

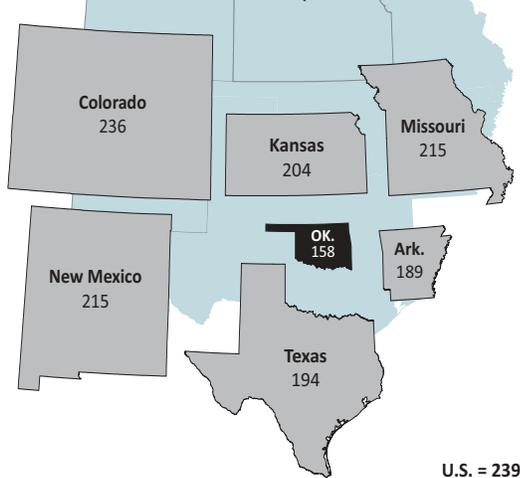


The Oklahoma Physician Shortage: OSU-CHS Responds

by John Fernandes, DO, MBA, William J. Pettit, DO, James D. Hess, EdD, and Chad E. Landgraf, MS

Oklahoma continues to rank at or near the bottom of national health measures. In 2006, the United Health Foundation gave Oklahoma a ranking of 47th in overall health status, and more recently, in the Commonwealth Fund's 2007 report, Oklahoma tied with Mississippi for last place in overall health system performance. Most troubling is the shortage of physicians. On a per capita basis, Oklahoma ranks last in the nation for physician coverage. Figure 1 shows how Oklahoma compares to its six neighbors. Over one-third of the physicians in the state are over the age of 55 and more than half are age 50 or older. As these physicians retire or are no longer able to practice, patient care will fall onto the shoulders of fewer and fewer physicians. As Table 1 shows, rural Oklahomans will endure the worst future physician shortages.

Figure 1
Number of Patient Care Physicians in Oklahoma and Bordering States
Per 100,000 Population



Source: Physician Characteristics and Distribution in the U.S. - 2007 Edition, American Medical Association

The route to practice in the United States and Oklahoma is through residency training programs approved by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME). These graduate medical education (GME) accrediting agencies apply strict criteria in approving new residency programs or the expansion of existing ones. In 1996, a census statement developed by the AOA, American Medical Association (AMA), Association of Academic Health Centers (AAHC), Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) and others proposed to “reduce the number of GME positions funded by the Federal government to a number closer to that of the graduates of US allopathic medical schools.” Consequently, when Congress passed the Balanced Budget Act of 1997, it froze Federal funding for GME

positions (slots) at the 1996 level. This momentous decision accounts for the current leveling off of the physician workforce pipeline and as the demand for physicians continues to increase, for future deficits. Not only has the current supply been held to mid-1990’s funding, but as the demand continues, the gap not filled continues to widen. Had this cap not been placed on GME slots, today’s current physician shortage wouldn’t exist. Since 1996, all of the signatories of the consensus statement have reversed their position and now advocate removal of Medicare’s GME caps.

The financing of GME by the Federal government began in 1965 through Medicare. The legislation says “educational activities enhance the quality in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the (Medicare) hospital insurance program.” Hospitals were reimbursed for these direct medical education (DME) costs until 1983 when Diagnosis Related Groups (DRG) were introduced and a formula separate from clinical services established payments. Federal support is in excess of \$2.5B for Medicare DME.

Table 1.
Age profile of Physicians in Oklahoma

| | Median Age | Under Age 50 | Over Age 50 |
|-------|------------|--------------|-------------|
| Urban | 50 years | 49.9% | 50.1% |
| Rural | 53 years | 40.5% | 59.5% |

Data Sources: Oklahoma Board of Osteopathic Examiners (2007); Oklahoma Board of Medical Licensure and Supervision (2007)

A second mechanism for Federal funding of GME through Medicare began in 1982 after passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) which allocated additional dollars for the increased costs of patient care in teaching hospitals. This funding called Indirect Medical Education (IME) payments was to account for any deficiencies in the DRG system “to fully account for factors such as severity of illness, and the requirement for specialized services and the costs of teaching residents.” Federal support for Medicare IME is close to \$5B. Additional sources of guaranteed DME support come from Medicaid, the Veterans Administration, and the Department of Defense. Nongovernmental GME funding comes from the private insurance industry through Medicare’s DME formula, clinical practice plan revenues, and endowments. Estimates are that total DME is \$8.8B. This equals approximately \$80,000 per medical resident.

