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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and the Association of Departments of Family Medicine

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

lower health care costs. NAPCRG is partnering with primary care organizations in both the United States and Canada to ensure that these arguments are heard and acted upon.

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JUNE HAPPENINGS: SIGNIFICANT FOR SPECIALTY?

June 2006 could prove to have been a watershed month for family medicine because of a convergence of events that bode well for the specialty's future. Many of the events were brought about by the AAFP's hard work over time, said AAFP President Larry Fields, MD, of Ashland, Ky. The events:

• *CMS proposed changes that should significantly increase family physicians' Medicare payments for evaluation and management services beginning in* 2007. For example, said Fields, if a family physician sees 86 patients a week, codes two thirds of the visits 99213 and codes the other one third 99214, his or her income could rise about $30,000 a year. These proposed changes reflect recommendations made by the Relative Value Update Committee. The AAFP has a representative and an alternate representative on RUC, as well as an adviser to RUC. The committee's recommendations speak volumes about the Academy's influence through these individuals, Fields said.

• *The AMA House of Delegates called for an increase in the number of primary care physicians and a change in payment systems to "incentivize" such an increase.* "Having AMA policy on our side may not sound all that sexy, but it's hard to overemphasize how important it is," said Fields. The Academy has intensified its efforts to influence the AMA through the AAFP delegation and other family physicians active in the AMA house—and it's paying off, he said. As of now, there are family physicians on every major AMA council and on several other groups within the AMA, and that includes the new chair-elect of the AMA board.

• *The AMA house also decided that comprehensive health system reform should "be of the highest priority."* Because of policies it now has in place, the AMA should be working in concert with AAFP for reform that has a primary care base, payment incentives to attract medical students to primary care, and liability system changes to preserve access and drive down the cost of defensive medicine. "Changes in these 3 areas are imperative no matter what kind of system we end up with—multiple-payer, single-payer or something in between," said Fields.

• *The Massachusetts Medical Society's annual physician workforce study shows that primary care physicians are in short supply in that state, including a "severe" shortage of family physicians.* "This acknowledges the strange paradox that the specialty most desired by people is in the shortest supply because academic health centers receive incentives to train and recruit subspecialists to get research dollars," said Fields.

• *The Institute of Medicine reported that emergency departments are overwhelmed, in part because of patients' lack of access to primary care services.* Fields noted, "We can hope that this will prompt the American College of Emergency Physicians to join the Massachusetts Medical Society, AAFP and AMA in calling for the training of more FPs, and to support FPs continuing to do a broad scope of practice, including working in the emergency room."

• Annals of Family Medicine *published a study showing that liability reforms other than caps didn't make a dent in the cost of malpractice awards or premiums.* Fields said it was gratifying to have an independent study confirm the conclusions reached last year by the AAFP Strike Force on Liability Reform, which he chaired. "It's high time policy makers stopped trying to blow smoke in the eyes of the American people with voodoo about solving the liability crisis," he said. "Instead, Congress should focus on legislating effective changes, such as caps on noneconomic damages and alternative dispute resolution, not on maintaining the earnings of trial lawyers." There currently is a Senate bill that would establish pilot projects for just such tort changes, he noted.

"I believe these happenings in June raised the collective consciousness about the value of primary care, bolstered the prospects for family medicine and set the stage for real health care reform," Fields said. "Everyone should keep the faith. We are not going to lie down, but rather we are going to keep the pressure on and continue the momentum toward a better health care system for us all."

Paula Binder
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