MD Shortage Yields the Unexpected

BY JOYCE FRIEDEN
Senior Editor

CRYSTAL CITY, VA. — Suppose the federal government has designated your part of the state as a physician shortage area, but charges haven't gone up and you still have lots of openings for new patients in your practice. Does that mean there's really not a problem getting care? Not necessarily, according to Carol J. Simon, Ph.D.

The usual symptoms of a "demand-driven" physician shortage are waits to see providers, new patients being turned away, and rising prices, Dr. Simon said at the 2008 Physician Workforce Research Conference. However, "we don't find a lot of systematic evidence of demand-driven shortage in [federally] defined primary care shortage areas. What we do find … is a lot of evidence of inadequate demand—inability to pay and inability to access the care that patients may need."

To find out more about access problems, Dr. Simon, vice president at the Lewin Group, a health care consulting firm, and her colleagues sent surveys to 2,834 primary care physicians in five states: California, Georgia, Illinois, Pennsylvania, and Texas. About half the physicians surveyed were pediatricians; 15% were African American or Hispanic. The response rate was 69% (n = 1,967).

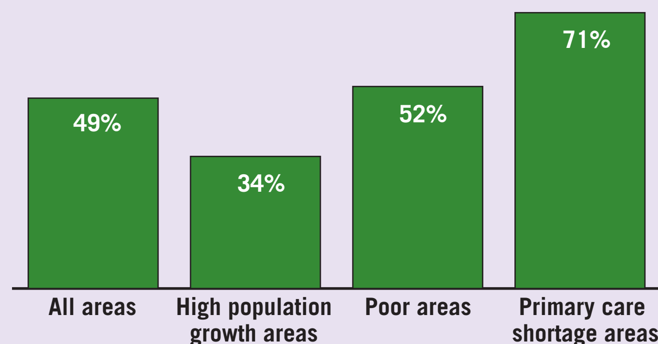
According to their preliminary findings, 49% of respondents overall were accepting all new patients, while 44% accepted some and 7% accepted none. But those numbers changed when looked at by the type of area surveyed. For example, in areas designated as having a primary care shortage, 71% of physicians were accepting all new patients, compared with only 34% of physicians in areas of high population growth and 52% of physicians in poor areas.

As to the growth in physician incomes, the data were not consistent with a lack of providers, Dr. Simon said at the meeting, which was sponsored by the Association of American Medical Colleges and Harvard Medical School. Over a 3-year period, physician incomes dropped an average of 4% per year in shortage areas, compared with a 5% annual increase in high-growth areas and a decline of 1.6% per year in poor areas. Physician incomes as compared with the national average also were not consistent with shortage designations: incomes of physicians practicing in designated shortage areas were found to be at 89% of the national average, compared with 107% for physicians in high-growth areas and 78% for physicians in poor areas.

The researchers also looked at a particular example of delayed follow-up care: follow-up exceeding 4 weeks for mild persistent asthma. There was little difference between the amount of delayed follow-up that occurred in the designated shortage areas and high-growth areas, but poor areas had a slightly higher percentage (see box). "It's hard to tell whether this is evidence of capacity issues or [of] scheduling difficulties," said Dr. Simon.

The results seem to suggest that in designated shortage areas, "the immediate need may be to bolster willingness and ability to pay for care—that is, [increasing] insurance coverage and incomes," she said. "Increasing supply alone in the absence of a basis for paying for care could threaten the financial viability of system providers."

In areas with high population growth, "there is indeed evidence of [lines], longer follow-up times, practices closed to new patients, and upward pressure on income and prices," she said. "Here, increasing supply will promote access to services and mitigate cost increases. Clearly we're seeing pressure in some areas not historically defined as shortage areas." ■



Feds Spell Out Strategic Plan for Health IT

BY MARY ELLEN SCHNEIDER
New York Bureau

If the feds have it their way, 40% of physician offices will be using certified electronic health records by 2012.

The goal is part of a strategic plan for coordinating the federal government's health IT efforts over the next 4 years, and seeks to further progress toward President Bush's goal, set out in 2004, that the majority of Americans to have access to an electronic health record (EHR) by 2014.

