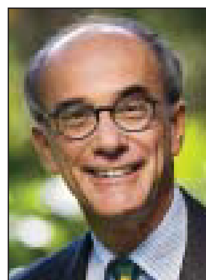
ACP Calls State of Nation's Health Care 'Poor'

BY JOYCE FRIEDEN

Expansion of the primary care workforce is necessary to improve the "poor" state of the nation's health care, according to Dr. Jeffrey P. Harris, president of the American College of Physicians.

"We have too many uninsured. We have too few primary care physicians. We spend more for health care and get less in return than most other industrialized countries," Dr. Harris said during the ACP's annual "State of the Nation's Health Care" briefing, which was held in Washington. He noted that "at this same event in 2006, the American College of Physicians warned that primary care was nearing collapse in the United States. Regrettably, primary care is in even more critical condition today than it was just 3 years ago."

Dr. Harris cited a recent report from the Institute of Medicine, which showed that 16,000 additional primary care physicians are needed to meet the current demand in underserved areas. "The primary care shortage is occurring at a time when the need for primary care is greater than ever," he said. "An aging population, with growing incidences of chronic illness, will increase the demand for general internists and other primary care doctors."



'Regrettably, primary care is in even more critical condition today than it was just 3 years ago.'

DR. HARRIS

The college has found that nations in which primary care physicians make up 50% of the total physician workforce have better outcomes and lower health care costs, according to Dr. Harris. Therefore, "we are calling for the federal government to convene an expert advisory group to recommend specific targets and the numbers and proportion of primary care physicians appropriate for the United States," which has only 30% primary care physicians in its workforce.

Robert B. Doherty, the ACP's senior vice-president of governmental affairs and public policy, outlined steps the college would like to see the government take to increase the number of primary care physicians:

► Make primary care compensation competitive with other specialties. "Specifically, a market and price sensitivity analysis should be conducted to set specific benchmarks for improving primary care compensation so that it is competitive with other career and specialty choices," Mr. Doherty said.

For instance, Dr. Harris said that Medicare payment increases of 7.5%-8% per year over 5 years would be needed to bring primary care compensation to 80% of that of all other specialties. Right now, the average compensation of primary care doctors is about 55% that of their non–primary care colleagues. Commercial payers would need to implement comparable increases.

► Expand the patient-centered medical home model to more states, more practices, and more patients. "This innovative model of primary care delivery offers enormous potential to improve quality and lower the costs of care, especially for patients with chronic illnesses," Mr. Doherty said.

► Conduct a systematic review of the paperwork burdens on primary care doctors that detract from the time they can spend with patients, and that add to physician dissatisfaction.

► Increase funding for primary care training programs and create new programs to eliminate medical education debt for internists, family physicians, and pediatricians who agree to provide primary care in a critical shortage area or clinic.

► Implement reforms to improve quality and efficiency of care for all patients, including those seen by specialists. This would include revising the Sustainable Growth Rate formula that governs Medicare payments, improving the Physician Quality Reporting Initiative, funding independent research on the comparative effectiveness of different treatments, and helping physicians acquire health information systems, Mr. Doherty said.

The ACP is making one additional request, Mr. Doherty added: President Barack Obama should consider issuing an executive order to "ensure that all federal agencies are working together seamlessly to design, implement, measure, and evaluate programs to increase primary care workforce capacity." ■

IOM Panel Outlines Strategies to Improve Adolescent Care

BY JEFF EVANS

Health care services in the United States for adolescents are fragmented, leaving gaps in care that "safety-net" resources cannot fill, especially for those who are uninsured or vulnerable to risky behavior or poor health, according to a report issued by the Institute of Medicine and the National Research Council.

The report, "Adolescent Health Services: Missing Opportunities," calls on federal and state agencies, private foundations, and insurers to develop a health care system that fosters coordination between primary and specialty care, as well as a way for primary care services to reach adolescents in safety-net settings, such as hospitals, community- and school-based health centers, and youth development programs. The report defines adolescents as individuals 10-19 years of age.

