

BACKGROUND

No. 3221 | MAY 30, 2017

Addressing the Physician Shortage by Taking Advantage of an Untapped Medical Resource

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Abstract

Despite the incredible advancements in American medical innovation in recent years, problems exist regarding access to care, particularly in rural areas of the country. These problems are due in part to misguided policy decisions, and as a result, the current U.S. system of training doctors after graduation from medical school fails to produce the proper number and mix of physicians, while leaving thousands of qualified medical graduates without a pathway to participate in the health care workforce. Allowing medical school graduates to practice under provisional medical licenses would take advantage of the existing surplus of medical talent in the U.S., thus mitigating the current shortage of practicing physicians.

In some regards, the United States of America is home to the greatest health care system in the world. However, problems exist regarding access to care, particularly in rural areas of the country. These problems are due in part to misguided policy decisions, and as a result, the current U.S. system of training doctors after graduation from medical school fails to produce the proper number and mix of physicians and leaves thousands of qualified medical graduates without a pathway to participate in the health care workforce.

This issue has never been adequately addressed in health care reforms, including in the Affordable Care Act (commonly known as Obamacare). It can, however, be significantly ameliorated by making some relatively modest policy changes to the current framework for physician training and licensure that would take advantage of the pool of available medical graduates to help alleviate the current and predicted physician shortage. In particular, if states were

KEY POINTS

- Despite the incredible advancements in American medical innovation in recent years, problems exist regarding access to care, particularly in rural areas of the country.
- There is a significant shortage of health care workers throughout the country, which is predicted to get worse over the coming decades.
- Due to misguided policies, the U.S. system of training fails to produce the proper number and mix of physicians and excludes many qualified medical graduates.
- To take advantage of the existing surplus of talent in the U.S., state policymakers should allow medical school graduates to practice under provisional medical licenses.
- Allowing graduates to practice under provisional medical licenses would take advantage of the existing surplus of medical talent in the U.S., thus mitigating the current shortage of practicing physicians.

This paper, in its entirety, can be found at <http://report.heritage.org/bg3221>

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to offer provisional medical licenses to these graduates, the U.S. health care system would be able to take advantage of an untapped source of medical talent and could address many of the problems regarding shortages of care. Furthermore, allowing these graduates into the market may open up new training mechanisms for medical graduates that could fundamentally improve access to care for many Americans.

A Shortage of Physicians

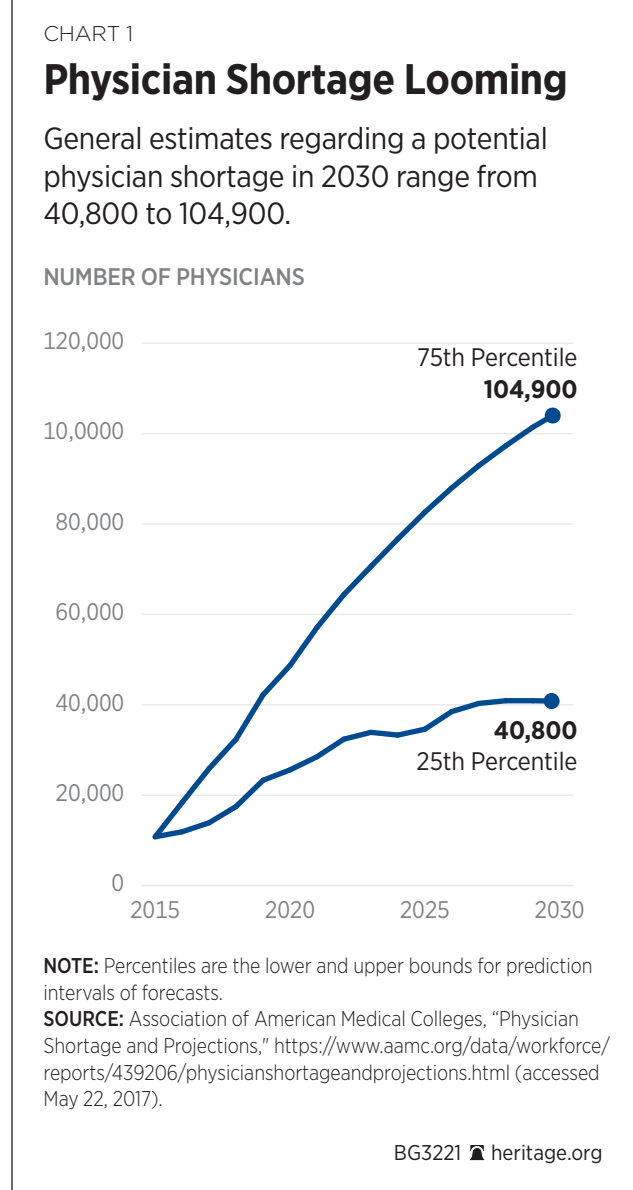
A recent analysis by the Association of American Medical Colleges identified a significant shortage in the health care workforce throughout the country and predicted that the situation will get worse over the coming decades. The study predicts that demand for physician services will grow faster than supply and ultimately result in a nationwide shortage of between 40,800 and 104,900 physicians in both primary and specialty care by 2030.