About 14% of physicians had adopted some form of health information technology (IT) by 2007, according to the Office of the National Coordinator for Health Information Technology, which released the strategic plan. The plan calls for removing business barriers and disincentives for adoption of EHRs and providing training and technical assistance. For example, it says by next year, information on low-cost and effective provider support on EHR adoption should be available online.

The plan also calls for increasing the health IT workforce by training more standards developers, ensuring vendors are trained in the implementation of health IT tools, and training physicians and other providers in informatics. It also highlights the need to address physician concerns about liability risks related to the exchange of electronic health information.

In addition to issues related to adoption, the plan lays out goals for achieving patient-focused health care through electronic health record access, and enabling the use of electronic health data to benefit public health, research, and emergency preparedness.

"[The plan] establishes the next generation of health IT milestones to harness the power of information technology to help transform health and care in this country," Dr. Robert Kolodner, national coordinator for health information technology, said in a statement.

The goals are all positive, said Dr. Steven Waldren, director of the Center for Health Information Technology at the American Academy of Family Physicians, but the plan does not sufficiently emphasize the need to provide financial incentives to physicians for purchasing and using electronic health record systems. "The real bottom line is getting the payment reform that is needed in health care today."

The strategic plan represents a "reasonable approach" going forward and gives a sense of how to achieve the President's objective of greater access to EHRs, said Dan Rode, vice president of policy and government relations at the American Health Information Management Association. Many of the items don't have specific timetables for completion but will instead be reassessed in 2010, he said, leaving a lot to be accomplished before 2014.

And while the plan outlines the objectives envisioned by the current administration, the goals and strategies could change with a new president who may be proposing changes to the way health care is delivered, Mr. Rode said.

The plan was developed by the Office of the National Coordinator for Health IT in collaboration with 12 agencies within HHS, and the Departments of Commerce, Defense, and Veterans Affairs, and the Federal Communications Commission. The National Committee on Vital Statistics and the American Health Information Community also contributed. ■

The strategic plan is available online at www.hhs.gov/healthit.

Private Groups Roll Out Health Reform Plans

BY MARY ELLEN SCHNEIDER
New York Bureau

In addition to the presidential candidates, other players in the health care arena are also unveiling their own detailed plans to provide health care coverage for all or most Americans.

The Commonwealth Fund's proposal, called "Building Blocks," seeks to cover 44 of the 48 million Americans estimated to be uninsured in 2008. At the center of the proposal is a national health insurance connector that would allow small businesses and individuals without large employer insurance to shop for a health plan.

The connector would feature private plans and a "Medicare Extra" option. The latter would offer monthly premiums of $259 for individuals and $702 for families, 30% lower than the average premium charged to employers today, said the Commonwealth Fund, a private foundation that supports research on health policy reform.

The plan also calls for expanding Medicaid and the State Children's Health Insurance Plan to cover all adults and children below 150% of the federal poverty level and would include individual and employer mandates for health coverage.

Using modeling from the Lewin Group, the Commonwealth Fund estimated the proposal would add $15 billion to current total health spending in the United States during the first year and about $218 billion over 10 years. But it could save $1.6 trillion over 10 years if it is combined with other reforms such as changing Medicare payments to hospitals and physicians, investing in better health information technology, allowing Medicare to negotiate drug prices, and improving public health.

In the meantime, the Healthcare Leadership Council, a coalition of hospitals, health plans, and pharmaceutical and device manufacturers that aims to improve the quality and affordability of health care, has brought forward its own market-based proposal aimed at covering all Americans. Called "Closing the Gap," it calls for subsidies and tax breaks to help individuals afford coverage, improving health care quality through health information technology and care coordination, and realigning the financial incentives in the health care system to pay for value.

The plan calls for the government to provide premium subsidies to help employees afford their employer-sponsored insurance premiums and for the same tax breaks to be applied to individually purchased health insurance as applied to employer-sponsored coverage. The group did not endorse individual mandates.

The plan also calls for a move away from a payment system that rewards physicians and hospitals for the volume of services provided, instead paying for evidence-based care and prevention, said Dr. Denis Cortese, chair of the Healthcare Leadership Council and president and chief executive officer of the Mayo Clinic, at a press briefing to release the plan. ■