



An NJAFP White Paper

**Perspectives on
The Need for Family Medicine Departments in New Jersey Medical Schools**

Executive Summary

Like much of the nation, New Jersey's ability to provide healthcare, especially to its most vulnerable citizens, is in crisis. As the population continues to age and the demand for quality care and lower costs increase, the need for family physicians, the only specialty dedicated exclusively to primary care, is critical. Research has shown that being in the care of a family physician results in decreased mortality rates, earlier detection of specific diseases, and better preventative care than that provided by sub-specialists.¹

The New Jersey Academy of Family Physicians (NJAFP) believes it is imperative for our state's publicly funded medical schools to support the training of family physicians for the benefit of the citizens of New Jersey. This can only be accomplished by supporting the growth and development of viable and vibrant Departments of Family Medicine as effective entities that will meet the needs not only of local New Jersey communities, but of the entire state. Such departments and their family physician educators should serve as role models for its students and contribute to the academic productivity of the school.

Specifically, New Jersey Medical School (NJMS) has an obligation to the city of Newark and the surrounding communities to improve the status of primary care through the robust and determined investment in Family Medicine training. Such support is the only proven solution to meeting the healthcare needs of any community, especially the underserved and disenfranchised communities that depend on NJMS. The NJAFP is fully committed to supporting NJMS in reinvigorating the Department of Family Medicine so that it can thrive, as Family Medicine Departments thrive not only in other medical schools across the country but also within New Jersey, where Robert Wood Johnson Medical School's Family Medicine Department is a shining example of how a department can not only meet the needs of its community, but of the institution as well. Working together, we can help the Department of Family Medicine at NJMS flourish.

The Current National Situation

The problems of the U.S. healthcare system are well documented. In addition to over 40 million people uninsured and countless others underinsured, we under-perform when compared to other

spend an average of 26% of their total revenue on administrative costs just for the purposes of getting paid for what they do.⁵

The payment system in the U.S. is dysfunctional. It rewards fragmented and episodic care and excess utilization of services. It does not compensate for comprehensiveness of care, longitudinal care, enhanced access to care, and the development of an infrastructure capable of producing better outcomes. This is in stark contrast to other industrialized countries which reward all of these elements of care and have much better outcomes at lower costs.

The Primary Care Crisis

Over the last decade, there has been a precipitous decline of interest in primary care. This has been caused by a perfect storm of decreasing absolute earnings, widening gaps in incomes compared to other specialties, increasing non-compensable physician time, increasing administrative burdens and menial tasks, and escalating levels of financial debt upon graduation from medical school. Colwill, Cultice and Kruse projected a deficit of 35,000-44,000 adult care generalists (general internists and family physicians) by 2025.⁶ Currently, residents in internal medicine and pediatrics are opting for more lucrative and less necessary specialties as opposed to primary care and the overall numbers going into primary care are decreasing at a time where they are needed even more (Figure 2).

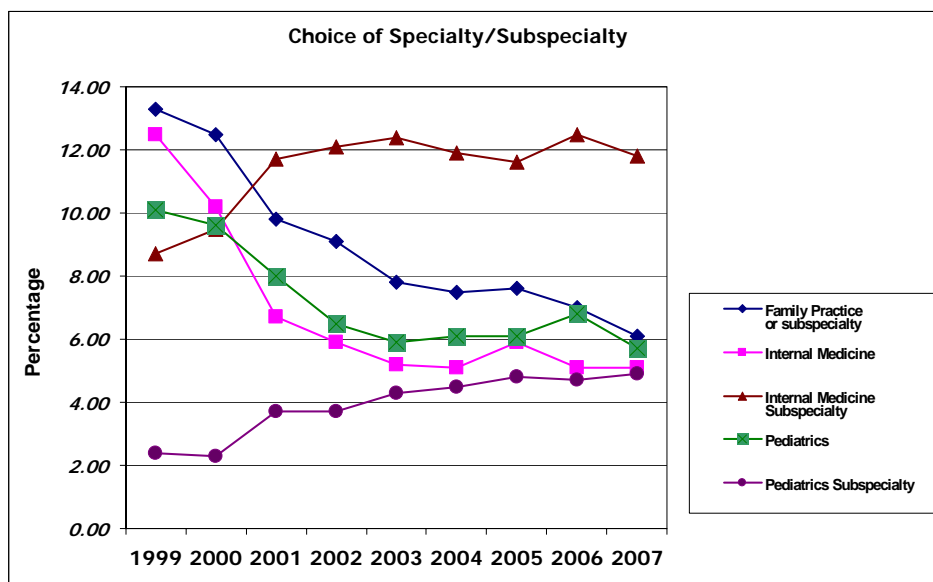
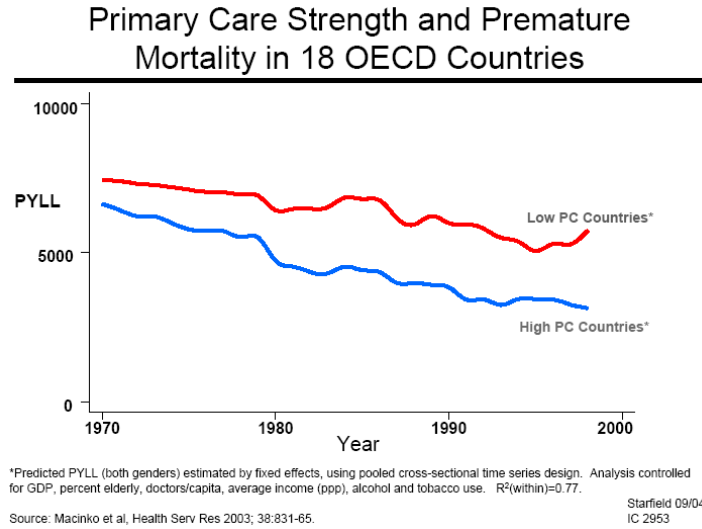


