



Statement

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Addressing Healthcare Workforce Issues for the Future

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by

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My name is Edward Salsberg, and I am the Director of the Center for Workforce Studies at the Association of American Medical Colleges (AAMC). Thank you for the opportunity to speak to you today regarding the physician workforce and the response of America's medical schools and teaching hospitals to a growing concern about potential future physician shortages.

The AAMC is a nonprofit association representing all 126 accredited U.S. allopathic medical schools; nearly 400 major teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

Our mission is to improve the health of the public by enhancing the effectiveness of academic medicine. Together with our members we pursue this mission through the education of the physician and medical scientist workforce, the discovery of new medical knowledge, the development of innovative technologies for prevention, diagnosis and treatment of disease, and the delivery of health care services in academic settings.

The AAMC is committed to promoting an adequate supply of well-educated physicians sufficient in number and competencies to assure access to high quality medical care in the future. To this end, the AAMC established its Center for Workforce Studies in 2004 to enhance and make publicly available comprehensive data and analyses regarding the supply of and demand for physicians. The Center is committed to providing the medical education community (medical schools, medical students, residency programs and teaching hospitals), the public, and policymakers with superior information on current and likely future physician workforce needs. The Center does this through original research, analysis of existing data, collaboration with other associations representing physicians and through an annual conference on physician workforce research. In recent months, the Center has updated a number of documents including our "2007 State Physician Workforce Databook" and a listing of "Recent Reports and Studies of Physician Shortages in the U.S." These reports accompany this statement and are available along with additional information on the Center on our website, <http://www.aamc.org/workforce>.

In my comments today, I want to provide you with some basic background on the physician workforce, why we are concerned about the likelihood of a future physician shortage, what the AAMC is recommending in terms of physician workforce policies, and finally, how the nation's medical schools and teaching hospitals are responding. I also want to specifically address the importance of the Title VII program in addressing physician workforce needs of the nation.

Background on the Supply of Physicians

The vast majority of licensed physicians in the U.S. are educated in allopathic medical schools—those that confer an MD degree—and residency training programs in the nation's teaching hospitals accredited by the Accreditation Council for Graduate Medical Education (ACGME). Allopathic medical schools and their affiliated teaching hospitals also are a critical source of research, new medical knowledge, and clinical care, and are a vital part of the nation's medical safety net.

- Physicians in the United States can practice medicine only after completion of a medical degree (“undergraduate medical education” or UME), and several years of post-graduate training in an accredited residency program (“graduate medical education” or GME).
- Each year approximately 16,000 physicians graduate from U.S. medical schools with an MD degree; these graduates fill roughly two-thirds of first-year residency positions in training programs—such as internal medicine, general surgery, pediatrics, and others—that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).
- In 2006-07, nearly 6,800 graduates of foreign medical schools, generally referred to as international medical school graduates or IMGs, entered residency training, representing about 27 percent of the new residents that year; of those, about 1 in 4 were U.S. citizens who attended schools outside of the U.S.
- Graduates of osteopathic medical schools (DOs) represent about 11 percent of all physicians entering graduate training each year. More than half of DOs enter ACGME accredited residency programs.
- Physicians in the U.S. are licensed by individual states, all of whom require an MD or DO degree, as well as some level of accredited graduate training (GME).
- In 2006, there were almost 870,000 physicians active in medicine in the U.S., of which 56,000 were osteopaths. This figure includes just under 105,000 physicians in residency training. About 25 percent of active physicians in the US are graduates of non-US medical schools.

