



SEIU Healthcare®



We Stand United: Primary Care & Specialty Physicians for Health Care Reform

2009 promises to be a historic moment in the decades-long effort to achieve universal, accessible and quality health care for all in the United States.

As leaders of the Committee of Interns and Residents/SEIU Healthcare¹ and physicians in training, we view this legislation as essential to achieving social justice *and* strengthening our failing economy. Every day, in public and private hospitals across the country, we see the serious (and all too often preventable) consequences of a system that denies care to those who cannot pay. Many of our members work in safety-net hospitals, financially-endangered institutions that have borne the brunt of the health care crisis and where the consequences of the current health care system are immediately obvious. We look forward to the day when our patients have the *right* to health care. We also look forward to the day when we can practice medicine in an environment where our first and only concern is to provide appropriate, quality care for our patients.

But merely ensuring access to care is not enough. Health care policy experts, lawmakers, physicians, nurses and other health care providers understand that just providing health insurance will not achieve our goal. Reforming the health care *delivery* system, including the mechanisms by which health care is paid for, is essential to providing quality and cost-effective care for all.²

CIR members provide round-the-clock care in the nation's teaching hospitals under the supervision of senior physicians. But as physicians in training, we are prohibited from billing for that care.³ That gives CIR a unique vantage point from which to assess the nation's delivery and payment systems. We see a system of care with perverse reimbursement incentives for hospitals and physicians that too often result in unnecessary care. Unnecessary and/or ineffective care drives up the cost of health care for everyone and often results in poorer outcomes for patients.⁴

We see a shortage of primary care physicians. That shortage has led to an increase in fragmented care, reliance on (and repetition of) diagnostic tests, specialty referrals and expensive

¹ CIR/SEIU Healthcare is the oldest and largest union of resident physicians in the country, representing 13,000 physicians in training in more than 60 public and private teaching hospitals. SEIU Healthcare is a one million member division of the over 2 million member Service Employees International Union.

² Call to Action: Health Reform 2009. Senate Finance Committee, US Senator Max Baucus, Chairman. Nov. 12, 2008 www.finance.senate.gov. p. 36.

³ Funding for resident salaries comes primarily from the Centers for Medicare and Medicaid. Other funding sources include the VA, DOD, HRSA, the US Public Health Service and private funders.

⁴ "...the more money Medicare spent per person in a given state the lower that state's quality ranking tended to be." A. Gwande, "The Cost Conundrum: What a Texas Town Can Teach Us About Health Care." *New Yorker* 6/1/09, P. 39.

emergency room care. Beleaguered primary care physicians are often trapped on the reimbursement-driven 15-minute patient visit treadmill: a rush to diagnose, treat and release that only encourages more costly diagnostic testing and at times reliance on unnecessary consultations.

We also see the role that ‘defensive medicine’ plays in driving up costs, as physicians attempt to insulate themselves from malpractice suits.⁵ This factor is only made worse by a shortage of primary care physicians, as heavy workloads lead to both less time with each individual patient and more patients using the Emergency Room for primary care. Both trends create situations where the chances of a missed diagnosis are great, making it more likely a doctor will prescribe an unnecessary or redundant test or treatment to protect against liability.

We will work to ensure that health care reform addresses these perverse incentives, thereby saving money which can be redirected to address other health care access and delivery problems, including the shortage of primary care physicians.

Unlike most physician organizations that are specialty-specific, CIR represents 13,000 resident physicians who work in *every* specialty, from Anesthesia to Urology. We train to become primary care physicians in the specialties of internal medicine, family medicine, pediatrics, and obstetrics; and we train as ER physicians, radiologists, general surgeons, subspecialty surgeons, and the full range of medical specialists from cardiologists to rheumatologists.

Residency training is very difficult, no matter what specialty, with punishing schedules and salaries that are just over the minimum wage when calculated based on the hours that we actually work. Our members in primary care complete their training in three years, while our specialty members remain in residency and fellowship for an *additional* two to five years. Despite this difference in length of training, CIR has always insisted on the importance of representing *all* of our members – primary care and specialists -- alike.

It is through the prism of this history and commitment that we view with great concern legislative proposals that pit primary care and specialists against each other. Increasing payment for primary care is essential, but achieving that goal by reducing specialty payment is a short-term strategy that is devious and destructive to the goal of attaining universal health care. We want the public, our lawmakers and health care reform activists to know that we stand as one – primary care and specialty physicians.

Together, we recognize the need to:

- **Adopt a universal, accessible, quality and affordable health care system**, whose guiding principles are embodied in the Health Care for America Now (HCAN) principles.⁶ This includes the creation of a viable and competitive public health insurance plan as a critical element to ensure honest competition with private insurance plans and to control costs.

⁵ Call to Action: Health Care Reform 2009, Senate Finance Committee. P. 74.

⁶ HCAN – Health Care For America Now, represents 1000 organizations working for health care reform.

http://healthcareforamericanow.org/site/content/what_comprehensive_reform_means.