A primary reason for this shortage is the aging American population, patients as well as physicians. The American population age 65 and older is forecasted to grow by 55 percent from 2015 to 2030. Additionally, more than one-third of currently active physicians will be 65 or older within the next decade, meaning that even if physicians are replaced at the same rate at which they retire, there is likely to be inadequate access to necessary health care services, especially in rural areas of the country.¹

A Surplus of Talent

Each year, medical school graduates apply for residency training positions through the National Resident Matching Program, commonly known as “The Match.” These three-year to seven-year programs are overseen by the Accreditation Council for Graduate Medical Education (ACGME) and provide training to enable medical school graduates to practice as physicians.

After completing a residency program, trainees are eligible to sit for a board exam, written by a member group of the American Board of Medical Specialties (ABMS). If successful, trainees then



receive certification in their chosen medical specialty. They are then eligible to pursue additional graduate medical education through fellowship training in even more specialized medical fields. In each of the past seven years, however, several thousand medical graduates—American as well as foreign—have failed to obtain residency training spots in the U.S., resulting in a frustrating situation: a shortage of practicing physicians despite a surplus

1. Association of American Medical Colleges, “Physician Shortage and Projections—The 2017 Update: Complexities of Physician Supply and Demand, Projections from 2015 to 2030,” <https://www.aamc.org/data/workforce/reports/439206/physicianshortageandprojections.html> (accessed May 22, 2017).

of talent.² It is reported that many of these graduates are often relegated to working entirely outside the medical field, including selling sunglasses, driving taxis, and working at restaurants.³

Funding of Graduate Medical Education (GME)

Post-graduate medical training has existed in some capacity in the U.S. since at least the 19th century. Much of the early training occurred through informal methods, such as apprenticeships and short courses. Hospitals traditionally absorbed the cost of graduate medical education without government subsidies until the middle of the 20th century.⁴

In the 1960s, the federal government became involved in post-graduate medical training when federal funding for GME became part of mandatory spending in the Medicare program. Federal support of GME was never intended to be permanent, yet has remained the primary funding source of residency programs for the past 50 years. Medicare contributes about \$9 billion per year to GME. In addition to Medicare, Medicaid (about \$4 billion), the Veterans Administration (\$1.4 billion to \$1.5 billion), and the Health Research and Services Administration (\$464

million) also provide support for GME.⁵ An unspecified amount of GME funding also comes from private sources, which is difficult to track.⁶

Partially to address the rapidly rising costs of GME and in response to warnings of a physician surplus, the Balanced Budget Act of 1997 included several provisions relating to GME, most importantly the imposition of a cap on the number of Medicare-funded allopathic and osteopathic residency slots at 1996 levels. This cap has remained in place ever since.⁷

Current Problems with GME. The U.S. GME system suffers from a number of serious problems, most notably a failure to produce an adequate number and mix of doctors to meet the health care needs of the American public. Because GME funding goes directly to the teaching institutions, this money is often focused on the narrow needs of the teaching hospital rather than the broader health care needs of the population as a whole. In general, the U.S. has not adequately supplied the training needed to meet the demand for, among others, primary care physicians and general surgeons, especially for rural areas of the country.⁸

Access to care in rural areas has been a particular problem for decades.⁹ Although nearly 20 percent of