Why a Physician Shortage Is Likely

The expected future shortage of physicians is driven by likely changes in both the supply and the demand for physicians. On the demand side, key factors include: (1) the growing U.S. population (more than 25 million each decade); In fact, between 1980 and 2005, the US population grew by more than 70 million people (31 percent) while medical school enrollment remained essentially flat. (2) the rapid increase in the number of people over the age of 65 (who use twice as many physician services per capita each year than those under 65); (3) advances in medicine that prolong life and improve the quality of life for millions of Americans; and (4) the rising expectations of Americans along with increasing wealth that will motivate and enable them to use more services. On the supply side, key factors include: (1) the aging of the physician workforce (36 percent of active physicians are over 55 and most will retire by 2020); and (2) a new generation of physicians, who value lifestyle and do not appear willing to work the long hours that prior generations of physicians have worked. At current levels of training, the physician-to-population ratio will peak before 2020 and then fall, just as the baby boomers begin to reach 75 years of age.

Since 2002, there have been at least 35 studies showing current or future physician workforce needs of a state or specialty.¹ An October 2006 report by the Health Resources and Services Administration (HRSA) predicts that the demand for physicians will exceed the supply by 2020.² The underserved and elderly populations are most likely to be affected. These shortages are

¹ <http://www.aamc.org/workforce/recentworkforcestudies2007.pdf>

² HRSA Bureau of Health Professions. Physician Supply and Demand: Projections to 2020. October 2006. <http://bhpr.hrsa.gov/healthworkforce/reports/physiciansupplydemand/default.htm> Accessed: February 5, 2008.

likely to exacerbate the existing lack of access for the 20 percent of Americans that live in government designated Health Professional Shortage Areas (HPSA).³ Many rural and urban communities, economically disadvantaged and underrepresented minority populations are likely to remain medically underserved for the foreseeable future, and certainly will be more underserved if a national shortage emerges.

The Supply of Physicians

For the last 50 years, the physician-to-population ratio has been growing steadily. This reflects a doubling in medical school enrollment in the 1960s and 1970s. However, with the report of the Graduate Medical Education National Advisory Commission (GMENAC) in the late 1970s predicting a large surplus of physicians, medical school enrollment stabilized. In fact, the number of graduates from U.S. medical schools has been virtually flat since 1980. As a result, a very large number of active physicians now are nearing retirement age. In 2005, a little more than 12,000 active physicians reached age 63; by 2017, this number will grow to more than 24,000.

The near-zero growth in U.S. MD graduates has translated to a decrease in the number of medical school slots per population in America. In fact, between 1980 and 2005, the US population grew by more than 70 million (31 percent)⁴ while there was no growth in allopathic enrollment; this has led to a significant and steady decline in enrollment per 100,000 population. In addition to the large number of physicians approaching retirement age, there are growing reports that the newest generation of physicians do not want to work the long hours of physicians in the past. Gender also plays a role. While only 10 percent of practicing physicians were female in 1980, they are now about 50 percent of the medical students. While this trend is encouraging from a societal perspective, it has implications for the physician workforce because women tend to work fewer hours than their male counterparts do. Moreover, there are growing reports that many of today's young physicians, male and female, are choosing to work fewer hours than their older counterparts regardless of their gender. As a result, the future physician workforce may effectively be 10 percent lower than their aggregate numbers may suggest.

In order to be able to forecast future supply of physicians more accurately, the AAMC, in collaboration with physician specialty societies and the American Medical Association (AMA) undertook two major surveys: one of more than 9,000 physicians over 50, the other of 4,100 physicians under 50. The "Over 50 Survey" was designed to understand factors influencing retirement patterns and plans; the "Under 50 Survey" was designed to assess whether in fact younger physicians are working fewer hours than physicians in the past. The surveys confirmed the likelihood of future physician shortages.

AAMC Workforce Policy Recommendations

While there are already shortages in many communities and for some specialties today, the potential major nationwide shortages loom in the future. However, we need to be concerned today as it takes at least a decade to impact the supply of US educated physicians due to the time

³ <http://bhpr.hrsa.gov/shortage/>

⁴ US Census Bureau

to develop additional capacity and the length of education and training. An appropriate supply of well-educated and trained physicians is an essential element to assure access to quality health care services for all Americans. The recommendations of the 2006 AAMC Position Statement on the Physician Workforce are intended to better assure an appropriate supply of physicians while increasing medical education opportunities for Americans. The AAMC recommendations include:

