Family Medicine Updates

From the Association of Departments of Family Medicine

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TITLE VII: OUR LOSS, THEIR PAIN

Despite spending more per capita on health care than any other nation, the United States lags behind other industrialized nations in all major health outcome measures. This is due to 2 main factors: (1) relative to the rest of the world, the United States places far less emphasis on public health and primary care, and (2) because socioeconomic disparity in the United States is high and one sixth of the people lack health insurance, the United States has a large medically vulnerable population.

Title VII of the Health Professions Education Assistance Act is the only federal program that has increased the production of primary care physicians who serve medically vulnerable populations.[1] Yet each year over the past 2 decades both Republican and Democratic administrations have recommended drastic cuts for this program. Until this year, Congress has annually restored the major portion of the funding for Title VII. In 2006, however, Title VII was severely slashed. The Title VII Primary Care Medicine and Dentistry Cluster received a cut of 54%, from $88.8 million for FY2005 to $41 million for FY2006. This cut will have a significant impact on family medicine programs. No new grants will be awarded this year, existing 3-year programs will be funded at reduced levels, and many important programs that have relied on 3-year cycles may cease to exist

Title VII grants have supported the development of innovative programs that have been generalized to the larger educational experiences of medical students and residents. They have, for example, spurred the development of curricula in community-oriented primary care and provided clinical training sites where physicians learn to serve vulnerable populations. More important, these grants are the foundation for programs that train academic leaders of the future who are more likely to instill in their students an understanding of the importance of personal medical homes and a sense of obligation to serve communities and populations.

A loss of federal funding for primary care and public health training programs will have a negative effect on the health of all Americans, but particularly for vulnerable populations. Who will be the doctors for rural Americans, for low-income and inner-city communities, for minority populations and for our burgeoning population of senior citizens?

Federal policies answer these questions with an inherent irony, illustrated in a study of all federally funded Community Health Centers (CHCs) by Rosenblatt and colleagues and the associated editorial by Forest.[2,3] From 2001 to 2005, the number of Americans in vulnerable populations served by community health centers rose 36%, from 10.3 to 14 million. In 2002, the Federal Healthcare Initiative became law, and established a $780 million plan to create new CHCs and expand existing CHCs. The initiative estimated that by 2007, 21 million Americans would be served by CHCs, thus expanding the true safety net of personal medical homes for medically vulnerable populations.

Rosenblatt found that 90% of the CHC physicians are primary care physicians, over one half of whom are family physicians, and that more than 400 family physicians are needed immediately to fill the vacancies in CHCs. Paradoxically, while the federal government has dramatically increased funding for new and expanded community health centers, it has drastically cut funding for programs like Title VII that train the health care providers who are needed in these vital personal medical homes. These policies will assure that the number of vacancies for primary health care providers will continue to rise and CHCs will struggle to meet the needs of their communities.

What should we do? We must petition our legislators with redoubled effort. We must parade our Title VII successes before them, and continue to provide the information and build the relationships that encourage them to make informed decisions. In particular, we should all vigorously support the following actions:

1. Restore and increase funding to Title VII, Section 747, the Primary Care Medicine and Dentistry Cluster of the Health Professions Education Assistance Act, and support the reauthorization of an improved Title VII.

2. Eliminate barriers that inhibit cooperative relationships between CHCs and family medicine training programs.

3. Earmark a large proportion of GME payments from CMS to support generalist physician training programs.

4. Develop stronger alliances with other primary health care providers, including general internists, gen-

eral pediatricians, nurse-practitioners, physician assistants and others who together give a stronger voice for primary care.

The programs supported by Title VII, which have been on the cutting edge of medical education, are now on the cutting room floor of a misguided federal healthcare plan. Supporting Title VII programs must be a priority in our efforts to reduce health disparities.

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References

1. Krist AH, Johnson RE, Callahan D, et al. Title VII funding and physician practice in rural or low income areas. *J Rural Health.* 2005;21: 3-11.
2. Rosenblatt RA, Andrilla CHA, Curtin T, et al. Shortages of medical personnel at Community Health Centers: Implications for planned expansion. *JAMA.* 2006;295:1042-1049.
3. Forrest CB. Strengthening primary care to bolster the health care safety net. *JAMA.* 2006;295:1062-1064.

From the North American Primary Care Research Group

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PRIMARY CARE RESEARCH IN CANADA AND THE UNITED STATES

The state of primary care research in Canada and the United States has much in common. The development of this important body of knowledge is still in an emergent phase in both nations and while different strategies have been implemented to catalyze growth in research capacity, most are still in their infancy.

It has been well demonstrated that a health care system founded on primary care is associated with improved health outcomes for a nation's population and enhanced cost-effectiveness. Research is vitally important to strengthen primary care through the generation of evidence-based medicine that informs both clinical practice and the organization of service delivery. Research conducted in the biomedical sciences and in the tertiary care setting—the predominant form in both countries—is often inappropriate to the needs of primary care clinicians, resulting in challenges to the dissemination and uptake of research knowledge.

Primary care clinicians themselves are best placed to generate relevant knowledge and ensure its translation into everyday practice because of their awareness of the needs of the communities they serve and the important research questions that need to be answered. Despite this opportunity, primary care has had a weak culture of formal inquiry, with poorly developed infrastructure and low levels of active participation in research. This has resulted in far fewer publications relative to other medical disciplines.

However, there are encouraging initiatives that have begun in Canada and the United States to enhance the profile of research within primary care. In the United States, one finds strategic government programs to promote primary care inquiry, while within Canada progress has been more fragmented.

One element common to both countries is the establishment of practice-based research networks (PBRNs). These networks recognize that primary care practices are the natural laboratories for primary care research and typically comprise a number of community-based practices that are linked with academic institutions. In this way, high-quality research can develop within a collaborative framework that includes academic and community based researchers.

US federal support for these networks is mainly through the Agency for Healthcare Research and Quality. Between 2000 and 2004, more than $8 million was awarded to 45 research networks comprising more than 10,000 primary care clinicians caring for more than 10 million Americans. These networks have done important basic descriptive work on the nature of primary care practice and patterns of medical errors and have also examined strategies for preventive service delivery and chronic disease management in a variety of settings and patient populations.

In Canada, despite an $800 million Primary Health Care Transition Fund established in 2000 to support primary care reform, little funding has been dedicated to developing primary care research infrastructure. The vast majority of this funding has been dedicated to clinical program implementation, often without the necessary research in place to underpin the programs. A number of PBRNs exist in Canada, particularly in Alberta, Ontario, and Nova Scotia, but are dependent on funding from local sources or are indirectly supported through research operating grants from agencies such as the Canadian Institutes of Health Research and Health Canada. Notable studies have been completed in the areas of cancer screening, management of hypertension, and diabetes education. What is clearly needed in both Canada and the United States is a strategic commitment at a national level to fund the infrastructure needed to support primary care research networks. There is still much to learn about improving the delivery of primary care services, including the impact of redesign at micro and macro levels. More effective and efficient systems of primary care will pay enormous dividends in improved population health and