

WHO WILL CARE
for
OUR COMMUNITIES?



**Executive Summary Report of the
North Carolina Academy of Family Physicians, Incorporated
WHO II Task Force
April 2001**



WHO WILL CARE
for
OUR COMMUNITIES?





INTRODUCTION

Ten years ago, the North Carolina Academy of Family Physicians, Inc. (NCAFP) authored a report, “Who Will Take Care of Our People?,” recommending the production of a greater number of primary care physicians for our state and the utilization of those new physicians in the most appropriate way. Our report’s recommendations were considered by various legislative study commissions and other policy-making bodies. In very meaningful ways, NCAFP’s report informed and shaped the debate on health care reform. Our “WHO” report resulted in the passage of legislation and the creation of regulations and policies, requiring more primary care physicians to be trained and establishing programs that encouraged their training and their appropriate distribution.

The following discussion is the prelude to a more comprehensive report soon to be issued from our Academy. We trust our comments will serve to stir and awaken readers to our mutually shared need to confront the health care challenges that lie ahead for our state and its people.

L. Allen Dobson, MD
Chair, WHO II Task Force,
NCAFP

Maureen E. Murphy, MD
President, NCAFP

Sue L. Makey,
Executive Vice President, NCAFP



WHO WILL CARE FOR OUR COMMUNITIES?-

A QUIET CRISIS

The projected shortfalls in North Carolina's Medicaid and the State Employees Health Plan (SEHP) are dramatic. Medicaid needs approximately \$400 million dollars and the SEHP is now projecting a \$778 million deficit in the upcoming fiscal biennium of July 1, 2001 to June 30, 2003.

A number of our hospitals throughout the state are also losing money. A Deloitte and Touche study conducted for the NC Hospital Association recently forecasted that 38 of the 111 acute care hospitals will be operating in negative margins by the end of year 2002 and that 11 of our state's hospitals will have operating deficits and be out of cash reserves by the end of next year. Our academic medical centers and associated teaching hospitals are experiencing budget tightening as they continue to serve a disproportionately large share of the uninsured and most complex and expensive patient needs while simultaneously carrying out their essential medical education missions.

Yet beyond this uproar, is yet another, larger crisis facing our state:

*the crisis of a state population with unmet health needs
and of communities losing their Family Physicians.*

This quiet crisis is unfolding in North Carolina, without fanfare and largely unmarked by the press, in community by community, family medicine practice by practice, and patient by patient.

Leadership over more than one legislative session will be required to address this quiet crisis for our state's citizens.



NORTH CAROLINA'S UNMET HEALTH CARE NEEDS

Despite eight years of prosperity, the health of North Carolinians remains at risk.

Approximately 1.2 million of our state's population do not have health insurance and 1.1 million are considered to be underinsured. Despite some progress made in our state over the last decade, North Carolina continues to rank in the bottom 10% of states in pregnancy outcomes. Our state's African American and poor populations also have dramatically higher rates of death from cancer and heart disease. Moreover, need is rising rapidly, as our expanding Hispanic and elderly populations will increase dramatically the need for and increased expense of health services.