There is little appetite on the national level for a review of Medicare’s GME funding, rather the Congress and Presidential candidates are focusing on universal access and total healthcare costs as opposed to physician manpower needs. Medicare’s contribution to GME comes primarily from Part A, the Medicare Trust Fund. This is mostly generated through payroll deductions. In the current hierarchy of political healthcare concerns, an increase in GME is in the bottom tier. In addition, there are still those who believe that the manpower issues are one of maldistribution as opposed to an absolute shortage. When affluent urban centers invest in healthcare resources, which then attracts specialists, they also serve the disadvantaged whose costs are high but whose outcomes are poor. This regional variation or maldistribution is a matter of social inequality, not inefficiency. Regional variation in healthcare will exist as long as differences in economic

status persist and the demand for physicians will vary accordingly. Physician manpower supply is best evaluated by long term economic and demographic trends.

Alternative funding schemes have been proposed as “the President’s Physician Shortage Act of 2007” by Senator Nelson of Florida. It would, if passed, lift the Medicare cap only for states that have fewer residents per capita than the national median. It is doubtful as to whether Oklahoma would benefit from this legislation. Going forward, it appears that other states that are growing faster than Oklahoma will become eligible sooner.

“All payor” systems which distribute GME funding responsibility beyond the Federal government have been instituted through a type of GME trust structure in New York, Minnesota, and Utah. This has not been a popular approach because private insurers maintain they already contribute disproportionately to the costs of the underinsured and the uninsured through cross subsidies. Private payors also contribute indirectly through the higher charges levied on them by teaching hospitals and, in this case, where there is no way for the uninsured to contribute.

In addition to GME training, medical schools certainly have a role in improving the physician workforce shortage. As of July 2007, sixteen new MD schools are in various stages of development. These new positions, when aggregated, comprise an increment of only a 15% increase, well short of the 30% population growth for the same time period. DO schools have increased from 15 schools in the 1980s to 24 schools with several new ones in the planning phase. The combined increased enrollments in both DO and MD schools still do not meet the current or projected demand. In Oklahoma, the OU-HSC medical school has increased its class size over the past four admission cycles from 150 to 162 and the OSU-CHS osteopathic medical school will expand its class size from 80 to 115 students. Unfortunately, medical school enrollment increases take a minimum of seven years to effect physician workforce numbers. Because of this lag and the costs involved in funding new medical school positions, expanding GME positions is the key to reversing physician workforce shortages both nationally and in Oklahoma. However, additional medical school and academic health center expansion at OU and OSU continues to be necessary to alleviate all healthcare workforce shortages in Oklahoma.

The mission of the OSU-CHS is to provide primary care physicians for rural and underserved Oklahoma. Its GME system is currently composed of 17 programs training 210 interns, residents and fellows. In accepting the challenge of the physician shortage in Oklahoma, OSU-CHS is planning a 71% increase in its number of GME trainees by 2013 bringing the total to 360 residents. This expansion will develop in two models. First is an urban triangle in northeast Oklahoma that will be composed of the OSUMC in Tulsa, the VA Medical Center in Muskogee and other partners in Tulsa. The second component will be a rural focus which will develop new programs in Enid, Tahlequah and Lawton. Other rural communities are under consideration.

Our medical school graduates and the 3,200 graduates from the 24 other osteopathic colleges in the US form the pipeline for OSU-CHS GME applicants. Last year alone OSU-CHS had over 360 applicants for 34 intern positions at OSUMC. Nine out of ten applicants were turned away. Considering that 80% of graduates of GME programs practice within 150 miles of their training site, Oklahoma lost a great opportunity.

Funding this process is critical to the efforts of putting more primary care physicians into Oklahoma. Any new GME programs at facilities that have never received DME funds are eligible for Federal funding on a three-year rolling average. The additional GME positions at facilities with existing programs could not, because of the 1996 freeze, receive additional Federal funding. State funds would be required to create these positions. Total estimated cumulative costs of the 71% increase of 150 positions over five years is \$25,483,000. Yearly costs extend from year one at \$2.8M to year five at \$7.4M.

The physician shortage in Oklahoma is critical, especially in light of the number of expected retirees leaving the workforce in the next five years. Oklahoma medical schools have expanded their class sizes to the extent that their faculty and resources permit. GME expansion is the key to the physician shortage both nationally and in Oklahoma and will require state dollars. With the state’s help, OSU-CHS is prepared to accept the challenge and produce more primary care osteopathic physicians for Oklahoma. ■

Suggested reading:

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