



AMERICAN OSTEOPATHIC ASSOCIATION

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**Statement of Karen J. Nichols, DO  
President-Elect American Osteopathic Association  
Presented to the Doctors Caucus  
U.S. House of Representatives  
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**The Current and Future Physician Shortage: How Health Care Reforms Can Address the Problem**

Congressmen Murphy and Gingrey, members of the Caucus, thank you for the opportunity to testify today. My name is Karen Nichols. I am the President-Elect of the American Osteopathic Association (AOA) and Dean of the Midwestern University Chicago College of Osteopathic Medicine. Prior to my career in academic medicine, I practiced in Phoenix, Arizona for almost 20 years. I am pleased to be here today to share the AOA's perspective on the impact current health care reform legislation will have upon the physician workforce, identify areas that will require attention in the future, and discuss ways that we can work together to meet the health care needs of our nation.

**Background on the Osteopathic Profession**

The osteopathic profession has a strong and distinguished history of educating, training, and placing physicians in underserved communities. This commitment began in the late 1800's and continues today. Our academic and training model, while not unique to the osteopathic profession, places an emphasis on preparing osteopathic medical students for careers in general physician specialties such as primary care, obstetrics, general surgery, and emergency medicine. Our academic curriculum, along with a community-based training model, is the primary reason that the profession has enjoyed great success in the production of primary care physicians and general surgeons. Today, 60.5 percent of all osteopathic physicians practice in a primary care specialty.

Currently, one in five medical students in the United States is enrolled in a college of osteopathic medicine. We are one of the fastest growing fields in the health care sector. Currently, there are 25 colleges of osteopathic medicine operating on 28 campuses. We estimate that 2 to 3 new colleges will open in the next few years. Many of our colleges are located in geographic regions with acute physician shortages, such as western Washington, Arizona, and the full span of Appalachia where we have four schools. This commitment to establishing colleges and training opportunities in areas of need is key to meeting the health care needs of underserved communities and is indicative of the profession's commitment to this cause. In 2009 the nation's colleges of osteopathic medicine graduated 3,724 osteopathic physicians. In 2011 that number will grow to 4,500 and by 2015 over 5,000 osteopathic physicians will graduate each year. If current trends remain consistent, by 2020 there will be over 110,000 osteopathic physicians in the United States.

### **Physician Workforce Shortage**

Both the House and Senate health care reform bills pay special attention to the looming physician workforce shortage through the creation of a “workforce commission.” This commission would be charged with analyzing current workforce capacity and future need, thus enabling policy development targeted at meeting such need. The AOA supports the creation of a federal workforce commission and we are pleased that it is included in the legislation.

It is well documented in academic and business literature that the United States faces a significant shortage of physicians in the near and distant future. The exact shortfall is open to debate, but the AOA recognizes that we must begin to educate and train more physicians immediately. Given the time gap between matriculation and entrance into the workforce – at minimum seven years – it is imperative that we increase our undergraduate and graduate medical education capacity, as well as residency training opportunities, immediately.

As I outlined in the previous section, the osteopathic profession is working hard to do our part and applaud our allopathic colleagues, who have increased enrollment at their colleges of medicine by 15 percent, for their efforts as well. Combined, the osteopathic and allopathic profession will graduate an additional 5,000 to 6,000 physicians above the current baseline in the near future. However, our shared goal of building a sufficiently robust physician workforce to treat our growing population cannot be realized without an expansion of Medicare-funded graduate medical education training opportunities. Current projections estimate the number of allopathic and osteopathic graduates will reach 24,700 by 2015, exceeding the number of available residency positions by 2,283. Action must be taken by Congress to ensure that this gap is closed.

Additionally, Congress must devote additional time and attention to the role of international and foreign medical graduates (FMG) in our nation’s physician workforce. Approximately 5,000 FMGs enter GME training programs each year, compounding the demand for residency positions, with no assurance that these physicians will remain in the United States to meet our long-term workforce needs. The AOA believes our graduate medical education system is stellar and the United States should continue to offer training opportunities to foreign medical school graduates. However, we question whether importing such a large number of foreign physicians to the United States is a sound, sustainable policy solution to addressing the workforce shortage.