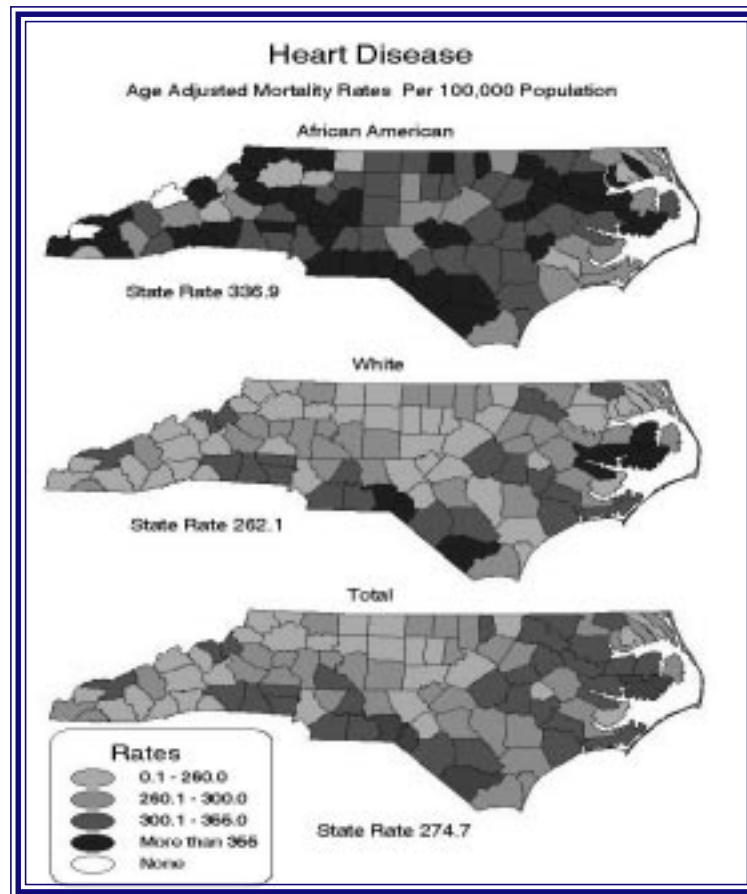


Figure 1. NC Mortality Comparison Rates for Heart Disease



THE DISINTEGRATION OF TRUST & CONTINUITY

Beyond the statistics is an even more sobering story:

the weakening of the “doctor-patient” relationship.

The heartbeat of medical care is the trusting relationship forged over time between a patient and his or her own personal Family Physician. Recent years have placed great stress on this critically necessary relationship:

- √ Mergers and acquisitions of hospitals and physician practices, often without a true relationship to the medical needs of the community;
- √ Frequent shifts in insurance contracts, making it difficult for patients to keep the same doctor and to receive continuity of care;
- √ Restrictive managed care policies have driven a wedge between patients and their Primary Care Physicians;
- √ Rapid increases in insurance premiums and the cost of drugs without readily apparent corresponding improvements in health; and,
- √ Decreasing reimbursement for the human face of medicine, in other words, the “cognitive services” such as counseling with patients about preventive care needs, talking to patients by telephone or coordinating care.

Much more has been expected of the Family Physician with the advent of managed care while resources and time have become increasingly more limited.

Public dissatisfaction is also substantial and rising. Sixty-nine percent (69%) of the public do not believe that managed care has decreased overall cost and 58% believe that access to care has not increased. An overwhelming 80% of the public believe that managed care has been bad for patient care.



CHOOSING NOT TO PRACTICE FAMILY MEDICINE-

OUR FUTURE?

According to the American Academy of Family Physicians, the average medical school debt in March 2001 had risen to almost \$94,901 with 13.2% of indebted students owing more than \$150,000 at graduation, and expected increases of these figures by as much as 7% to 10% annually. Primary care salaries have been outpaced by this indebtedness, a concern that, coupled with other key job satisfaction factors, will surely have impact on future specialty choices. Nationally, of 3,096 Family Practice positions offered in 2001, only 1,516 (49%) of the positions were filled with U.S. seniors, down 8% from 2000 figures. The National Resident Matching Program results of 2001 also reflect a fourth consecutive year of fewer positions filled in Family Practice.