2. These statistics include students and graduates of American allopathic and osteopathic medical schools as well as students and graduates of international medical schools who are U.S. citizens or non-U.S. citizens (and are hence authorized to work). This number nearly doubles if non-U.S. citizen international medical students and graduates are taken into consideration. National Resident Matching Program, "Advance Data Tables: 2017 Main Residency Match," <http://www.nrmp.org/wp-content/uploads/2017/03/Advance-Data-Tables-2017.pdf> (accessed April 14, 2017), and National Resident Matching Program, "Results and Data: 2016 Main Residency Match," April 2016, <http://www.nrmp.org/wp-content/uploads/2016/04/Main-Match-Results-and-Data-2016.pdf> (accessed April 14, 2017).
3. American Medical News, "Foreign-Trained Health Professionals Put on Path to Practice in U.S.," July 25, 2011, <http://www.amednews.com/article/20110725/profession/307259952/2/> (accessed May 10, 2017).
4. John S. O'Shea, "Becoming a Surgeon in the Early 20th Century: Parallels to the Present," *Journal of Surgical Education*, Vol. 65, No. 3 (May-June 2008), pp. 236-241, [http://www.jsurged.org/article/S1931-7204\(07\)00292-9/pdf](http://www.jsurged.org/article/S1931-7204(07)00292-9/pdf) (accessed December 1, 2014).
5. John O'Shea, "Reforming Graduate Medical Education in the U.S.," Heritage Foundation *Backgrounder* No. 2983, December 19, 2014, p. 3, <http://www.heritage.org/health-care-reform/report/reforming-graduate-medical-education-the-us> (accessed April 14, 2017).
6. Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026*, December 2016, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52142-budgetoptions2.pdf> (accessed April 13, 2017); U.S. Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimates for Appropriations Committee, FY 2017*, <https://www.hrsa.gov/about/budget/budgetjustification2017.pdf> (accessed April 13, 2017); Department of Veteran Affairs, *Budget in Brief, 2017*, <https://www.va.gov/budget/docs/summary/Fy2017-BudgetInBrief.pdf> (accessed April 13, 2017); and Renee Butkus et al. and the Alliance for Academic Internal Medicine and American College of Physicians Graduate Medical Education Task Forces, "Financing U.S. Graduate Medical Education: A Policy Position Paper of the Alliance for Academic Internal Medicine and the American College of Physicians," *Annals of Internal Medicine*, Vol. 165, No. 2 (July 2016), p. 134-137, <http://annals.org/aim/article/2520466/financing-u-s-graduate-medical-education-policy-position-paper-alliance> (accessed April 13, 2017).
7. The growth of residency positions since the Balanced Budget Act suggest that private funding of GME training may have increased in response to these caps. See O'Shea, "Reforming Graduate Medical Education in the U.S."
8. O'Shea, "Reforming Graduate Medical Education in the U.S."
9. *Ibid.*

the country lives in rural areas, fewer than 10 percent of primary care providers practice there. In fact, as of 2016, more than 6,000 federally designated areas of the country had a shortage of primary care physicians.¹⁰ Additionally, graduates of residency programs have consistently demonstrated a preference for working in areas near where they completed their residencies. Since most teaching hospitals are not in rural areas, this trend does not suggest that the current arrangement will alleviate the problem.¹¹

Given the predicted shortage of up to 104,900 primary and specialty care physicians, the U.S. will face considerable health care access problems unless these physician-supply restrictions are alleviated. In a free market, resources are consistently adjusted in a manner that allows supply to be consistent with demand. When demand changes, supply also responds in a corresponding manner. The current GME system, on the other hand, is incapable of adequately responding to market forces, leaving many highly qualified medical school graduates without residency training positions in the main residency match.¹²

As a result, despite the growing physician shortage, many medical graduates are unable to enter the field and treat patients in any capacity.¹³ In 2017, there were nearly 5,000 medical graduates in the U.S. who did not place into a residency program during the main residency match.¹⁴ Some medical graduates are so eager to enter the field that they may be willing to work without pay, just to gain the experience, as

interns do in many other fields, such as government, law, engineering, architecture, and data science.¹⁵

Provisional Licenses Can Alleviate Physician Shortage

To take advantage of the existing surplus of talent in the U.S., policymakers should allow medical school graduates to practice under provisional medical licenses. State governments could establish provisional licenses that would enable medical graduates to work under the supervision of a primary care physician or hospital to assist in care and acquire training. Medical graduates, both American and international, who have passed the United States Medical Licensing Exams, or equivalent proficiency examinations, should be eligible for this type of licensing.

Policymakers should ensure that, under these provisional licenses, medical graduates can enter into collaborative, contractual agreements with practicing physicians who agree to supervise the trainees. The license would enable the graduate to have more independence treating patients than a medical student, but with an appropriate level of supervision from the collaborating physician.

