Reverse Shortage of Doctors and Nurses

by Pat Salisbury

In what many consider an extraordinary turnaround, in the last few years, the major gate-keepers of the medical profession have been forced to acknowledge that the shortage in the supply of physicians in the United States has reached a crisis level. Until 2003, except for a few bold voices, such as that of Dr. Richard A. Cooper (see interview this issue), the official, uncontested position of these institutions has been, that there is, and will continue to be a glut of physicians in the United States, and that therefore, measures need to be taken to reduce the number of doctors, with the possible exception of primary-care physicians.

Reality, and the stubborn refusal to buy into the fraud by a few, such as Dr. Cooper, have forced a grudging reassessment. The dimensions of the shortage crisis have thus begun to emerge. Immediate action to begin the reversal of this crisis is necessary if all Americans are to receive decent health care.

More Primary-Care Physicians Needed

A report on the status of officially designated Health Professional Shortage Areas (HPSAs) from the Government Accountability Office (GAO), released in October 2006, provides some basic figures on the shortage throughout the United States, of primary-care physicians, the first line of defense against ill-health. Updated in 2005, it shows that as of September of that year, there were more than 5,500 health-professional shortage designations, indicating not enough doctors in either a geographic area, among a population group such as migrant workers, or a particular health-care facility such as a rural health clinic.

Looking at the deficit for geographic areas and population groups, the study showed that 831 entire counties were designated as HPSAs, while another 815 consisted of service areas within counties. There is no state that does not have some HPSA designation. The GAO estimate concluded that 6,941 additional full-time primary-care physicians are needed to achieve ratios that would eliminate HPSA designations; this is based on a ratio of one physician for every 3,500 people in a geographic area, and 1:3,000 persons in a population group.

While the HPSA designation was created in 1978 to identify areas and populations that needed doctors, and is used by a number of Federal programs to make decisions about financial and manpower aid, it has a built-in rationing system. The administering agency, Health Resources and Services Administration (HRSA) designates HPSAs based on the ratio of population to the number of primary-care physicians and other factors, such as the area's infant mortality rate, the percentage of the population below the poverty level, or the area's birth rate. HRSA then gives each HPSA a score based on specific criteria that ranks its shortage of primary-care providers or other needs, relative to other HPSAs. Each HPSA is ranked from 0-25. A low score can disqualify an HPSA for certain Federal aid programs.

The GAO study was conducted to prove that the number of HPSAs in the nation is over-estimated, and through the usual process of redefinition and sleight of hand, manages to assert exactly that: a finding which, if left standing, would have dire consequences for numerous under-serviced areas and population groups.

The Fraud of Physician Oversupply

In 1994, the Council on Graduate Medical Education (COGME), the body authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends and make accompanying policy recommendations, reported that the nation would have 165,000 surplus specialists, and the notion of a glut of specialists remained the official position until 2003.

Based on this assumption, residency slots for training specialists were reduced, and Federal financial support for speciality physician training was cut. To foster this fraud, the most basic demographics on population growth and aging, and the aging of currently practicing doctors were ignored.

The assumption that the managed health care organizations would reduce effective demand for medical treatment, was elevated to a universal truth. As the population grew and aged, and doctors retired, the supply of new specialists was held at a constant of approximately 16,000 each year. Meanwhile, the vicious HMOs did their best to deny health services, but failed to convince the population that it was unreasonable to want to live and be healthy. Thus the reality that there are too few physicians, a shortage that Dr. Cooper expects to reach 200,000 by about 2020, has been greatly aggravated by the official claims made in 1994 by COGME, that there would be a glut of specialist physicians.

The fraud simply could not stand up to the overwhelming reality of the medical needs of the aging Baby Boomers and the refusal of a few, like Dr. Cooper, to buy into the lie or remain silent. In its 2003 report to Congress, COGME changed course, acknowledged at least a future shortage, and made some modest recommendations for increases in the number of physicians entering residency training each year, from 24,000 in 2002 to 27,000 in 2015.

In March 2005, the Association of American Medical Colleges (AAMC) called for medical schools to boost their enrollment over the next decade by 15%, a move which, if followed by every medical school, would result in an additional 2,500 graduates per year. The call by the AAMC marks

Conyers Bill Would End Physician Shortage

One in five Americans lives in a rural or urban area deemed to be without an adequate number of physicians to provide care. This reality, as Dr. Richard Cooper's interview (below) shows, is a national disaster in the making. Rep. John Conyers (D-Mich.), the incoming chairman of the House Judiciary Committee, took the initiative to reverse this, when, on July 12, 2006, he introduced H.R. 5770, titled, "United States Physician Shortage Elimination Act of 2006." The bill died with the close of the 109th Congress, having been stalled in committee.

The bill remains a critical initiative to address the problem. A reintroduced bill in the 110th Congress, would be greatly improved by including a provision to issue grants for construction and/or renovation of full-service public hospitals in the medically underserved areas which the Conyers bill targets for expanded service by newly trained physicians. Such a provision could amend the existing Hill-Burton Act, which provides funding for construction of hospitals.

The core findings of Conyers' bill are:

Over the next ten years, as physicians who graduated in the 1970s retire, the U.S. will have a 30% deficit in the supply of physicians, while at the same time, the U.S. population is expected to grow by 24%. This will create a shortage of at least 90,000 full-time physicians by 2020.