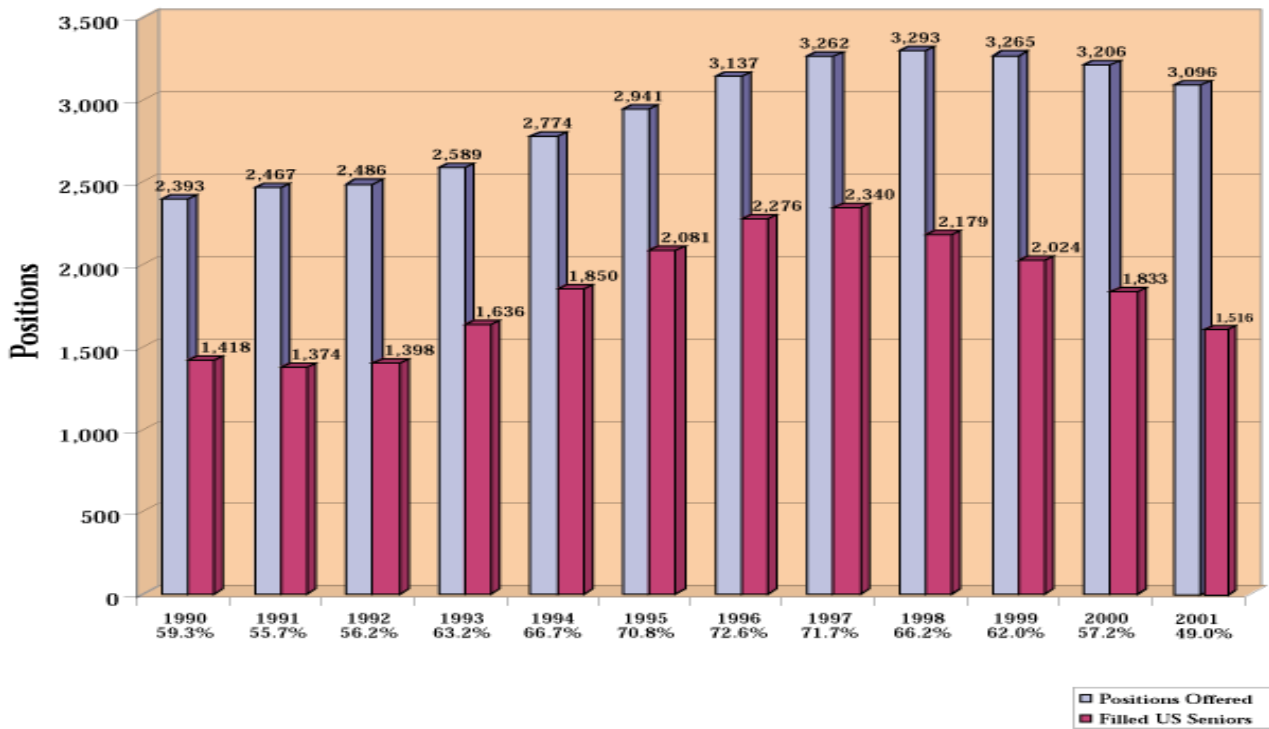


Figure 2. Family Practice Positions Offered VS Filled With US Seniors, 1990-2001
National Resident Matching Program

FAMILY PHYSICIANS- OUR SAFETY NET



Family practice, unlike any other specialty, is the safety net of North Carolina's health care system. It is, after all, family physicians who live in and participate in their home communities, practicing for generations out of their heartfelt commitment to the patients and families they serve. Furthermore, family physicians are the only physicians among all medical specialties who are as likely to reside and practice in the nonmetropolitan areas as is the general populace.

Areas with shortages of practitioners are designated as Health Professional Shortage Areas (HPSAs) by the Federal government, using a ratio of one Primary Care Physician per 3,500 population or more as the standard for Primary Care HPSA designation. The Department of Health and Human Services' recommended ratio for an "adequately served" population is one Primary Care Physician for 2,000 people. The two maps below reflect North Carolina's HPSA-designated counties for 1999 (Figure 3) and the 39 additional counties that would be wholly designated as Primary Care HPSA if family physicians were withdrawn from our state's provider base (Figure 4).