Details of the collaboration, training, and level of supervision would be documented via contract. Over time, the supervising physician can allow the trainee more independence, commensurate with his or her experience and level of competence.¹⁶ By

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10. Health Resources and Service Administration, "HRSA Data Warehouse, Shortage Areas," <https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx> (accessed May 10, 2017).
 11. Advisory Board, "Why Rural America Doesn't Attract Doctors," *Today's Daily Briefing*, September 2, 2014, <https://www.advisory.com/daily-briefing/2014/09/02/why-rural-america-doesnt-attract-doctors> (accessed April 13, 2017); American Academy of Family Physicians, "Rural Practice, Keeping Physicians In," Position Paper, 2014, <http://www.aafp.org/about/policies/all/rural-practice-paper.html> (accessed May 22, 2017); and Joshua Ewing and Kara Nett Hinkley, "Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Providers," *The Rural Health Connection*, April 2013, <http://www.ncsl.org/documents/health/RuralBrief313.pdf> (accessed April 13, 2017).
 12. President and CEO Darrell G. Kirch, M.D. "AAMC Concerned About Reports of Unmatched Students," *Today's Daily Briefing*, Association of American Medical Colleges, March 15, 2013, <https://www.aamc.org/newsroom/newsreleases/331096/031513.html> (accessed May 24, 2017); National Resident Matching Program, "NRMP Historical Reports," <http://www.nrmp.org/match-data/nrmp-historical-reports/> (accessed May 10, 2017); National Resident Matching Program, "Advance Data Tables: 2017 Main Residency Match," <http://www.nrmp.org/wp-content/uploads/2017/03/Advance-Data-Tables-2017.pdf> (accessed April 14, 2017); National Resident Matching Program, "Results and Data: 2016 Main Residency Match," April 2016, <http://www.nrmp.org/wp-content/uploads/2016/04/Main-Match-Results-and-Data-2016.pdf> (accessed April 14, 2017).
 13. American Medical News, "Foreign-Trained Health Professionals Put on Path to Practice in U.S."
 14. This number exceeds 8,000 if non-U.S. citizen international students and graduates are considered.
 15. USMLE Forums, "Unpaid Residency; I Don't Need Salary!" forum post, November 10, 2013, <http://www.usmle-forums.com/img-residency-match-forum/52159-unpaid-residency-i-don-t-need-salary.html> (accessed May 10, 2017).
 16. The collaborating physician will have a vested interest in monitoring and maintaining the quality of the graduate's work at the risk of losing patients, having his own license revoked, or lawsuits and even criminal sanctions.
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allowing medical graduates to work under a provisional license, the health care system can take a big step toward mitigating access to care problems, especially in rural areas and for primary care, where there is significant demand and a shortage of physicians.

Current Experience with Provisional Licenses

Some states have begun to pursue legislation to allow provisional licensing. In fact, Arkansas, Kansas, Missouri, and Utah have passed legislation to provide licenses to medical graduates to treat patients under the supervision of a practicing physician.¹⁷ Although these reforms are definitely a step in the right direction, these states have also imposed a number of unnecessary restrictions on their provisional licenses that seem to be counterproductive.

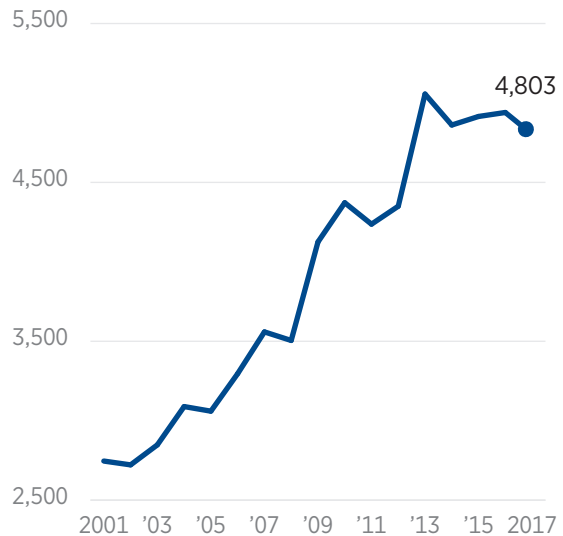
For example, Arkansas and Missouri limit eligibility to graduates who have completed medical school within several years of applying (four years and five years, respectively).¹⁸ Although this restriction is likely intended to prevent doctors who have been out of practice for a significant amount of time from treating patients, this restriction also precludes doctors with years, and possibly decades, of experience from being able to practice. The legislation passed in Kansas is especially restrictive, limited to students who have attended a particular medical school within the state. Private parties, such as hospitals and medical practices, as well as trainees, should be able to contract at will, provided the medical graduate meets the basic qualifications.¹⁹ These types of restrictions will reduce the effect of these efforts by failing to take full advantage of the available pool of qualified medical graduates.

