Pennywise and Pound Foolish
Written Testimony for US Senate Subcommittee on Primary Care and Aging
January 29, 2013

Claudia M. Fegan, MD, CHCQM, FACP
Chief Medical Officer, John H. Stroger Jr. Hospital of Cook County
Past President, Physicians for a National Health Program

Thank you Senator Sanders, Senator Enzi and other distinguished Senators for affording me this opportunity to address the issue of inadequate access to primary care in the United States.

The lack of adequate access to primary care speaks to the much larger issue of inadequate access to health care in this country as a whole.

As the chief medical officer of John H. Stroger Jr. Hospital in Chicago, known to most people outside of Chicago as Cook County Hospital, I confront on a daily basis the reality of our country's failure to provide universal access to health care as a right to which I believe everyone is entitled.

Every single day, people without a physician line up across the street from our hospital to be seen in our walk-in clinic. Hundreds of people a week—tens of thousands a year—stand in line in the wee hours of the morning, hoping to be one of the 120-200 people who will be seen that day and even better, hoping to be one of the 12 patients who will be assigned to a primary care physician and given an appointment so they won't have to come back.

They hope to be one of the lucky ones who will be given a physician of their very own, who will get to know them and take care of them and be available when they have a problem or question, someone to help them meet their medical needs, someone to help them navigate our complicated health care system to get what they need. I have to admit I hesitate to refer to health care delivery in this country as a system, because so little is connected to anything else.

Every day I look at the charts of patients admitted to our public, safety net hospital who were told by another hospital to come to us because they are uninsured. They come from distances great and small. I see patients who come from other cities, other counties, other states, other countries and patients who come from just a few blocks away.

Sometimes they come with their films or slides and have been told they need surgery or chemotherapy or a diagnostic study and they would be better off at "the County." These patients come to us in a state of desperation with great expectations. We take care of them and do the best we can with the limited resources we have. This is as we prepare to absorb the beginning of the phase out of Disproportionate Share Funds for Safety Net Hospitals on October 1st of this year. The elimination of DSH funds with the presumption that everyone will be insured is just another challenge as we continuously struggle to meet the needs of all who come to our doors.

I know the Affordable Care Act promises to provide insurance coverage to more Americans, but I know there will still be 30 million people who will remain uninsured even after the Affordable Care Act is fully implemented. So I know the need for the safety net and places like Cook County will remain. I also know there are not enough primary care providers to care for all the patients who will need them.

Whereas in 1930 the ratio of generalists or primary care physicians was about 80:20, today that ratio is reversed. It's not an exaggeration to say we are facing a crisis in this vital area.

Research show that primary care is the foundation of any high functioning health system. A well-developed primary care infrastructure makes access to care easier and more efficient; it contains cost, such as identifying and treating problems before they become more severe or advanced. It improves the coordination of resources and care; and most important, it yields better medical outcomes than when such an infrastructure is missing. It saves lives. I might add, studies have noted more expensive for profit hospitals, do not have better outcomes than our public safety net hospitals. There is no correlation between the amount of money we spend on care and the quality of the outcomes.

Our current influenza epidemic highlights the vulnerabilities of our current patchwork for health care delivery. Too few people in this country have access to a primary care provider. Their primary care provider could have educated them about influenza and the need for influenza vaccine, especially in vulnerable populations and those in contact with those populations. Then their primary care provider could have provided them with that vaccine.

Instead we are witnessing tens of thousands of people presenting to our emergency rooms sick and looking for help. At the peak, our emergency room at Stroger was seeing 450 patients a day while hospitals around the city closed their doors and went on bypass. At Cook County, we never go on bypass, we never close our doors.

People don't understand that influenza vaccination is not just about you and whether you get sick, but about everyone you encounter and the risk you will infect them. After we had a patient in our hospital infected by a visitor and a pregnant patient who wound up on a ventilator, we were forced to limit access to the hospitals in our System for visitors who might be sick. People are dying, dying from influenza, a preventable disease. This is an example of our tendency in this country to be pennywise and pound foolish in our funding of health care.

There is no doubt that for many years we have undervalued primary care. It shows up in a variety of ways.