### **Graduate Medical Education**

The nation’s graduate medical education capacity has been stagnant since the enactment of the Balanced Budget Act of 1997. At the time of enactment, the general opinion among academic experts was that the United States would have a surplus of physicians over the coming decades. Due to faulty assumptions, these projections have proven false and these same experts now acknowledge that our nation faces a significant shortage of physicians.

The House and Senate health care reform bills include numerous provisions that are supported by the AOA and have an opportunity to reform our nation’s graduate medical education system. Both bills place an increased emphasis on the training of primary care physicians and general surgeons. Additionally, both bills allow for the redistribution of funded, unfilled graduate medical education positions. The AOA supports the redistribution process, but we fear that the overall impact of this

policy will be limited. We believe that the limitations on the number of funded positions should be increased, at minimum, by 15 percent – thus creating an additional 15,000 training positions.

Reforms to the GME training system are also an essential component of workforce development. The AOA supports reforms included in current health care reform bills that would allow for training in community-based settings. Research has shown that physicians trained in community health centers, for example, are twice as likely to work in underserved settings and four times more likely to work in health centers after completing their residency. However, qualitative assessments reveal that the affiliation between health centers and primary care residency programs is hindered by financial and administrative barriers. To this end, the AOA supports the establishment of demonstration projects that would create “Teaching Health Centers,” whereby community-based education settings could secure financing for graduate medical education.

We urge Congress to maintain provisions in health care reform legislation that will create new training opportunities in non-hospital settings and clarify existing regulations governing non-hospital training. Under existing law, hospitals often continue to incur the costs of the stipends and fringe benefits of the resident during this time, but are unable to recoup these costs through GME payments. Providing training opportunities in “real world” settings such as ambulatory care centers provides residents with exposure to primary care specialties and increases the likelihood that residents will choose to practice in these settings.

Current legislation takes appropriate steps to clarify that the time residents spend training in non-hospital settings can be counted as long as the hospital pays “all or substantially all” of the training costs at that site and the resident spends his or her time in patient care activities. The AOA strongly supports this provision. Measures to provide greater flexibility for residency training programs should include a clarification of the meaning of “all or substantially all” to allow for the counting of patient care activities as long as the hospital continues to incur the costs of the stipends and fringe benefits of the resident during the time the resident spends training in the non-hospital setting.

### **Primary Care Shortage**

The Health Resources and Services Administration (HRSA) predicts that our nation faces a shortage of primary care physicians today and that shortage will grow to exceed 40,000 by 2025. We see a similar shortfall in general surgery. These shortages likely will grow more severe as fewer and fewer medical students enter these specialties and those that do tend to sub-specialize after their initial training.

During my career I have witnessed first hand the challenges of addressing our nation’s physician workforce shortage, particularly in the field of primary care. Despite a strong commitment from our leadership, colleges, and students, the challenges of training more primary care physicians and general surgeons are increasingly prohibitive. Policy issues such as education debt, limited graduate medical education opportunities and an inequitable and broken physician payment system all create disincentives that push young medical students away from primary care and general surgery.

Studies indicate that income disparities have a significant negative impact on specialty choice of primary care physicians and general surgeons over subspecialties in which incomes are nearly three times higher. This trend in income disparities will only exacerbate the shortage of physicians in

lower-paying fields of medicine. A major driver of income disparities are current physician payment methodologies.

Measures of professional satisfaction among primary care physicians and general surgeons indicate an increasingly dismal practice environment. While physicians in all specialties face unnecessary and costly administrative hassles, the burden on primary care physicians in small practices is particularly excessive, detracting from the time available for patient care. Primary care physicians' role in coordinating care and making needed referrals to specialists typically involves frequent interaction with managed care organizations and other third-party payers to obtain required approvals, services, and payment, resulting in paperwork and overhead expenses almost twice as great as those of other physicians. A typical primary care physician must coordinate care for Medicare patients with 229 other physicians working in 117 different offices, yet receives no compensation for these care coordination services. As a result, the average primary care physician spends only 55% of his or her workday on face-to-face patient care.

