

Editor's Notes

Clogged Pipelines Create a Physician Workforce Crisis in California

By Stephen Jackson, M.D., Editor



Having attended the CMA Legislative Day in Sacramento, I was both amused and disheartened by Gov. Jerry Brown's address, which might best be described as a "barrel of laughs" by a comedian, reminiscent of the Laurel and Hardy convention I attended last year just a few steps from our esteemed State Capitol. Perhaps I needed a reminder of the fact that the jokesters in Sacramento linger on ... and on ... and on.

Upon studying the bills for which we were to advocate, I became even more aware that we should be seriously concerned for the adequacy of the (aging) physician workforce in California. Moreover, physicians are unevenly distributed, with the rural and poorer urban areas having the greatest shortfall (especially in primary care physicians—PCPs) yet, not surprisingly, with some excesses in more affluent locations.

Californians are beset with a "tsunami" composed of national health care reform that will add coverage to *millions* of previously uninsureds, baby boomers embarking on (or considering) retirement, and our nation's and state's recessions accompanied by California's crippling and unresolved budget debacle. (In fact, one of the few to escape California's epidemic of obesity is our state's exchequer!) However, most prominent among the impediments to serious health care reform is the simple fact that the backbone of any health care system consists of sufficient and timely access to physician care. This truth notwithstanding, legislators and regulators, and certainly many gleeful allied health professionals, are not alarmed by the evolving paucity of physicians. Their solution is much more complicit to damaging our nation's quality of care: expand the scope and independence of practice of non-physicians so as to "replace" or "fill the void" of the inadequate number and distribution of physicians. As we well know, this already has begun—witness the aggressive opt-out tactics of nurse anesthetist organizations; optometrists' lobbying for more prescriptive and therapeutic entitlements; physical therapists seeking to de-link themselves from physician direction; psychologists' attempts to enter the catacombs of prescriptive psychiatry; and podiatrists creeping toward "accessing" the full leg.

California's culturally and ethnically diverse population is growing rapidly—and, importantly, aging—and the populations that have been identified as being traditionally medically underserved are the source of a disproportionate segment of that growth. But, as our large population of aging physicians—*approximately 30 percent of our active physicians are older than 60, a figure larger than that of any other state*—approaches retirement, the pipeline to replace them is being choked off at the medical school and residency levels, which I shall detail below. Heaped upon this clogged supply line is the financial debt with which medical students graduate (the average approaches \$175,000, but this figure fails to acknowledge the actual massive costs of a medical education already contributed fully or in part by students and their families), one that prompts them to eschew the poorly compensated primary care specialties. As the supply/demand model of capitalism—with the push and pull among corporate America, government and unions—continues to hold significant sway over key decision-making processes, physician reimbursements have for the most part been rigidly controlled and limited without much, if any, recourse, especially in light of physicians' prohibition from collective bargaining (one might want to read about a problematic response by some physicians on pages 91–92).

California has almost 120,000 actively licensed physicians, of which one third are PCPs, but only 56 percent practice more than 20 hours a week. The Council on Graduate Medical Education (not immune from erroneous pronouncements) recommends that states should have 60–80 PCPs per 100,000 population and 85–105 specialists/100,000. Although our state barely satisfies the former (and actually exceeds the latter), their distribution results in shortages of PCPs in three quarters of our counties, and even a shortage of specialists in almost half of them. Three quarters of our PCPs originate from out-of-state or foreign medical schools, international medical graduates comprising about one quarter of our state's actively practicing physicians. Morally, one might consider that our society's gains are other, less developed countries' losses, but this assuredly does not apply only to medicine. Another challenge lies with the fact that our physician workforce does not reflect our state's ethnic and racial diversity.

What of the supply side? The 1980s projections of a physician oversupply by the year 2000 effected a concerted and successful effort by medical schools to cap their enrollment while the federal government froze graduate medical education funding. So, while the number of California medical school graduates has held steady (roughly 45,000 applicants for 1,100 places in our eight medical schools), we are burdened with the dismal rate of only 40 percent in-state matriculation for our homegrown physician aspirants. Physicians who are educated and trained in California want to remain here, and indeed,

we lead the nation (62 percent) in retention of medical school graduates. However, they represent only a quarter of California's physician workforce. We also retain 70 percent of our residents and fellows, accounting for 55 percent of our workforce. Importantly, California-born physicians who are educated or trained out-of-state do *not* return in appreciable numbers. Thus, we need to expand the capacity of California's medical schools. The clog: no money for this (or just about anything else) in the foreseeable future.