As a nation we provide little incentive for young physicians to become primary care providers. By contrast there are strong incentives for young clinicians to pursue higher compensated specialties.

A medical education is expensive and most young physicians leave medical school with hundreds of thousands of dollars in debt. Because primary care physicians are the lowest compensated of physicians, and because the prospect of a heavy, long-term debt is so unappealing, medical students find themselves gravitating away from primary care toward higher paid specialties.

We say we value primary care physicians and yet we pay them half as much as we pay specialists. We say we appreciate the cognitive skills of primary care physicians so necessary to see patients as a whole and make decisions in the best interests of each individual, but we make it financially difficult for young clinicians to take this path.

Another example: We created the RBVS system to compensate physicians for their cognitive effort in the care of patients. It was hoped this would begin to level the playing field between primary care physicians and procedure based specialists. Yet the RVS Update Committee, which is tasked with annually reviewing how Medicare compensates physicians for care provided, has only a paltry few seats allocated for primary care when setting reimbursement rates.

We want to increase the number of primary care physicians, but when Medicare funds graduate medical education in hospitals, we disburse the same amount for a plastic surgeon as a primary care physician. If we increase hospital reimbursement for primary care physicians in training over specialists in training, we will have more primary care physicians. You could do that.

I have to say that I have the privilege of being a primary care physician myself—previously in private practice and now at a large public hospital—and I love taking care of patients. It is one of the most fun things I do. My patients invite me into their lives as I teach them how to take care of themselves and get what they need. These experiences are often deeply moving and rewarding and they remind me why I chose medicine as a profession.

The daughter of a labor union organizer and a social worker, I would have never been able to afford medical school. I was fortunate enough to be a member of the National Health Service Corps, which paid for my medical education, so I was free to make the decision to follow my passion and become a primary care physician without having to worry how I would pay off my loans.

While the National Health Service Corps still exists, it is a shadow of its former self; more students receive funding in the form of loan repayment.

I would say to you: if medical students know before they begin school that they will have no debt upon completion of their studies, they are more likely to make the decision to pursue a career in primary care rather than a more highly compensated specialty.

There are other ways to make primary care more attractive to the next generation of physicians too.

The administrative burden we have placed on physicians is the product of our nation's fragmented, dysfunctional system of financing care through multiple private and public payers, including hundreds of private insurance plans, each with its own rules. The costly paperwork and headaches inflicted on our physicians, including primary care physicians is enough to drive many to distraction or exit from our profession.

If we would enact a single-payer national health care program, where everyone was entitled to health care as a right, we could focus on delivering to our patients the best care in the world and relieve our physicians of the administrative hassles required to ensure proper billing for services provided.

As a primary care provider myself, I feel the external control in the exam room with me and my patient as I struggle to make sure I have completed all the required elements on the computer screen, sometimes at the cost of neglecting to ask what the patient's concerns are today.

Because of this onerous administrative burden, primary care physicians have lost something of their precious connection with their patients. Lifting that burden would help strengthen the doctor-patient relationship.

The stresses on primary care physicians are tremendous with the implementation of the electronic health record (EHR) that force them to spend more time looking at a computer screen than looking at the patient. Most EHR systems today were designed to enhance more efficient billing, not patient care. As a result, EHR's create a hideous documentation burden that robs precious time from physicians that they would rather spend engaging with their patients and understanding their needs.

There is no question, if we had designed the electronic health record to further clinical care we would have developed a very different tool. While it is true there are elements of the EHR that will improve patient safety, they are far overshadowed by the demands for administrative documentation. We lose the narrative of the individual patients to improve the point and click documentation and make billing more efficient.

It's just one more example of where we expect primary care doctors to address more and more issues, even as we expect them to see more and more patients.

I would say to the members of this committee, as members of Congress you have the opportunity to increase the number of primary care providers in this country.

1. Adjust the funding for graduate medical education to reimburse hospitals more for the primary care physicians than specialists.
2. Insist the American Medical Association increase primary care representation on RVS Update Committee

3. Increase National Health Service Corps scholarship program.

I urge you to work to make a difference, not for me or you, but for the patients I have the privilege of serving, who desperately need their elected officials to care about what happens to them.