Consensus Group Members

Baylor College of Medicine

Texas A&M Health Science Center: College Station, Temple, Bryan, Dallas, and Round Rock

Texas Tech University Health Sciences Center: Lubbock, Amarillo, and Odessa; and Paul L. Foster Medical School in El Paso

The University of Texas System

The University of Texas Health Science Center at Houston

The University of Texas Health Science Center at San Antonio; and Lower Rio Grande Valley Regional Academic Health Center in Harlingen and Edinburg

The University of Texas Health Science Center at Tyler

The University of Texas M.D. Anderson Cancer Center at Houston

The University of Texas Medical Branch at Galveston

The University of Texas Southwestern Medical Center at Dallas and Austin

University of North Texas Health Science Center at Ft. Worth

Teaching Hospitals of Texas

Texas Medical Association

CONSENSUS STATEMENT

83rd Texas Legislature

UPDATED 3/2013

All Texas medical schools, teaching hospitals, and the 47,000+ members of the Texas Medical Association agree:

- ✓ **Texas has a shortage of physicians.**
- ✓ **The shortage *will* get worse.**
- ✓ **Texans — whether in rural or urban areas — will be adversely affected, in varying degrees, by the shortage.**
- ✓ **Having insurance coverage will not necessarily ensure access to a physician.**

The future health of Texans is dependent on our ability to educate and train more physicians NOW.

continued on next page

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

CONSENSUS

All nine Texas medical schools, all regional medical school campuses, other health-related institutions in Texas joined by the state's largest professional associations for teaching hospitals and physicians as listed on the first page, offer our state's leaders this 2013 consensus statement on medical education and the physician workforce.

We agree:

- ✓ **The lack of adequate graduate medical education (GME) funding prevents the state from achieving the needed numbers of GME training positions. GME training is a lengthy and costly process, and funding is required for the full duration of the training, three to seven years depending on the specialty, to qualify a physician for practice.**
- ✓ **The state's ability to retain Texas medical school graduates for training, and ultimately for entry into practice, is seriously jeopardized by recent cuts in state support for GME programs and expansions.**
- ✓ **How successful the state will be in further building the physician workforce to meet growing demands is largely dependent on continued success in recruiting a strong influx of new physicians from outside the state, as well as a stable and adequately resourced medical education and GME pipeline.**

Texas continues to be overly dependent on other states and countries for supplying new physicians to our workforce. Three of four of the newly licensed Texas physicians in the past fiscal year graduated from medical schools outside of Texas. This places the state in a vulnerable position for meeting workforce needs, subject to external forces beyond the state's control that can adversely affect future numbers available for possible recruitment to the state.

We must educate and train sufficient numbers of new doctors. And, we must have adequate numbers of GME slots to keep young doctors in the state for residency training. Physicians who complete both medical school and GME in Texas are three times more likely to remain in the state to practice than those who are educated or trained elsewhere.[i]

Will There Be Enough Physicians for Texans?

In evaluating the state's physician workforce, there is good news, but several factors are likely to serve as barriers to improving access to care.

The Good News: RECORD HIGH NUMBERS OF NEWLY LICENSED PHYSICIANS

The Texas Medical Board licensed the highest-ever number of new licensees in FY 2012. This followed several years of new peaks in the number of newly licensed physicians.

The Barriers to Improving Access to Care

Multiple complicating factors have prevented greater improvement in access to health care in many areas of the state, despite the growth in physician numbers. These factors are not expected to improve in the near future, as discussed below.

INCREASING PHYSICIAN DEMAND

Several powerful trends are generating physician demand that is pushing physician shortages to levels that threaten the ability of Texans, regardless of where they live or whether they have health insurance, to access health care. Those trends include:

- ✓ **No. 1 IN POPULATION GROWTH AMONG ALL STATES FOR TWO DECADES** — Texas' growth has prevented the substantial gains in new physicians from having the full beneficial impact on physician access. Without the large numbers of new physicians, the ratio would have fallen much lower.
  - Addition of 8 million residents from 1990 to 2010
  - Projected net increase of more than 5 million Texans by 2020

- State birth rate that ranks No. 4 among the states[ii]

✓ **AGING OF THE POPULATION** — The first of 5.7 million Texas baby boomers, the age group with the highest demand for physician services, started becoming eligible for Medicare in 2011.