In the last 20 years, the median tuition and fees at medical schools have exploded by 745% at private medical schools, and 876% at public medical schools, thereby restricting those who can afford to apply.

What is to be funded and created under the Conyers bill:

1. A national health service corps medical school scholarship program to train 5,000 additional medical students each year.

2. Scholarships would be granted to individuals who agree to serve for six years after medical school in a Federally designated professional shortage area, and incentives would be created to encourage them to remain in these areas thereafter.

3. $425 million in contracts would be allocated to award scholarships to individuals based on various priorities, including to those who are from disadvantaged backgrounds and who would otherwise be unable to afford a medical school education, thereby augmenting pipeline program for minority students, ensuring an increase in the number of minority health professionals serving medically underserved communities.

4. $500 million in grants to medical schools would be made to increase the number of available slots for new applicants by providing funds to develop curriculum; acquire equipment; recruit, train, and retrain faculty; and provide aid to students completing residency training programs at recipient medical schools.

5. $200 million in grants would be provided to community health centers—facilities designated to serve adults and children in rural and urban areas who have financial, geographic, or cultural barriers to care, including primary and preventative health care, mental health and dental services, and transportation and translation services. These funds would be used to acquire or lease facilities; construct new or repair or modernize existing facilities; and purchase or lease medical equipment.—*Mary Jane Freeman*

the first time since the 1960s-70s that medical schools have been asked to boost enrollment. This hit like a shock wave, as talk of a crisis in the supply of doctors spilled over from professional journals into the popular media, including reports on current shortages in states such as California, Texas, and Florida.

Those who engineered the crisis are now trying to manage a half-hearted solution. Dr. Cooper estimates that the remedies proposed thus far are, in general, inadequate by about half; even in a best-case scenario, the shortage will persist for 10-15 years, since it takes at least 8 years to educate a physician. A gear-up period also has to be expected, as new medical schools are built or existing ones expanded. The impact on mortality and life expectancy of this too-many-doctors fraud has yet to be measured.

In addition to the shortage of doctors in all areas, there is an even more dire shortage of nurses.

A report updated in September 2006 by the American College of Nursing, reported the following summary numbers from a variety of sources.

- An HRSA study released in April 2006, projects that the nation's nursing shortage would grow to 1 million by 2020. All 50 states will experience a shortage of nurses to varying degrees by the year 2015.
- Currently, according to a report from the American Hospital Association released in April 2006, U.S hospitals need approximately 118,000 registered nurses to fill vacant positions nationwide. This translates into a national vacancy rate of 8.5%. Another survey reported that 85% of hospital CEOs reported shortages of RNs. Another study conducted in 2004, found that "a clear majority of RNs (82%) and doctors (81%) perceived shortages where they worked."

Qualified Applicants Turned Away

Similar to the failure to build schools to train the necessary number of doctors, the nursing supply crisis is directly related to the failure to continue to develop physical infrastructure in the medical field. HRSA officials stated in April 2006, that the U.S must graduate approximately 90% more nurses. But in 2004, U.S nursing schools turned away 41,683 qualified applicants due to an insufficient number of faculty, clinical sites, and classroom space.

This situation has resulted in some nursing schools resorting to a lottery system. According to a March 2005 report in the local California media, San Jose State University, Chabot College, De Anza College, Evergreen College, and Ohlone College are among those which are using a "luck of the draw" system to determine admission, a system that is criticized as degrading and discouraging to the applicants.

In addition, a 2005 survey of nursing schools found that 73.5% reported faculty shortages as a reason for not accepting qualified applicants, and most nursing professionals report that nurses do not join the faculties of nursing schools because the positions are poorly paid.

Study after study shows that even the current inadequate staffing levels, with nurses responsible for more patients than they can safely care for, leads to stress, exhaustion, and retirement. Another study indicates that one-third of hospital nurses under the age of 30 are planning to leave their current job in the next year. Given these dynamics the average age of nurses has increased from 45.2% in 2000, to 46.8% in 2004.

A 2005 study showed that the average registered nurse turnover rate was 13.9%; the vacancy rate was 16.1%. Another study in 2005 had more than one in seven hospitals reporting a vacancy rate of over 20%. High vacancy rates were measured across rural and urban settings, and in all regions of the country. Shortages are contributing to emergency department overcrowding and ambulance diversions.

Several of the studies cited document the obvious connection between shortages of nurses and quality of care, presenting statistics that are hair-raising with regard to the variation in survival rates.

HMOs Drove Nurses Out of Hospitals

As with the shortage of physicians, the crisis in nursing is entirely manufactured. By at least the mid-1990s, HMOs were putting every hospital in the country under pressure to reduce the cost of delivering hospital care in order to increase the HMO profits. A major target was the allegedly "high labor costs" associated with the most highly skilled and experienced registered nurses. So-called experts were brought in to reorganize the hospitals, cutting the nursing staffs and replacing them with "aides" or "techs" who had minimal training. The remaining nurses were run into the ground with lengthy shifts and impossible patient loads. No need to build schools to train nurses, if the nurses could be replaced or worked to exhaustion.