- **Enrollment in LCME-accredited medical schools should be increased by 30 percent from the 2002 level by 2015. This expansion should be accomplished by increased enrollment in existing schools as well as by establishing new medical schools.**

The United States medical education community has spent decades developing standards and methods to help assure that schools meet appropriate minimum standards and that physicians that graduate from these schools have the skills and knowledge necessary to provide high quality care. The nation is better served when a greater, not lesser, proportion of future physicians are held to these standards. Moreover,

- There are large numbers of Americans who aspire to attend U.S. medical schools but have been unable to gain admission due in part to limited capacity. Many are so committed that they are willing to pay high tuitions at schools with varying standards and leave the U.S. for several years to reach their goal. We estimate that more than 3,000 U.S. citizens enter medical school outside of the U.S. each year;
- There is growing international concern that English-speaking countries may be draining valuable human resources from less-developed countries. Increasing U.S. medical school graduates will reduce the “pull” of physicians from less developed countries without creating barriers for individual migration.

Achieving the desired growth in medical school graduates will require an increase in enrollment at most existing schools as well as the creation of new medical schools. Increases in enrollment are particularly appropriate in areas of the country where the population has grown rapidly over the past 25 years and areas where the population is projected to grow rapidly in future years. In addition, states with low medical school enrollment per capita, with numerous underserved areas and states with large and growing elderly populations may also be appropriate areas for medical school enrollment growth.

The AAMC is making every effort to inform the medical education community about the growing likelihood of a physician shortage but does not control the number of medical student enrollments or training positions available. The AAMC’s recommendation to increase enrollment has not gone unnoticed. The 2007 entering class to U.S. medical schools is the largest in the nation’s history. The number of first-year enrollees totals almost 17,800 students, a 2.3 percent increase over 2006. More than 42,300 individuals applied to enter medical school in 2007, an increase of 8.2 percent over 2006. Nearly 32,000 were first-time applicants, the highest number on AAMC record. According to a 2007 survey of medical school deans, 100 of the nation’s 126 medical schools already have increased their enrollment or plan to increase their enrollment by five or more students within the next five years, when compared to their baseline 2002-03 enrollment. Data from this survey projects that first-year enrollment will grow to

19,909 in 2012 from 16,488 in 2002, an increase of nearly 21 percent. It appears that our member institutions will reach the 30 percent increase in enrollment goal from both existing and new schools by 2017.

- **The aggregate number of graduate medical education (GME) positions should be expanded to accommodate the additional graduates from accredited medical schools.**

U.S. medical schools face many challenges in increasing the number of medical school graduates. A primary goal of this expansion is to increase the supply of physicians available to assure access to services in the future. Since all physicians must complete accredited graduate training to become licensed in the U.S., the number of GME positions is a critical choke point to increase the supply of physicians available to care for Americans.

We strongly urge Congress to preserve Medicare support for GME. The AAMC also recommends that Congress eliminate the current limit on the number of Medicare-funded residency positions. This will allow GME programs to expand in response to increased medical school enrollment and other physician workforce dynamics. The AAMC welcomes the opportunity to work with the Committee to educate the public and policymakers about the importance of stabilizing and expanding GME support in the context of an impending physician shortage.

The AAMC believes the *Resident Physician Shortage Reduction Act of 2007* (S. 588) is a useful beginning in meeting the nation's needs for future physician services. We express support for this important first step in what we hope will be a systematic and rapid process to eliminate the Medicare resident cap. However, we do wish to be clear that financing this legislation from other cuts in Medicare in which we have any interest will be self-defeating and unacceptable.

On a related matter, the President's fiscal year (FY) 2009 budget proposes, over five years, to cut indirect medical education (IME) payments to teaching hospitals by a total of \$21.75 billion. The Administration would accomplish this by reducing the add-on payment from 5.5 percent to 2.2 percent over three years, as well as eliminating IME payments to hospitals treating Medicare Advantage beneficiaries. We ask Congress to reject these proposals, which are shortsighted in light of the looming physician shortage.