✓ **POTENTIAL FOR INCREASED MEDICAID ENROLLMENT** — There is potential for significant increases in Medicaid-eligible populations in the near future.

✓ **HEALTH STATUS** —The prevalence of chronic diseases, such as diabetes and hypertension, is growing. These diseases frequently require more health care services

STATE RANKING OF NO. 42 IN RATIO OF PHYSICIANS PER PERSON

Texas has historically had a lower ratio of physicians per person. Although there has been some improvement, the high rate of population growth has made it difficult to recruit sufficient numbers of physicians to keep up with gains in population. Of the 50 states (and District of Columbia), Texas ranks 42nd in the ratio of patient care physicians per 100,000 people.[iii]

When focusing only on the states with the largest populations, Texas ranks LAST in a comparison of the ratio of physicians per 100,000 people behind New York, Pennsylvania, Illinois, California, and Florida (see table below).

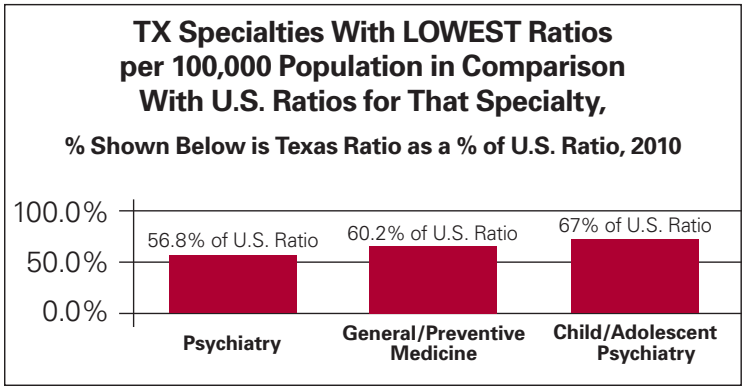
Most-Populous States by Population Size	TOTAL POPULATION		Patient Care Physicians per 100K Pop.	
	# (in millions)	State Ranking Among Most-Populous States	Ratio	State Ranking Among Most-Populous States
California	37 M	#1	237	#4
New York	20 M	#3	327	#1
Florida	19 M	#4	229	#5
Illinois	13 M	#5	249	#3
Pennsylvania	13 M	#5	266	#2
TEXAS	**25 M**	**#2**	**193**	**#6**
U.S. Total	309 M		240	

M=Millions. Source: Physician Characteristics and Distribution in the U.S., *2012 Edition, American Medical Association.*

BROAD PHYSICIAN SPECIALTY SHORTAGES

Texas has too few of most medical specialties, falling below U.S. ratios for *36 out of 40 specialties.*

There are shortages in primary care and in 32 nonprimary care specialties. The greatest shortages are in mental health specialties, both child and adult psychiatry.[iv] For example, the Texas ratio of 5.94 psychiatrists per 100,000 population was only 57 percent of the U.S. ratio of 10.46 psychiatrists per 100,000 population. The three major specialties with the lowest Texas specialty ratios in comparison with the United States are shown in the graph below.



GEOGRAPHIC PHYSICIAN MALDISTRIBUTION

Due to the state's broad geographic expanse and population distributions combined with economic and other factors, geographic physician maldistribution remains a challenge.

✓ Twenty-eight Texas counties, with a combined total of 90,431 residents, have NO physician.

✓ Fifteen additional Texas counties, with a combined population of 66,745, have only one patient-care physician each.

✓ Fifty-five Texas counties have a ratio of primary care/patient-care physicians above 3,500 per person, the federal threshold for primary care physician shortage areas.

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GRADUATE MEDICAL EDUCATION "BOTTLENECK"

With the help of Texas legislators, medical schools are doing their part to grow admissions to better meet physician demands; however, medical school graduates are not qualified to enter medical practice upon graduation. Three to seven years of GME in a particular specialty are required for graduates to qualify for practice.

Texas does a good job of keeping young physicians in the state for residency training, in comparison with other states. In fact, our state ranks No. 2 in the country. But when medical graduates have to leave the state for GME due to a shortage of available positions in their chosen specialty, those physicians are less likely to practice in Texas than a home-trained physician. Further, when they leave Texas for GME and stay away, they take with them the state's investment of more than $170,000 for their four years as a medical student.