Current physician payment methodologies place a greater value on the volume of services than on prevention and the coordination of care that can lead to better outcomes. The AOA seeks to reform this model and encourages Congress to support efforts to adopt the patient-centered medical home. This model would provide additional reimbursement and potentially reduce administrative burdens for practices that have the infrastructure and capability to provide patient-centered, physician-guided, coordinated, comprehensive, and longitudinal care.

Practices that organize to deliver patient-centered care through the medical home model should be paid a monthly, risk-adjusted care management fee for each eligible patient, fee-for-service payment for face-to-face encounters with patients and performance-based payments for reporting on quality, patient satisfaction, and efficiency metrics. The total payments for the patient-centered medical home must be high enough to fully cover associated costs and must result in an overall and substantial gain in net revenue to primary care physicians in such practices. Total compensation for PCMH should support the goals of making primary care more attractive, thereby bolstering the workforce.

Finally, the threat of annual cuts triggered by the sustainable growth rate (SGR), creates an unpredictable practice environment that forces small primary care and general surgery practices, with limited revenues and narrow margins, to make difficult decisions about whether to lay off staff, reduce their Medicare patient population, defer investments or opt for early retirement. We believe that a comprehensive overhaul of the payment system to accurately reflect the cost and value of providing care is essential to maintaining our existing workforce and community-based health care delivery system.

The current health care reform proposals include a number of significant provisions aimed at both increasing payments for primary care physicians and reforming the delivery system. The AOA strongly supports the "Medicare Physician Payment Reform Act" (H.R. 3961) approved by the House. This legislation would repeal the current Medicare physician payment formula and replace it with a new payment model that places greater emphasis on those services provided by primary care physicians and general surgeons. Additionally, the AOA strongly supports bonus payments for primary care physicians included in both bills. We prefer the permanent primary care bonus included in the House bill, but applaud the Senate bill for taking significant steps to increase payments for primary care physicians. The AOA also strongly supports provisions in the House bill

that would increase Medicaid payment rates to parity with Medicare payments. We believe that this provision is essential to securing access to care.

Finally, the AOA appreciates the inclusion of provisions in the House and Senate bills that would expand the patient-centered medical home to a larger number of Medicare and Medicaid beneficiaries. While we continue to believe that the medical home model should be more widely implemented, we applaud the commitment to further promoting this delivery model in the Medicare and Medicaid programs.

### **Educational Debt**

Our nation's medical education system also plays a central role in deterring young physicians from entering certain fields of medicine and plays a large role in the geographic distribution of physicians. The average osteopathic medical school graduate has a debt load of \$168,031 which, as you can well understand, makes the prospect of entering a primary care specialty or general surgery daunting.

Congress, through the American Recovery and Reinvestment Act (Public Law 111-5), took significant steps to finance scholarship and loan repayment programs offered by the National Health Service Corps (NHSC). Further modifications to the NHSC are made in both the House and Senate health care reform bills. The most significant provision exempts scholarship and loan repayment dollars from personal income tax, thus making the financing mechanism more appealing to medical students and young physicians.

The NHSC, if appropriately funded, has the ability to both increase the supply of primary care physicians and meet the needs of underserved communities. However, we must continue to examine and develop additional programs that can complement the work being done by the NHSC. The AOA is a strong supporter of legislation that would restore the 20/220 pathway allowing students to qualify for loan deferment during their initial training years. The 20/220 pathway was eliminated as part of the "College Cost Reduction and Access Act of 2007" (Public Law 110-84).

Additionally, the AOA is interested in a loan repayment model that would resemble Teach for America, whereby young physicians who agree to practice in underserved communities could obtain financial assistance, loan deferment, reduced interest on their federal student loans, or a combination of these options.

In closing, the AOA believes that current health care reform bills include a number of significant provisions that address the nation's projected physician workforce shortage. With this said, there are a number of areas in which the legislation falls short and we look forward to continuing our work with you to address these issues.

I would like to thank you and members of the Caucus for affording me the opportunity today to share the AOA's perspective on issues most important to osteopathic physicians. The AOA appreciates the work that you do to promote policies that advance our profession and allow us to focus on the care of our patients. We look forward to working with you in the days and weeks ahead to ensure that any legislation passed by Congress fosters rather than impedes upon the physician-patient relationship.