Figure 2: Medical School Graduates, Choice of Specialty, AAMC⁷

Primary Care Physicians Are Essential to Improving Care and Lowering Costs

As seen in Figure 1, the states with the highest ratio of specialists to primary care physicians tend to have higher costs and worse quality. Baicker and Chandra looked at previously reported quality outcomes and costs to Medicare beneficiaries, then correlated the results with the relative supply of specialists and general practitioners.⁸ They concluded that “States with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality. Improving the quality of beneficiaries’ care could be accomplished with more effective use of existing dollars.”⁸ Starfield et al. has also shown similar

results on a county by county basis.⁹ Furthermore, we see the same relationship when we look at the supply of primary care physicians and specialists internationally (Figure 3).



OECD = Organization for Economic Cooperation & Development
 PYLL = Potential years of life lost

Figure 3: Primary Care Strength and Mortality

Current State of Affairs in New Jersey

Value is usually measured as a combination of cost and quality. We are willing to pay more for better outcomes. However, looking at the relationship between cost and overall quality in health care (Figure 1), only Louisiana, Texas, and California offer worse value to their citizens than New Jersey does. The imbalance of primary care to specialist care is also associated with high costs and lower quality (Table 1).

	New Jersey Rank
Availability of Primary Care Physicians	43 rd
Specialist Surplus	2nd highest
Medicare costs	41 st
Overall Quality	42 nd
Overall Value	48 th
Medicare costs in the last 2 years of life	50 th

Table 1: New Jersey Rankings – Summary of Dartmouth Atlas Data¹⁰

Dartmouth Atlas

AL	25,344	IL	31,197	MT	25,056	RI	29,028
AK	31,957	IN	23,874	NE	25,838	SC	27,095
AZ	27,843	IA	23,746	NV	27,950	SD	24,072
AR	25,724	KS	25,740	NH	25,706	TN	26,464
CA	38,573	KY	25,012	NJ	39,810 #1	TX	28,466
CO	25,888	LA	26,830	NM	24,616	UT	23,936
CT	32,636	ME	25,196	NY	38,369	VT	27,050
DE	28,450	MD	36,337	NC	25,829	VA	25,435
DC	39,637	MA	31,985	ND	23,855	WA	27,698
FL	29,604	MI	28,427	OH	25,005	WV	23,789
GA	26,267	MN	27,411	OK	25,227	WI	25,343
HI	33,518	MS	25,705	OR	25,509	WY	25,173
ID	23,697	MO	25,681	PA	28,487	US	29,199

Inpatient and Part B spending per decedent during last 2 years of life

Source: Dartmouth Atlas of Healthcare. 2006.

Dartmouth Atlas

AL	1.09	IL	1.07	MT	1.24	RI	1.20
AK	1.44	IN	1.01	NE	1.41	SC	1.01
AZ	0.91	IA	1.20	NV	0.77	SD	1.67
AR	1.35	KS	1.37	NH	1.32	TN	1.17
CA	0.83	KY	1.19	NJ	0.70 #50	TX	0.95
CO	1.06	LA	1.03	NM	1.37	UT	0.98
CT	1.13	ME	1.47	NY	1.17	VT	1.37
DE	0.93	MD	0.95	NC	1.21	VA	1.06
DC	0.69	MA	1.23	ND	1.32	WA	1.07
FL	0.77	MI	1.30	OH	1.04	WV	1.41
GA	0.89	MN	1.47	OK	1.19	WI	1.15
HI	1.22	MS	1.24	OR	1.27	WY	1.49
ID	1.29	MO	1.45	PA	0.97	US	1.04

Variation, by State, in the Ratio of Primary Care to Medical Specialist Labor Inputs

Source: Dartmouth Atlas of Healthcare. 2006.