Additionally, the AAMC strongly urges Congress to preserve Medicaid support for GME. As you know, CMS has issued a proposed rule that would reverse a long-standing policy of providing federal matching funds for state Medicaid GME payments. The AAMC asks you to delay further action on this proposed rule by immediately taking up and passing S. 2460, which extends by one year a current moratorium prohibiting CMS from moving forward with these Medicaid GME cuts.

The AAMC also asks Congress to take up legislation to remove regulatory barriers that penalize GME programs that train residents in outpatient settings such as community-based primary care offices. We also encourage Congress to continue funding programs that offer higher reimbursement levels for physicians who practice in underserved areas.

- **The AAMC should continue to advocate for and promote efforts to increase enrollment and graduation of racial and ethnic minorities from medical school; and promote the education and training of leaders in medical education and health care from racial and ethnic minorities.**

Studies repeatedly have shown that medical students from racial and ethnic minority groups are more likely to practice in underserved communities and to care for a disproportionate number of disadvantaged patients. This information, coupled with other compelling arguments, underlies the AAMC's strong advocacy for greater diversity in medical education. The implementation of lawful, race- and ethnicity-conscious decision making in medical school admissions and in faculty recruitment and retention is essential to meet society's need for a physician workforce capable of caring optimally for our increasingly diverse population.

In the fall of 2006, the AAMC launched the AspiringDocs.org campaign, which seeks to encourage well prepared African American, Hispanic/Latino, and Native American college students from all undergraduate majors to pursue medicine as a career. U.S. medical schools and teaching hospitals have a decades-long commitment to building diversity in medicine. To complement efforts to increase the pipeline of prospective students, the AspiringDocs.org campaign takes a new approach – career marketing – to reach an untapped segment of potential minority student applicants in America's colleges and universities that was revealed by an innovative AAMC analysis.

- **The J-1 visa is the most appropriate visa for non-U.S. citizen graduates of foreign medical schools entering graduate medical education programs in the U.S. and should be encouraged.**

The primary purpose of graduate medical education is education. The J-1 program's purpose is educational and its administration by the Educational Commission for Foreign Medical Graduates (ECFMG) assures that J-1 residents and fellows possess valid educational credentials, have successfully passed Steps 1 and 2 of the United States Medical Licensing Examination (USMLE), and that their country of origin needs the knowledge and skills that they will obtain through their education in the U.S. No other immigration program or visa category is as consistent with the aims of U.S. graduate medical education or offers an equal assurance of the quality of entrants.

The H-1 visa (an employment visa) is not appropriate for physicians coming to the U.S. for education and training purposes. At the national level, consideration should be given to clarifying and expanding the types of visas available for physicians seeking GME in the U.S.

- **The National Health Service Corps (NHSC) has played an important role in expanding access for underserved populations, and continued expansion of this program is strongly recommended.**

The NHSC is a program sponsored by the Department of Health and Human Services (HHS) that helps place physicians and other health care providers in communities where they are most needed, both through scholarships and through loan repayment. The NHSC has a

proven track record of serving the underserved in both rural and urban settings; 60 percent of its clinicians are located in rural areas, while the remainder serve urban populations in settings such as Community Health Centers (CHC), health departments, and other critical access facilities. A recent report in the *Journal of the American Medical Association* by Rosenblatt and colleagues demonstrates the reliance of CHCs on NHSC scholars and loan repayment recipients and the inability of these safety net sites to recruit an adequate number of physicians.⁵

Since its creation, the NHSC consistently has received significantly more applications for positions than it is able to support with the funding provided by Congress. Funding for the NHSC has decreased by \$47 million (27 percent) since FY 2003, when its budget was \$171 million. Limited funding has reduced new NHSC awards from 1,570 in FY 2003 to an estimated 947 in FY 2008, a nearly 40 percent decrease.