The American Medical Association and the American Osteopathic Association have opposed provisional licensing laws, suggesting that allowing

CHART 2

Medical Graduates Struggle to Find Training in the U.S.

MEDICAL GRADUATES NOT MATCHING IN A FIRST-YEAR RESIDENCY DURING THE MAIN RESIDENCY MATCH



NOTE: Statistics include unmatched seniors of U.S. allopathic medical schools, previous graduates of U.S. allopathic medical schools, students/graduates of osteopathic medical schools, and U.S. citizen students/graduates of international medical schools during main residency match.

SOURCES: National Resident Matching Program, "NRMP Historical Reports," <http://www.nrmp.org/match-data/nrmp-historical-reports/> (accessed May 22, 2017), and National Resident Matching Program, "Advance Data Tables: 2017 Main Residency Match," <http://www.nrmp.org/wp-content/uploads/2017/03/Advance-Data-Tables-2017.pdf> (accessed April 14, 2017)

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these medical graduates to enter the field will jeopardize patient safety and create an underclass of

17. Kansas Statute 65 § 2811a, http://www.ksrevisor.org/statutes/chapters/ch65/065_028_0011a.html (accessed May 19, 2017); Missouri SB 716 (2014) and Missouri SB 754 (2014), <http://pr.mo.gov/assistantphysicians.asp> (accessed May 19, 2017); Arkansas Graduate Registered Physician Act, Arkansas HB 1162 (2015), <http://170.94.37.152/REGS/060.00.15-014F-16505.pdf> (accessed May 19, 2017); and H.B. 396 Medical School Graduates Associate Physician Licensure, 2017, <https://openstates.org/ut/bills/2017/HB396/> (accessed May 24, 2017).

18. The Arkansas law requires that licensing exams be passed in the first two years before application for licensure "but not more than two (2) years after graduation from a medical school, an allopathic medical college, or an osteopathic medical college." The Missouri law has a similar clause but requires exams be passed "in no event more than three years after graduation from a medical college or osteopathic medical college." These clauses thus preclude people who graduated from medical school more than four years preceding application for licensure in Arkansas, and five years in Missouri. The law in Utah is similarly restrictive.

19. Prospective trainees with less recent experience, as in other industries, would need to demonstrate competence (via shadowing, proficiency examinations) before being able to enter a collaborative agreement with an existing practitioner.

medical providers.²⁰ However, physician assistants and nurse practitioners do not receive substantially more training than medical students receive, yet they still treat patients throughout the country with a significant level of autonomy without having to undergo nearly the extent of post-graduate training that medical graduates are currently required to receive.

If done correctly, providing provisional licensure for medical graduates could open up an entirely new and competitive market for physician training, ultimately giving these graduates more choice and enabling them to receive as good, or even better, training than that available under the existing system dominated by the ACGME and ABMS.²¹ Recently, several major medical specialty boards, including the American Board of Internal Medicine, have received heavy criticism regarding their maintenance of certification requirements that a growing number of doctors view as costly, burdensome, and useless, spawning a number of alternative certifying entities that are challenging the status quo.²²

Conclusion

Well-trained doctors are the heart of the American health care system. Unfortunately, the existing framework for physician training and licensure restricts the supply of practicing physicians, thus exacerbating issues regarding access to care. Fortunately, market-based reforms concerning medical licensure and training can address current health-care-workforce and access-to-care issues. Allowing medical school graduates to practice under provisional medical licenses would take full advantage of the existing surplus of medical talent in the U.S., thus mitigating the current shortage of practicing physicians.

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20. “AOA Convenes Coalition to Address Assistant Physician Legislation,” The DO, April 10, 2016, <http://thedo.osteopathic.org/2016/04/aoa-convenes-coalition-to-address-assistant-physician-legislation/> (accessed May 10, 2017).
21. For some ideas about this, see Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What’s Holding Back Health Care and How to Free It* (Washington, DC: Cato Institute, 2007).
22. Paul S. Teirstein, “Boarded to Death—Why Maintenance of Certification Is Bad for Doctors and Patients,” *New England Journal of Medicine*, Vol. 372, No. 2 (January 8, 2015), pp. 106–108.
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