Table 1: Summary of Dartmouth Atlas Data ¹⁰

- **A STATE IN CRISIS:** There is a crisis on the horizon for the delivery of health care in New Jersey. We are at risk of being incapable to care for our patients, especially our most vulnerable residents. In addition, we face an antiquated "system" of delivering individual care that is not up to the challenge of efficient, quality care in the 21st Century.

Significant socioeconomic disparities exist within the New Jersey population which impacts the utilization of resources. It is a fact that less affluent counties have significantly higher hospital admission rates, widely attributed to a lack of access to preventive and primary health care services. For example, quality indicator data from 2005 shows that hospitalization rates for short term complications of diabetes were higher in **Essex County (81.7/100,000) than in Morris County (19.2/100,000).** ¹¹

New Jersey's direct and indirect costs related to Charity Care and services for the uninsured, as well as the consequences of cost shifting among payers, has led to a financial crisis which has positioned most hospitals and providers in precarious financial circumstances. Over utilization, prolonged lengths of stay and one of the highest per capita hospital bed expenses in the nation all reflect the failure of traditional responses to the growing health care crisis in New Jersey.

The Unique Role of Family Medicine's Contribution to Primary Care

Family Medicine has several unique attributes in terms of its contribution to primary care:

- **SCOPE OF CARE:** Family Medicine is the only primary care specialty that cares for all people without consideration of age or sex. In addition, by virtue of its emphasis on a broad scope of primary care issues, Starfield and others have singled out Family Medicine as having the best contribution to improving outcomes and lowering cost of all the primary care specialties.^{Error! Bookmark not defined., 12, 13}
- **SOLE FOCUS OF PRIMARY CARE:** As opposed to Pediatrics and Internal Medicine, virtually 100% of Family Medicine Residents who go into practice are practicing primary care (Figure 2). Furthermore, there is waning interest in primary care as a vocation among internal medicine residents. A recent survey of medical students conducted by the American Board of Internal Medicine (Figure 4) found that only 8% were considering Internal Medicine and only 2% of all students were considering a career in General Internal Medicine.¹⁴

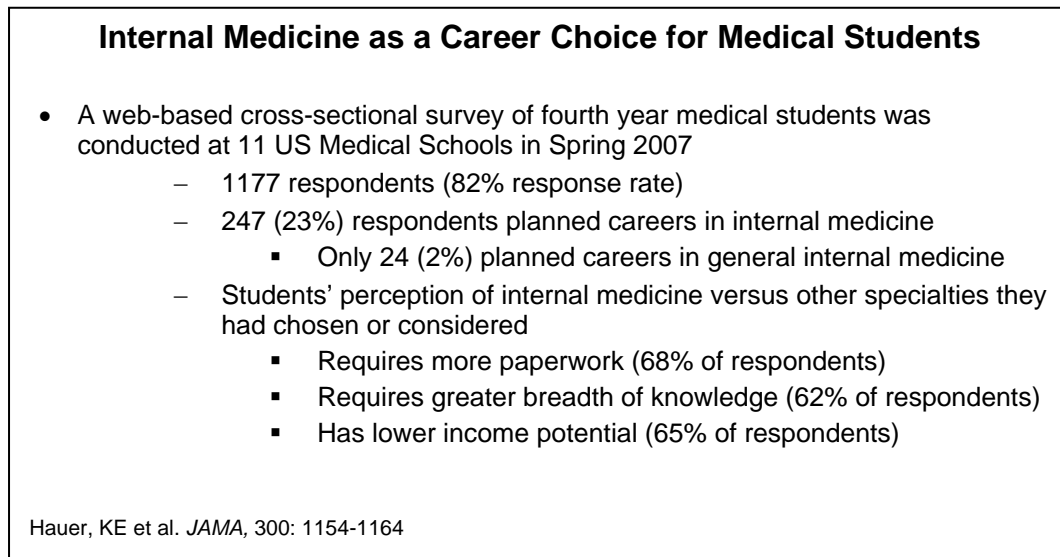


Figure 4: Student Career Choices

- **LOCATION IN UNDERSERVED AREAS:** Whether in urban or rural areas, family physicians, to a greater extent than any other specialty, locate in underserved areas. Removing family physicians greatly accentuates the physician manpower shortage in New Jersey and across the country (Figure 5A and 5B).