The growing debt of graduating medical students is likely to increase the interest and willingness of U.S. medical school graduates to apply for NHSC funding and awards. The scholarship program funds tuition and other fees for over 150 medical students annually. Moreover, almost 80 percent of the NHSC budget funds loan repayments (numbering about 1,200 annually) for physicians that agree to serve underserved communities after the completion of residency training. The AAMC has recommended increasing annual NHSC awards by 1,500 to allow more graduates to practice in underserved areas. A NHSC appropriation of at least \$400 million is necessary to sustain current NHSC levels and the AAMC-recommended increase.

AAMC Recommendations for Title VII Reauthorization

While we are encouraged by the response of the medical education community to our call for an increase in medical school enrollment, the AAMC and our constituents recognize that increasing the supply of physicians will not in and of itself address the problems of geographical and specialty mal-distribution. Having an adequate national supply of physicians is necessary but not sufficient to assure access to health care services for all Americans. The AAMC believes that Title VII of the Public Health Service Act is an essential part of the elements needed to assure access.

Federal funding for the Title VII health professions training programs administered by the Health Resources and Services Administration (HRSA) has been instrumental in increasing the supply of the primary care workforce and in addressing the needs of the underserved. Title VII programs support the training and education of health care providers through loans, loan guarantees, and scholarships to students, and grants and contracts to academic institutions and non-profit organizations.

The statutory authority for these programs provided by the Health Professions Education Partnerships Act of 1998 [P.L. 105-392] expired in September 2002. Each year, the community,

⁵ Rosenblatt RA, Andrilla CH, Curtin T, Hart LG. Shortages of medical personnel at community health centers: implications for planned expansion. *JAMA*. 2006; 295(9):1042-9.

in its efforts to preserve funding for these programs, faces opposition from the Office of Management and Budget, and in FY 2006, the programs sustained a 51.5 percent cut in federal funding. The President's budget request for FY 2009 recommends eliminating all funding for the Title VII programs.

Recognizing that a new approach to the Title VII programs is needed to strengthen them and improve their prospects for long-term survival, the AAMC in September 2004 appointed a committee to review the missions and effectiveness of the programs and propose recommendations as Congress considers reauthorization. The AAMC Committee agreed that the programs' shared goals should continue to be enhancing primary care, bringing care to underserved areas, and improving the diversity of the health care workforce. The Committee also agreed that the reauthorization of the Title VII programs should improve accountability of the programs by creating outcomes measures and enhancing the collection and analysis of data to monitor the programs' impact.

The Committee set forth a series of recommendations to align current funding streams with these goals and enhance the future viability of the programs. A copy of the AAMC Committee's final report accompanies this statement.

- **Diversity (Sections 736-739)**

The AAMC recommends the programs under Sections 736-739 of the Public Health Service Act be retained in their current structure, which includes the following programs: Centers of Excellence, Health Careers Opportunity Program, Faculty Loan Repayment Program, and the Scholarships for Disadvantaged Students. They should be funded at \$155 million. Additionally, the AAMC notes the need for increased emphasis on the development of underrepresented minority faculty, as these mentors create an environment that allows minority health professions students to succeed and graduate to provide care in their communities. The AAMC recommends the creation of a new program to support demonstration projects designed to increase the number of underrepresented minority faculty. The program should receive \$5 million of the \$155 million recommended for Sections 736-739.

- **Health Workforce Information and Analysis (Section 761)**

Despite the emphasis of Title VII programs on bringing care to underserved areas, there continues to be a dearth of information on their impact on workforce distribution. Additional funding is needed to establish and maintain a system for linking physician practice location and their medical education and graduate training experiences. A national workforce-tracking database is needed to identify where Title VII-trained professionals are practicing and to produce benchmark data to be used in evaluating the programs and determining preferences for the granting process.