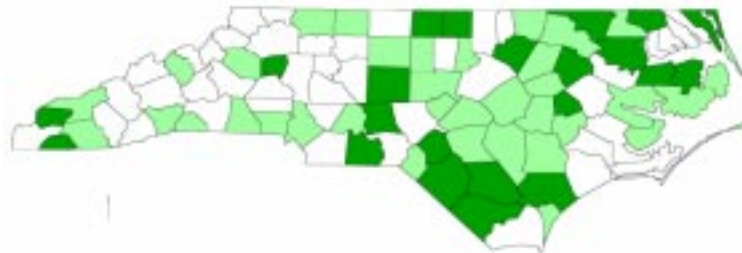


Figure 3. NC HPSA County Designations

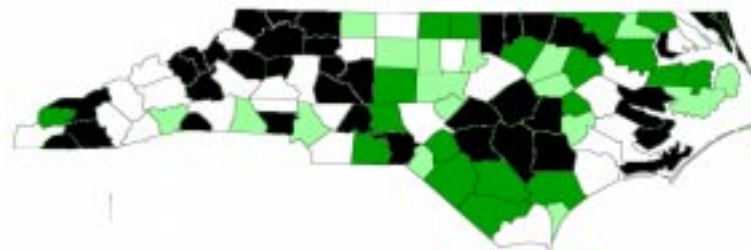
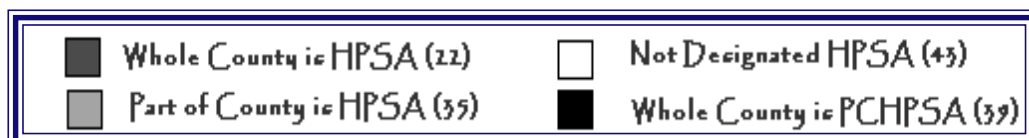


Figure 4. PCHPSAs if FP's Withdrawn from Provider Base





Throughout North Carolina, our Family Physicians are the primary medical specialty taking care of the state's uninsured and marginally poor populations. Without the Family Physician specialty, roughly 60% of our state would be designated as Health Professional Shortage Areas.

New PCHPSA- Designated Whole Counties
if FPs Withdrawn From Current Provider Base

Alexander	Cumberland	Halifax	Pamlico	Swain
Alleghany	Currituck	Harnett	Perquimans	Vance
Ashe	Dare	Haywood	Polk	Warren
Avery	Davidson	Johnston	Richmond	Wayne
Beaufort	Davie	Lincoln	Rowan	Wilkes
Caldwell	Duplin	McDowell	Sampson	Yadkin
Carteret	Gaston	Macon	Stanly	Yancey
Clay	Granville	Mitchell	Surry	

The change in economic outlook has affected our future supply of family physicians, with fewer graduates of U.S. medical schools choosing Primary Care careers. This disturbing trend is just now being felt in our communities as the first time in over a decade, the number of Primary Care Providers is decreasing in our North Carolina counties. According to the Cecil G. Sheps Center for Health Services Research's 1999 *NC Health Professions Data Book*, 40 counties experienced a reduction in their total number of Primary Care Physicians, while only 15 counties had a drop in 1998.

The safety net itself is in trouble.



THE ECONOMIC CRISIS OF FAMILY PRACTICE

Most family practices across the state still operate as small independent businesses. In recent years, the administrative burdens experienced by physicians through the increases in regulation and the implementation of managed care have substantially inflated the cost of doing business, while the relative levels of reimbursement decreased and have continued to fall.

Family Physicians have the highest practice overhead costs at 59.31% among all of the medical specialties.