Medical school graduates in Texas are projected to reach 1,700 in 2015. This increase will mean an even greater demand for GME to enable graduates to remain in the state for residency training. The Texas Higher Education Coordinating Board recommends a ratio of 1.1 to 1 for entry-level GME positions to number of medical school graduates. To achieve the 110-percent goal after graduates reach 1,700, an additional 400 entry-level GME positions will be needed to accommodate graduates. This growth will be even more difficult to achieve with the recent 41-percent reduction in overall state support for residency training.

Medicare provides the largest amount of direct GME funding to teaching hospitals, but Congress capped these funds at 1996 levels. Teaching hospitals that received Medicare GME funding in 1996 generally cannot expand this funding to include additional GME positions. Another disadvantage is deep cuts to state Medicaid GME funding after 2005.[v] As a result, hospitals with Medicare GME caps have to cover the full cost of newly added GME positions, without GME funding from Medicare or Medicaid for these positions.

Medical education and GME are considered a public good. Not only do medical schools, GME programs, and teaching hospitals prepare the next generation of physicians, but also residents provide medical care for the sickest and poorest among us as they train in their individual specialties. Teaching facilities typically treat the most complex and challenging diseases and medical conditions. Our academic health centers are among our state's major employers and a tremendous economic asset to their communities. Health-related institutions generate an estimated $1.30 in economic activity for every dollar spent, on average.[vi]

STATE MEDICAL STUDENT FORMULA FUNDING

Support for medical students through state formula funding peaked in the 2002-03 biennium. The per-capita amount for the 2012-13 biennium is the lowest level since formula funding was instituted in 1999, dropping 25 percent from the peak in 2002-03. The Texas Higher Education Coordinating Board recommends restoration of the state formula funding base rates for medical education and other formulas for the health-related institutions over three biennia (six years) to the levels in FY 2000-01.

STATE GME FORMULA FUNDING

Medical schools have received some state support for a portion of faculty costs or the development of new slots from Texas legislators since 2006. This funding was reduced by 30 percent, to $4,682 per resident per year for 2012-13, over the prior biennium. Funding at this level represents about one-fourth of the $18,000 in estimated annual faculty costs per resident. Further, this does not provide for the actual stipends for residents, which average about $50,000 a year or the other training-related costs at teaching hospitals which together are estimated to be more than $100,000 per resident. Adequate state GME formula funding is key to the state's ability to maintain, and in some cases, grow the number of GME positions.

JOINT ADMISSION MEDICAL PROGRAM

Texas legislators developed the Joint Admission Medical Program (JAMP) to help economically disadvantaged students achieve success in a medical

career. All nine Texas medical schools work in collaboration with state colleges and universities to provide the additional resources these students need to obtain a medical education. JAMP student admissions have two times more underrepresented minorities than other medical school admissions. And, JAMP students are more likely to stay in the state for residency than other medical graduates. JAMP received the Texas Higher Education Coordinating Board's Texas Higher Education Star Award in 2010 for exceptional contributions toward the agency's initiative, *Closing the Gaps by 2015*.

STATE GME APPROPRIATIONS

Public funding for GME programs has fluctuated in recent years. The current budget, all funds, provides $119.9 million less than a decade ago and $45.2 million less than the previous biennium, as shown in the table below.

State support for medical education and other important programs for developing the physician workforce also saw significant reductions in the current biennium, as shown in the table below:

