and we can we also view it--I would like you to speak
3123 in terms of addressing the workforce issues, internships,
3124 residencies and other things that are associated with those
3125 structures, and I would add as well the concept of medical
3126 home which is typically talked about when you are addressing
3127 the individual's care but I think we should be thinking in
3128 terms of the medical home for certain communities, so in
3129 other words, the medical home for a school is that clinic.
3130 The medical home for a naturally occurring retirement
3131 community where people are aging in place, you know, in
3132 significant levels would be a clinic. In the school, it
3133 could be a clinic that is being staffed by not just nurses
3134 but pediatricians so you can get the workforce issue there.

3135 In a clinic where people are aging in place, it is a way to
3136 expand the geriatrician workforce, et cetera, et cetera. So
3137 speak to place-based health care as really potentially being
3138 a revolution in the way we address a lot of these needs and
3139 the public health needs. Anybody who wants to jump in?

3140 Mr. {Smedley.} Congressman, I would just echo your
3141 thoughts. A focus on place and on communities can help us to
3142 really think more creatively about how to prevent illness in
3143 the first place and as a result lower health care costs. The
3144 examples that Representative Weiner gave of beginning to
3145 emphasize prevention are critically important. One of the
3146 things that we haven't talked about is good community-based
3147 primary prevention. A recent report by the Prevention
3148 Institute showed that if we invest just \$10 per person per
3149 year for 5 years, we can save \$16 billion in health care
3150 costs by helping people to avoid illness in the first place.

3151 Mr. {Sarbanes.} Anyone else? Yes.

3152 Dr. {Harris.} The American College of Physicians I
3153 don't believe has policy per se about community-based
3154 clinics. However, obviously the notion of primary care
3155 physicians in schools, pediatricians and then the family
3156 practitioners and internists in settings in adult settings,
3157 we have said that the patient-centered medical home is not
3158 the only solution, that we may need to redefine, and the

3159 ultimate product will be quite different and perhaps along
3160 the lines that you are suggesting.

3161 The last point which I believe is relevant to this is
3162 what was alluded to, the role of nurses or nurse
3163 practitioners in this outreach program. The American College
3164 of Physicians met with much of the leadership of the nurse
3165 practitioner community last July to talk about we can work
3166 collaboratively to try and expand in this team-based concept,
3167 and Mr. Sarbanes, as you may be aware, we just published a
3168 paper in which we felt that this Medicare demonstration
3169 projection with the notion that homes may in certain areas be
3170 headed by a nurse practitioner, not necessarily a physician,
3171 obviously within the scope of practice of nurse
3172 practitioners, but it does get to the idea that the end
3173 product of this discussion will probably be a very varied set
3174 of options and not one simple solution to our health care
3175 needs.

3176 Mr. {Sarbanes.} Thank you all. The other day I was
3177 thinking about which level of schools is it most important to
3178 have these health centers in, so elementary, you think about
3179 elementary and it is obvious why you should have that kind of
3180 resource there. Then you think about middle school and it is
3181 absolutely obvious why you would need it there. And think
3182 you think about high school and it is beyond obvious why you

3183 would need it there. So 1,500, like I said, it is a starting
3184 point and we also have to make sure that the financing
3185 mechanism for these centers is one that is not subject to the
3186 typical way education gets funding because then they will
3187 just sort of come and go depending on the situations that the
3188 schools face. So anyway, we will continue to pursue this
3189 topic. Thank you for your testimony.

3190 Mr. {Pallone.} The gentlewoman from Florida, Ms.
3191 Castor.

3192 Ms. {Castor.} Thank you very much.

3193 Just picking up on what Mr. Sarbanes and Ms. Capps were
3194 saying, I want to ask a quick SCHIP question. Years ago the
3195 precursor to SCHIP started in Florida under Governor Lawton
3196 Chiles. It was conceived early on as making it as easy as
3197 possible for parents to enroll their children in health
3198 insurance when they started school, when they started the
3199 school year. Unfortunately, in the intervening years the
3200 political leadership in Florida changed and folks there saw
3201 enrolling kids as a cost rather than an investment and we
3202 lost a lot of ground and we lost that link between the start
3203 of school and signing up children for health insurance,
3204 making sure they got their checkups and immunizations. Are
3205 States across the country, do other States still have that
3206 link?