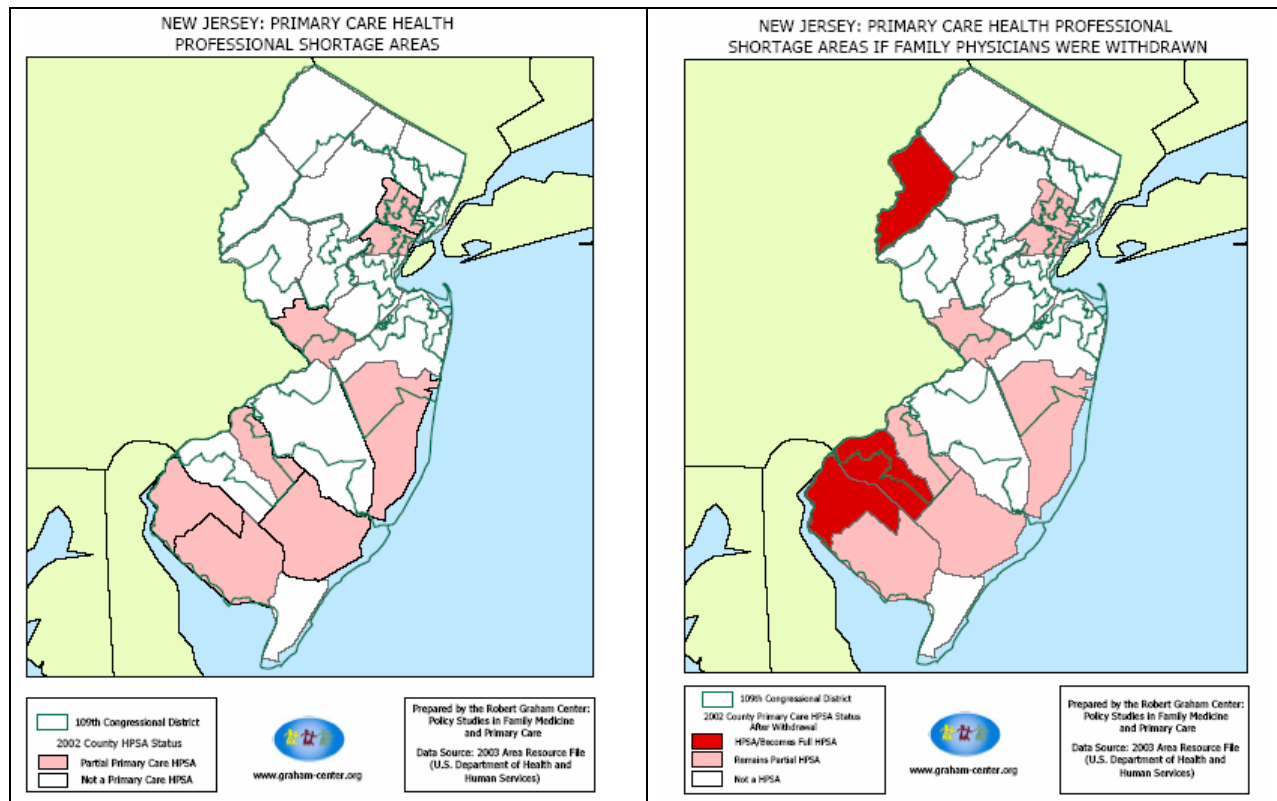


Figure 5A: Primary Care Shortage Areas

5B: Primary Care Shortage Areas With No Family Physicians

Question: Do schools that do not have full formal departments of Family Medicine do as well as other schools in turning out Family Physicians?

The answer is an emphatic no! Data from 2009 data illustrates this case (Table 2).

School	Percent Going Into Family Medicine
Yale	3.1%
Johns Hopkins	0.0%
George Washington	5.5%
Cornell	1.1%
Columbia	1.3%
Mt Sinai	1.7%
Stanford	2.4%
NYU	0.0%
Average of Schools without depts.	1.9%
National Average of All Schools	7.5%
Publicly Funded (State) Schools	8.8%
Privately Funded Schools	5.3%

Table 2: Medical Schools without Independent Departments of Family Medicine

It is important to note that none of the medical schools without an independent Department of Family Medicine were state supported schools.

Bolstering the Ability of the New Jersey Medical School to Meet the Needs of the Greater Newark Community and the Needs of the Citizens New Jersey

The New Jersey Academy of Family Physicians believes that it is imperative for New Jersey Medical School to support the growth and development of the Department of Family Medicine into a vibrant and effective department which will meet the needs of the local community and the state as a whole, serve as effective teachers and role models for its students, and contribute to the academic productivity of the school. Throughout the country we can find example after example validating this model as the only viable solution to our healthcare crisis, and in fact, also validating the failure of attempts to move away from this model.

The NJAFP is fully committed to supporting NJMS in working to reinvigorate the Department of Family Medicine. We also stand ready to mobilize the community at large, as well as the physician community, to ensure that NJMS meets its obligation to the primary care needs of the community so crucial to the improved outcomes and lower costs required to rebuild our fragmented healthcare delivery system. Across the country, and here in our own back yard, we have seen that support and commitment to Family Medicine in other medical schools allows Family Medicine to flourish. No less can be expected at NJMS, a vital institution to the community it serves.

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