As for the residency and fellowship segment of our supply network, about 38,000 candidates applied for 25,000 residency slots nationwide in 2010. While this scarcity of slots is a national dilemma, the Golden State is more heavily affected because despite having 12 percent of the nation's population, we house only 8.3 percent of the nation's medical residency positions. In 2008, we had 25.1 residents per 100,000 population, distressingly less than the national average of 35.7/100,000. Again, any solution to unplugging the pipeline will be impeded by the financial realities of the federal and state budgets.

There now is a projected shortage of 17,000 physicians for California by 2015! Indeed, the trend is that retiring physicians are exceeding those entering the workforce. And, it may well be that our upcoming generation of physicians will sagely choose quality of life and lifestyle in preference to selfless (and potentially personally harmful) dedication to their professional lives, working fewer hours and retiring earlier than their predecessors. To their credit, they already appropriately have gained improved working hours and conditions in their postdoctoral training programs. Meanwhile, we must seek creative accommodations in practice that would retain physicians within the workforce for a fuller and longer period of time (read the stimulating opinion piece on "The Mommy Track" on pages 52–56).

Meanwhile, our state's population expanded 20 percent between 1995 and 2009 (7 million), far above the national average. In roughly the same period, those over age 65 grew by 22 percent, a predictably continuing trend. Furthermore, the regions projected to see most of this population expansion would be the South and Central valleys as well as the Inland Empire, which include some of the most medically underserved areas of our Golden State.

Medical student debt, the high cost of living in this state (ranked second nationally, and dominated by home prices), and the compensation disparity separating PCPs from other specialists combine to persuade many young physicians to choose the higher-paying specialties and avoid practicing in "impoverished" areas. Add to this the dismal Medi-Cal situation, where we have the fourth lowest reimbursement rate in the nation (56 percent of the federal Medicare rate) and are last in ranking of benefits paid per enrollee.

Editor's Notes (cont'd)

And do note that Medi-Cal would expand dramatically with federal health care reform. Assuredly, the death knell of physician workforce numbers would be sounded immediately if MICRA were to be disembodied.

Medicare is the largest source (70 percent) of graduate medical education (GME), equating to \$8.4 billion in 2008. However, with the U.S. government's freezing residency positions in 1997, our teaching institutions have not been able to secure further federal financial support to permit expansion of their residencies. The second largest GME source, the Medicaid (Medi-Cal) program, determines funding *inversely* based on the (higher than national) per capita income for California, and therefore is grossly underfunded, not to mention that such calculations fail to take into account our (nationally) above-average poverty rate. It is imperative that we build coalitions to aggressively advocate for better and more realistic GME funding.

The ASA is in the process of looking for solutions for our anesthesiology workforce issues, and soon should have results of surveys already conducted (such as anesthesiologists over 50 years old, our "senior," "aging" colleagues), as well as plans for more comprehensive and well-designed studies in the future.

Furthermore, the ASA will have to deal effectively with the complexities not only of achieving, but also of *maintaining* ABA diplomate status (see the article on maintenance of state licensure on pages 59–62, as well as the article on MOCA in our last issue). Which leads me to sign off with the admonition that we must be mindful that simple "certification" already is an accepted "standard" of allied health professionals, and that conveniently constructed and easily obtained "doctorates" can further obfuscate truthful distinctions between physicians and those who disingenuously claim to be our equivalent.

This editorial has drawn heavily on another of the superb California Medical Association products, the "Issue Brief on the California Physician Workforce," well researched and written by Mark Kashton and Christina Lee.

CSA Bulletin Cover for Volume 60, Number 2 "Dunes at Morning"

The cover photograph of this *Bulletin* issue was taken in Death Valley in 2003 using a film camera. Even at dawn, footsteps in the sand were inescapable. The slide was scanned and the image was processed in Photoshop and Silver Efex Pro.

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