"Adolescents have unique health needs, and our health system should not approach their care the same way it does children or adults," Dr. Robert S. Lawrence of Johns Hopkins University, Baltimore, said in a written statement. Dr. Lawrence is the chair of the 19-member committee that issued the report.

The Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development advised that disease prevention, health promotion, and behavioral health should be major components of routine health services. It also acknowledged that primary care providers will need adequate financial support from payment systems in order to manage and coordinate specialty services.

Public and private programs within communities will be required to manage referrals between providers of primary care services and other health services, the committee determined. Electronic health records could assist in this regard by providing opportunities for messaging, reminder services, and personalized health education services to improve interventions, especially for adolescents who may be most vulnerable to risky behavior or poor health. This population includes adolescents who are poor; are members of ethnic or racial minorities; are recent immigrants; are in foster care; are in the juvenile justice system; or are lesbian, gay, bisexual, or transgender.

The committee said that many of the existing specialty services in mental health, sexual and reproductive health, oral health, and substance abuse treatment "are not accessible to most adolescents, nor do they always meet the needs of many adolescents who receive care in safety-net settings," especially if confidentiality is not fully ensured.

The system of mental health services for adolescents is especially uncoordinated and fragmented because of financial barriers, gaps in eligibility, and concerns about confidentiality and privacy.

Throughout the report, committee members recommended that federal and state policy makers should continue to support laws that enable adolescents to give their own consent for health services and to receive services confidentially when necessary, such as for contraception, mental health care, and substance abuse treatment.

In the report, the committee proposed several options for federal and state policy makers to develop to ensure that all adolescents have comprehensive, continuous health insurance coverage:

► Require states to provide Medicaid or other forms of insurance coverage for vulnerable or underserved adolescents.

► Design and implement Medicaid and State Children's Health Insurance Program policies to increase enrollment and retention of eligible but uninsured adolescents.

► Improve incentives for private health insurers to provide coverage, such as by requiring school-based coverage and allowing nongroup policies tailored to adolescents.

Because physicians and other health care providers frequently lack the skills to interact effectively with adolescents, the report advised that those who serve adolescents should receive a "specific and detailed education in the nature of adolescents' health problems and have in their clinical repertoire a range of effective ways to treat and prevent disease in this age group, as well as to promote healthy behavior and lifestyles within a developmental framework." These skills should also be a part of the minimal set of competencies that need to be demonstrated for the licensing, certification, and accreditation of providers, according to the committee.

The report was sponsored by the Atlantic Philanthropies Ltd., an international charitable foundation. ■

INDEX OF ADVERTISERS

BioPelle, Inc.
Auriderm 9

CORIA Laboratories, Ltd.
Cloderm 7-8

CosMedical Technologies, Inc.
Corporate 29

DPC Dermatopathology Consultants
Corporate 14

DUSA Pharmaceuticals, Inc.
Levulan 43-44

Galderma Laboratories, L.P.
Cetaphil 5
Corporate 17, 55
Metrogel 21-22
Tri-Luma 25-26
Vectical 30-32, 55
EpiDuo 36-38
Clobex 50a-50b

Graceway Pharmaceuticals, LLC
Aldara 10, 33-34
Corporate 19
Atopiclair 23

Intendis Inc.
Finacea 45-46

Merz Pharmaceuticals
Naftin 39-40

NeoStrata
Psorent 41

OrthoNeutrogena
Retin-A Micro 3-4
Biafine 13
Ertaczo 59-60

Spear Dermatology Products, Inc.
Tretinoin 34a-34b

Stiefel Laboratories, Inc.
Extina / Xolegel 14a-14f

Unilever
Vaseline 49

Wyeth Pharmaceuticals Inc.
Enbrel 26a-26d, 27, 46a-46d, 47