- **Rein in destructive aspects of our current health care system**, a system that is controlled by health insurance companies too often intent on NOT providing care; by pharmaceutical and device manufacturers intent on reaping huge profits; and by some hospitals and physicians who game the system to increase their revenues and compensation.
- **Move our payment system away from fee-for-service reimbursement**, with its perverse financial incentives for hospitals and physicians to provide more care than can be justified by the evidence, and *towards* a system which incentivizes evidence-based, integrated care in “medical homes,” coordinated by primary care providers who work closely with specialists to provide an appropriate, effective level of care.⁷ Physicians have an important role to play in moving from a system that rewards volume to one that rewards value.⁸
- **Train more primary care physicians and reimburse them appropriately** by building a payment system which reflects the complex cognitive and diagnostic skills required, as well as the important coordination of care that should be *expanded* in a new health care delivery system. There is no doubt that our health care delivery system will continue to be in crisis without an increase in primary care physicians, primary care nurse practitioners, and physician assistants. Improving the quality of life and financial picture for primary care physicians will help to encourage more medical students to join these specialties. Assisting these physicians with subsidies for the crushing burden of medical student debt will also encourage more physicians to stay committed to the provision of primary care.
- **Understand the critical role that specialists play in the delivery system.** In the rush to champion primary care, some lawmakers have demonized this group of physicians as overpaid with respect to their qualifications or greedy, i.e. driven to their career choice solely by financial motivation. Others argue that the only way to fund an increase in the number of primary care physicians and the payment they receive is to reduce payments to specialists.⁹ CIR finds these arguments divisive and shortsighted. While we deplore those physicians who manipulate the current system for financial gain, we believe the majority of physicians do not deserve this stereotype. Proposals to limit specialty payments encourage scapegoating and ignore the far greater role that insurance companies and the pharmaceutical and device manufacturers play in driving up costs, as well as the increased costs that are inherent in a fragmented, fee-for-service system of care which lacks an emphasis on quality and an evidence-based standard of care.

⁷ The Path to a High Performance US Health System: A 2020 Vision and the Policies to Pave the Way. Commonwealth Fund Commission. February 2009. P. 10

⁸ A. Gwande, “The Cost Conundrum...” New Yorker 6/1/09. P. 42-44.

⁹ “Budget-neutral changes to Medicare payments mean that any increase to primary care providers requires a corresponding cut to specialist services. This approach has the potential to create significant controversy among physicians, however. Any reforms along these lines must be crafted in collaboration with the entire physician community and other practitioners to ensure appropriate valuation of, and access to, primary care services.” Call to Action: Health Care Reform 2009. P. 39.

A successful health care reform bill – transforming our payment system from one based on volume to one based on value -- should generate sufficient savings to allow for increased reimbursement for primary care without penalizing specialty reimbursement.¹⁰

Reducing payments to specialists also runs the danger of encouraging fewer people to choose the lengthy training that specialization requires -- at a time when we cannot afford to train fewer specialists. Shortages of general surgeons already exist in rural and urban areas,¹¹ and other specialty shortages already exist or are predicted.¹² Research has shown that the choices we make in our medical career are already complicated by many factors. These include our level of student loan debt and our projected ability to pay back that debt after residency, to say nothing of factors like whether we went to a public or a private medical school, grew up in a rural or inner-city area, our gender, race and ethnicity -- all of which have a profound effect on whether individuals with aptitude pursue a career in medicine in the first place.¹³

- **Transform our tort laws into a more patient-friendly *and* physician-friendly system** that guarantees speedy payment for patients harmed by medical error, roots out unqualified physicians, and brings down malpractice insurance costs, especially for those who practice in fields with unusually high risk, such as neurosurgery.¹⁴

CIR represents physicians who will be responsible for helping to fix a health care system that was not of our making. We embrace the fundamental move away from fee-for-service reimbursement and towards a collaborative, comprehensive system of care that brings the health care team – primary care physicians and specialists – together to provide evidence-based and appropriate care to our patients.

As our system expands to include the currently uninsured and aging baby boomers, we will rely more heavily on health care services, including both primary care and specialty services. We urge lawmakers, as well as the larger progressive health care movement that Health Care for America Now represents, to resist the false choice of thinking that the expansion of primary care can only be done at the expense of payments to specialists. That move will fracture important physician support for health care reform when that unified support is both needed and possible.

**National Executive Committee
Committee of Interns and Residents/SEIU Healthcare
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¹⁰ The Path to a High Performance U.S. Health System, Executive Summary p. 7-22.

¹¹ American College of Surgeons. <http://www.facs.org/news/accessatrisk.html>.

¹² A NJ Physician Workforce Policy Task Force reports current unmet need for family medicine, numerous pediatric sub-specialists, neurosurgery and hematology/oncology. NJ Council of Teaching Hospitals, 2007.

¹³ Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices? Robert Graham Center: Policy Studies in Family Medicine and Primary Care. March 2, 2009.

¹⁴ Call to Action: Health Care Reform 2009, Senate Finance Committee. P. 75-76.