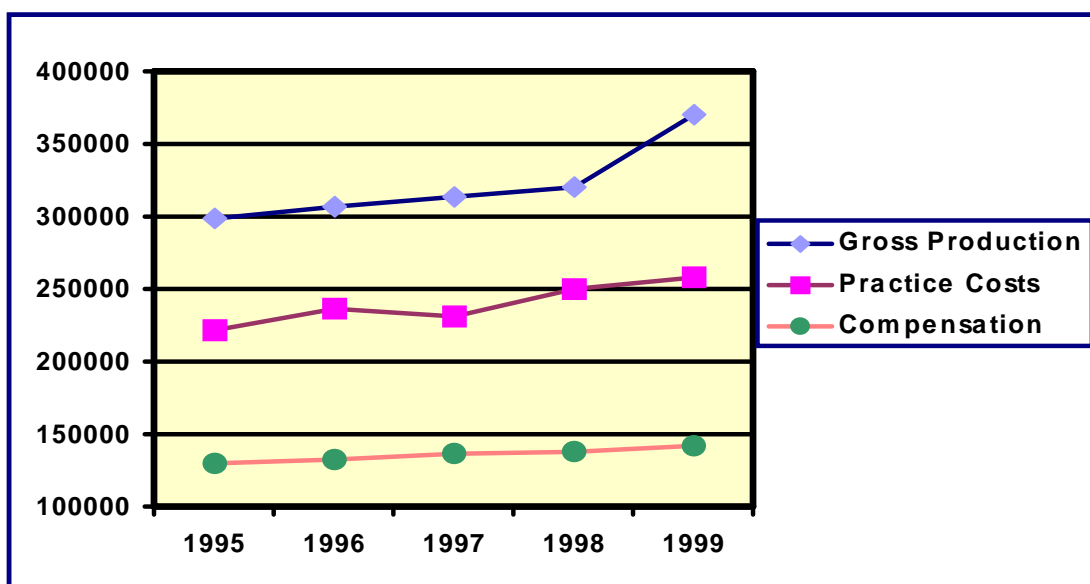


Figure 5. Family Physician Gross Productivity, Practice Costs and Compensation- A 5- Year Trend

Over the last five years however, the average Family Physician's income has increased only 7% while productivity has increased over 22%. The NC Medical Society's recent release of the document, **Results of the NC Medical Society's Managed Care Report Card Findings: NC Physicians Speak Out on Managed Care in the Year 2000 and the Impact of Information Technology, November 2000**, found that nearly 77% of our state's full-time physicians are spending greater than 40 hours in direct patient care and that 40% of physicians spend more than 11 hours per week just attending to administrative duties, mostly paperwork.



Family Medicine practices serving the rural populations and the most vulnerable of our North Carolina citizens are experiencing serious financial jeopardy and facing insolvency.

Many of our state's independent Primary Care practices will not be financially viable in the future. Overall, the specialty of Family Practice remains undercompensated and undervalued in the medical payments system.

With expected increases in early retirements, more practice closures on the horizon for insolvency, and with fewer physicians making the choice to enter the specialty of Family Medicine:

“Who Will Care For Our Communities?”

IMPROVING THE HEALTH OF THE POPULATION-



THE NEED FOR LEADERSHIP

There are no simple answers. The new health care crisis in North Carolina has many roots: managed care, inadequate access to care, inattention to the health needs of our communities, and the rapid spread of expensive technologies that do not improve the health of our state's overall population.

We believe, however, that the time is at hand to work on a comprehensive solution. All must come together in a collaborative effort and address the public good. Our Academy looks forward to participating actively with you and others in the process.

As we work together to develop solutions for the people of our state, we propose that the following principles be the basis of our work, with the goal to sustain and improve health outcomes for North Carolina's communities:

- √ The doctor-patient relationship needs to be supported;
- √ Access to quality primary care should be improved;
- √ Emphasis should be placed on improving the effectiveness of care for all of North Carolina's citizens in the communities in which they live;
- √ The economic crisis of primary care must be addressed;
- √ The supply and distribution of Family Physicians and other health professionals needs increased support and government guidance;
- √ New models of organizing care in communities are necessary; and,
- √ There must be open dialogue and public accountability.

We must begin to address:

“Who Will Care For Our Communities?”

Resources

- Figure 1:* NC Mortality Comparison Rates for Heart Disease
Source: NC Center for Health Statistics
Produced By: NC Center for Health Statistics
Raleigh, NC
- Figure 2:* Family Practice Positions Offered VS Filled With US Seniors, 1990-2001
National Resident Matching Program
Source: National Resident Matching Program (data)
Produced By: The Division of Medical Education
American Academy of Family Physicians
Leawood, KS
- Figure 3:* NC HPSA County Designations
Source: United States Federal Register, September, 1999
Produced By: NC Rural Health Research Program
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill, NC
- Figure 4:* PCHPSAs if FP's Withdrawn from Provider Base
Source: United States Federal Register, September, 1999
Produced By: NC Rural Health Research Program
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill
Source: American Academy of Family Physicians
Produced By: The Robert Graham Center for Policy Studies
in Family Practice and Primary Care
Washington, DC
- Figure 5:* Family Physician Gross Productivity, Practice Costs and Compensation-
A 5-Year Trend
Source: Medical Group Management Association (data)
Produced By: L. Allen Dobson, MD
Director, Cabarrus Family Medicine Residency Program
Concord, NC