3207 Ms. {Rowland.} Many states really use and the Johnson
3208 Foundation has helped to promote through its Covering Kids
3209 initiative the first day of school as a real day to try and
3210 alert parents to the fact that their children may be
3211 eligible. There is more than can be done to use the schools
3212 as an enrollment facility and to simplify the enrollment but
3213 it has been one of the main outreach focuses for many of the
3214 States in their efforts to enroll more children and I think
3215 it is a very critical place in the community for people to
3216 come. One of the things I was going to note is in New
3217 Orleans where Katrina destroyed so much of the health care
3218 system, they are rebuilding it community by community and
3219 using the schools as really the focus for where they put
3220 their clinics and for where they organize their services
3221 which will also help contribute to more people being able to
3222 gain access and participate.

3223 Dr. {Lavizzo-Mourey.} I would just add that there are
3224 other ways for people to find out about SCHIP but there are
3225 other areas, other locations where people naturally gather
3226 than can be used to increase enrollment and tying enrollment
3227 to other kinds of services like school lunch programs and the
3228 like, makes it easier for parents to make that linkage and
3229 not have to go to extraordinary ends to actually get enrolled
3230 and stay enrolled.

3231 Ms. {Castor.} Yes, I was surprised to learn when I had
3232 my local housing authority director paying a visit on a
3233 totally separate topic, he said back a few decades ago the
3234 housing authorities used to have very expansive clinics in
3235 some urban areas. That makes a lot of sense. In my urban
3236 county in Tampa, Florida, it is Hillsborough County, it is
3237 about 1.2 million people, about 15 years ago there was a fork
3238 in the road. They were paying for very expensive care in our
3239 emergency rooms out of property taxes. I said there must be
3240 a better way, and said instead, let us shift from property
3241 taxes to a different revenue source. We would take a half-
3242 cent sales tax and develop this collaborative effort with the
3243 hospitals and doctors and community health centers and have
3244 established a number of neighborhood clinics that really out
3245 in the neighborhoods. Some community health centers and then
3246 other hospitals have their own clinics where their doctors
3247 have to take turns and teaching hospitals, a lot of the
3248 residents from the University of South Florida are there, and
3249 it is a model program, and I know there are some other models
3250 in San Antonio and I believe in Oakland. How do we--as part
3251 of this health care reform effort, how do we incentivize
3252 these communities? What is going to be the role? I don't
3253 want health care reform to happen in a vacuum. There are
3254 some good things going on out in the world.

3255 Dr. {Lavizzo-Mourey.} I am familiar with some of those
3256 programs because our foundation helped fund many of them, and
3257 I think before I address the issue of incentives, let me just
3258 speak to one of the major disincentives that was operational
3259 in many of those programs. They were, as you say, locally
3260 generated, addressed the needs of the local population but
3261 many of them found that they could not sustain themselves
3262 because the base was not large enough to cover the costs of
3263 people's insurance and health needs over a longer period of
3264 time, and that is really one of the things that has made us
3265 favor federal programs that can ensure that these locally
3266 generated programs actually have the funding base to provide
3267 care not just in prosperous times but also in times when the
3268 community is not as prosperous.

3269 In terms of the incentives, I think one of the things we
3270 saw in putting out applications for these kinds of programs
3271 is that communities do know the kinds of services that they
3272 need and they will come together and organize to provide
3273 those kinds of services, so I think that providing that kind
3274 of a mechanism is going to be a valuable incentive.

3275 Ms. {Castor.} And it takes money. The administrative
3276 costs are very low. They aren't any HMOs involved. It is
3277 administered by the county and the hospitals love it because
3278 they are getting compensated for medical services that

3279 otherwise would go uncompensated and charity care. But if
3280 you have some other ideas and examples of communities that
3281 have programs like that that are working, I would appreciate
3282 it.

3283 Thank you, Mr. Chairman.

3284 Mr. {Pallone.} Thank you. I think that concludes our
3285 questions but I really want to thank you all for being here
3286 today. I know it was a large panel, it covered a lot of
3287 things, but it was very worthwhile in our efforts to put
3288 together reform legislation. The way it works, you may get
3289 additional questions in writing and then we would ask you to
3290 respond in writing, I think within the next 10 days or so.
3291 But again, thank you for your input. As you can see, there
3292 is really a lot to cover here but we are determined to move
3293 forward with reform this year.

3294 So without objection, the meeting of the subcommittee is
3295 adjourned.

3296 [Whereupon, at 1:10 p.m., the subcommittee was
3297 adjourned.]