The Regional Centers for Health Workforce Studies supported by HRSA have led the way in conducting health workforce studies and collecting data to inform state and national programs regarding state and regional health workforce needs. In addition, the Regional Centers have been able to leverage federal funding to obtain additional state and private

support. Yet, this component of Title VII has remained unfunded since FY 2006. The AAMC supports the continuation and expansion of these Centers, by reauthorizing section 761 at \$2 million for the six regional centers and authorizing \$3 million for a new national workforce database to track the location of health professionals educated and trained in programs receiving Title VII support.

- **Primary Care (Section 747)**

Primary care is an effective and necessary investment that benefits the health of all people. Title VII funding is key to producing primary care providers and improving their education. The Section 747 programs are guided by two agendas: caring for the underserved and preserving and promoting primary care.

The AAMC recommends a new structure, in which grants are preferentially awarded to applicants who enter into a formal relationship and submit a joint application with a Federally Qualified Health Center (FQHC), an FQHC Look-Alike, Area Health Education Center (AHEC), or a clinic located in a HPSA or MUA or a clinical practice setting in which at least 40 percent of its patients are either uninsured or supported by Medicaid. The AAMC recommends the continuation of the funding priorities and preferences included in the current statute.

Additionally, the AAMC proposes the creation of a new program under Section 747 in which grants will be awarded to schools or departments to administer demonstration projects centered on improving the quality of primary care in selected emphasis areas. A funding level of \$198 million is recommended for Section 747, with the distribution among the disciplines and between undergraduate and graduate programs to remain the same.

- **Address Inefficiencies in Title VII loan programs.**

The Title VII student loan programs offer long-term, low interest loans for economically disadvantaged and underrepresented minority students in the health professions. The average medical student participating in the Title VII student loan programs will save over \$50,000 when compared to current Stafford loans. Unfortunately, many medical students will not accept a Primary Care Loan (PCL) due to the extended service requirement and harsh default penalties. Students' avoidance of the PCL program has resulted in a large portion of available funds going unawarded each year, undermining the original intent of the program, and thereby subjecting the program to annual federal rescissions.

In addition to reducing these harsh default penalties, the AAMC recommends that the eligibility requirements for all HHS Title VII and Title VIII health professions loan programs be amended to allow for the waiver of parental financial information in extraordinary circumstances.

Currently, the HHS Student Financial Aid Guidelines (section 101.3.142) indicate that "institutions still must take parents' information" into account to determine students' eligibility PCL, HPSL, LDS, and Nursing Student Loan (NSL) programs. In other federal financial aid programs — for instance, under the auspices of the Department of Education —

financial aid officers have the ability to adjust this parental financial information requirement to reflect an individual's specific situation; however, HHS regulations state that the requirement to include parental data "cannot be waived."

There are compelling instances in which it would be appropriate for financial aid officers to use professional judgment to waive parental data for one or both parents, such as when a parent is incarcerated or incapacitated during long-term hospital care, or when a parent's whereabouts are unknown. Permitting financial aid officers to use their professional judgment to waive this requirement in appropriate cases would afford them greater flexibility in ensuring that scarce resources are best targeted to those students who are truly in need. Furthermore, the AAMC believes this is a more appropriate interpretation of the federal regulations that require the consideration of the "expected contribution from parents." (42 CFR Part 57.206).

Report language accompanying the FY 2007 Senate Labor-HHS-Education Appropriations bill (S. 3708, S. Rept. 109-287) encouraged "HRSA to omit the consideration of parental income from the fiscal year 2007 competitions as well as from future guidance and methodology" for administering the Title VII student loan programs. As you are aware, discrepancies in availability of parental financial information have disqualified already disadvantaged students from obtaining these affordable loans. The AAMC has been working with HRSA to ensure that students' fiduciary abilities are more appropriately represented in the student aid process by granting financial aid administrators greater professional discretion. The AAMC believes Congressional direction through Title VII reauthorization will help ensure that Title VII funds are more appropriately allocated in the future.

The issues surrounding the physician workforce and potential shortages are complex. The AAMC and our member institutions are committed to assuring an adequate supply of well-educated physicians to ensure that the future needs of Americans are met.