TEXAS STATE APPROPRIATIONS FOR GRADUATE MEDICAL EDUCATION	2002-03 Biennium	2008-09 Biennium	2010-11 Biennium	2012-13 Biennium	Difference 2010-11 and 2012-13 *(in millions)*
	(in millions)				
Texas Health and Human Services Commission (Article II, Appropriations Act)					
Medicaid GME (estimated General Revenue [GR])	$67.5*	$0	$0	$0	**$0**
Medicaid GME (estimated federal funding)	$101.7*	20.1**	39.4**	38.6**	**-$0.8****
Health-Related Institutions* ** (Article III)					
GME Formula	-0-	62.8	79.1	56.9	**-$22.2**
Texas Higher Education Coordinating Board (Article III)					
Family Practice Residency Program (GR)	$20.6	17.5	22.2	5.6	**-$16.6**
Primary Care Residency Program (GR)	$5.9	5.0	5.0	-0-	**-$5.0**
GME Program (GR)	$15.2	0.6	0.6	-0-	**-$0.6**
Resident Physician Compensation Program (GR)	$8.1	-0-	-0-	-0-	**-$0-**
Family Practice Pilot Projects (GR)	$2.0	-0-	-0-	-0-	**-$0-**
GENERAL REVENUE (GR) TOTAL	$119.3	$85.9	$106.9	$62.5	**-$44.4**
ALL FUNDS TOTAL	$221	$106	$146.3	$101.1	**-$45.2**

**Medicaid GME was provided in Fiscal Year (FY) 2002-03 to Texas teaching hospitals, but this funding was discontinued in FY 2006.*
***Since FY 2009, Medicaid GME payments to hospitals have been limited to the five state-owned teaching hospitals. Please note, funding shown in the table for Medicaid GME in FY 2008-09 is for one year only as this funding began in FY 2009. Funding shown for FY 2010-11 is for two years, and funding for FY 2012-13 is projected for two years. Since the funding amount for FY 2013 is not yet known, funding for FY 2012 was used as an estimate for FY 2013 as well.*
****Does not include special item appropriations to health-related institutions for GME programs.*
Note: Detail may not add to totals due to rounding. Base report prepared by The University of Texas System and used by permission, with updates by Texas Medical Association.

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State support for medical education and other important programs for developing the physician workforce also saw significant reductions in the current biennium, as shown in the table below.

STATE APPROPRIATIONS FOR OTHER MEDICAL STUDENT AND PHYSICIAN WORKFORCE-RELATED PROGRAMS	2002-03 Biennium	2008-09 Biennium	2010-11 Biennium	2012-13 Biennium	Difference 2010-11 and 2012-13
State Medical Student Per-Capita Formula Funding	$55,971*	$51,527	$52,896	$42,180*	**-$10,716**
(Numbers below are in Millions)					
Primary Care Preceptorship Programs	$2.0	$0.9	$0.9	$-0-	**$-0.9**
Physician Education Loan Repayment	2.0	2.1	25.4	5.6	**-19.8**
Joint Admission Med. Program (JAMP)	4.0	5.6	10.6	7.0	**-3.6**

**Medical student per-capita formula funding reached a historic peak in 2002-03 and a historic low in 2012-13.*

Will There Be Enough Physicians for Texans?

CONSENSUS PRIORITY ISSUES FOR TEXAS

- ✓ **Preserve the state's investment in medical education by:**
  - **Funding sufficient GME positions to meet the goal of 1.1 entry-level GME positions for each medical school graduate in the state, and**
  - **Supporting Texas medical schools in their efforts to secure sufficient clinical clerkship space to enable medical students to remain in Texas for this training.**
- ✓ **Reverse cuts to state formula funding base rates for medical education and other formulas for the health-related institutions over three biennia (six years); restore funding to FY 2000-01 levels, as recommended by the Texas Higher Education Coordinating Board.**
- ✓ **Provide state GME formula funding at the highest per-resident levels possible.**
- ✓ **Restore adequate support for the state's Physician Education Loan Repayment Program as an effective tool for addressing physician shortages in underserved areas.**
- ✓ **Restore support for the state's Joint Admission Medical Program as an effective program for promoting diversity among the state's physician workforce.**

i TMA annual surveys of graduating medical students.
ii U.S. Centers for Disease Control www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_05.pdf.
iii American Medical Association, "Physician Characteristics and Distribution in the US, 2012."
iv Texas Medical Association analysis of 2010 physician workforce data, American Medical Association, "Physician Characteristics and Distribution in the US, 2012."
v Since 2009, only five state-owned teaching hospitals received Medicaid, GME funding, at the exclusion of other teaching hospitals.
vi Study measured the effect of medical education programs on direct and indirect business volume, employment, and government revenue. Association of American Medical Colleges. "The Economic Impact of AAMC Medical Schools and Teaching Hospitals, 2012." www.aamc.org/economicimpact.