REPORT OF THE HOUSE STUDY COMMITTEE
ON MEDICAL EDUCATION

REPRESENTATIVE BUTCH PARRISH, CHAIR

EXECUTIVE SUMMARY

HR 1722, adopted by the House of Representatives in the 2014 session, created the Study Committee on Medical Education. The committee was charged with studying the physician pipeline and making recommendations to ensure that the state has enough doctors for the future.

After conducting hearings across the state and hearing from a cross-section of medical and educational stakeholders, as well as prospective physicians, the committee has concluded its work. This executive summary will illustrate key findings and make recommendations on steps that Georgia can take to bolster the physician workforce.

I. Shortages Predicted

Georgia is ranked 39th in physicians per capita. By 2020, our state is projected to be 50th in the number of primary care physicians (PCPs) per capita.1 While metropolitan markets are not currently experiencing drastic health provider shortages, many rural areas are without access to core specialties or even an acute care hospital.

The primary issue that must be addressed in order to achieve the goal of a sufficient number of providers, according to nearly every witness, is the number of residency slots available to train physicians in Georgia. A resident is a graduate with a medical or osteopathic degree who is undergoing supervised clinical training at a teaching facility, usually a hospital. A doctor may not practice medicine without completing at least one, typically three but up to eleven, years of residency.

Since 2001 Georgia and the nation followed recommendations from the AAMC2 and the AMA3 to increase the number of medical school students by approximately a third in order to meet projected demand for health services posed by an aging and growing population. Georgia increased the number of medical graduates by 51%. This expansion has created a bottleneck. While the number of medical graduates has been increased, there has not been a corresponding increase in the number of residency slots, especially in growing states like Georgia. This bottleneck is described as the “UME to GME ratio” and depicted in the chart below. Georgia ranks 32nd nationally in this key figure and well below the US average and state median.4

This means that Georgia, a growing state with a looming physician shortage, is an exporter of medical graduates. In 2013, only 122 (22.3%) of the state’s 558 medical graduates entered a Georgia residency.5 For 2,707 total medical students in 2015, there were only 1,927 residency slots in the state.6 A key figure is the number of PGY-1 slots: Georgia has only 504. Many studies cited by witnesses attest to the fact that physicians have a high probability of practicing where they trained and attended medical school. Additional steps must be taken to increase the number of opportunities for Georgia students to train and practice here.

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1 Denise Kornegay, Assoc. Dean, AHEC; GRU
2 Association of American Medical Colleges
3 American Medical Association
4 AAMC, State Health Data Book, 2014
5 GBPW 2013 Medical School Grad Survey Report
6 Cherri Tucker, Executive Director, GBPW
7 Program Year 1, or the first year of residency
II. The Physician Pipeline

Training residents is very expensive, highly regulated, and lengthy. After graduation from medical school, depending on specialty, a residency can last from 3 to 8 years.

Most of the estimated $15 billion in public financial support for GME is provided by Medicare, as illustrated below.

Federal support, as a result of the Affordable Care Act, is set to decline. According to GBPW: “the federal government is proposing to reduce the Direct Medical Education (DME) and Indirect Medical Education (IME) payments to teaching hospitals. This funding provides approximately $90,000 per resident in training at teaching hospitals. It is estimated that the cost of training a physician at the GME level is $140,000 and this cost increases depending on specialty.”

Additionally, Medicare support has been frozen in place at 1997 levels for existing teaching hospitals as a result of the Balanced Budget Act of 1997.

State governments, medical schools, and teaching hospitals provide the remaining financial support that underpins the system. Georgia, through the GBPW, the Board of Regents, and Medicaid, provides roughly $85 million annually in state funds to support GME efforts.

III. Trends

Student debt emerged as a key issue that drives decisions that medical students make regarding their chosen specialty and practice location. One witness reported that the proportion of Georgia medical graduates with student loan debt in excess of $200,000 had increased tenfold over the previous decade, from 8.4% to over 40%.

Given that PCPs earn approximately half the incomes of specialists, the prospect of practicing in a rural or underserved area with few paying patients is a major deterrent to establishing a practice where they are most needed. For some specialties, like OB/GYNs, there is no obstetrical unit available to conduct deliveries. In some rural areas, Medicaid pays for 80% of births, rendering a practice uneconomic. The cost of doing business does not justify practicing in these locations. In some areas, there are simply not enough births to cover the fixed costs of operation.

The students interviewed by the committee gave similar reasons behind their decisions about where and what to practice:

- Prestige of the training program
- Availability of residency slots
- Location (metropolitan areas)
- Proximity to family (or spouse’s)
After the 2014 academic year, 48 (15%) of the Georgia medical graduates who left the state reported that they wanted to conduct their residency in state, but no slot was available in their chosen specialty.\textsuperscript{14}

IV. Summary

A common phrase related to medicine is taken from Luke 4:23: “Physician, heal thyself.” Georgia must find a way to retain and attract more physicians for the state to have an adequate supply. This begs the question: how many is enough?

Although technology like telemedicine will disrupt practice patterns and physician extenders will increase the productivity of individual caregivers, we cannot hope that IT improvements or changes to the scope of practice will have sufficient impact.

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<tr>
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<th>Rate per 100,000</th>
<th>Rank</th>
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<tr>
<td>U.S.</td>
<td>36.6</td>
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<tr>
<td>Contiguous States</td>
<td>25.4</td>
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<td>TN</td>
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<td>NC</td>
<td>31.7</td>
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<td>AL</td>
<td>26.8</td>
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<tr>
<td>SC</td>
<td>25.4</td>
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<tr>
<td>GA</td>
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<tr>
<td>FL</td>
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Source: GBPW; Residents per 100,000 pop. (2012)

To reach the national average, the state would require an additional 1,456 residency slots. This is unattainable without new federal support. To reach the Southeast US average, 357 new slots are required.\textsuperscript{15} To date, Governor Deal and the Board of Regents are set to meet this goal by 2020.

The General Assembly should support and extend these efforts. Increasing the number of physicians will have a positive impact, but will not address the geographic mal-distribution of doctors. Finding and focusing resources on doctors who will serve in rural or underserved areas should be emphasized.

Adequate health care is a precondition to economic development in remote regions.

Loan forgiveness programs should be provided with additional resources to remain competitive with other states and the National Health Service Corps. These programs provide the greatest return on investment and can be coupled with existing programs like the Rural Physicians Tax credit or the Preceptor Tax Incentive Program to push physicians into areas where they otherwise may not elect to practice.

Finally, like many of the seemingly intractable problems facing the American health care system, the Congress must act to move federal support for physician training to where the people are and will be in the future, not frozen in places more appropriate in 1997 than 2017.

KEY FINDINGS

A. Georgia will face a worsening shortage of Primary Care Physicians. Some areas, particularly rural counties, are experiencing acute shortages now.

B. Physicians have a high likelihood of establishing a practice where they conduct their residency.

C. Student debt is a key driver behind student decisions about electing primary care versus more lucrative specialist training.

D. Georgia has expanded the number of medical graduates produced each year by 51% from 2000 to 2011; an additional 35% increase is likely by 2020.

E. The state has not increased the number of residency slots to accommodate these students, creating a bottleneck.

F. This means that Georgia is exporting trained graduates to other states for residency, where they are more likely to stay.

G. The state should increase the number of residency slots and provide enhanced loan forgiveness to retain and attract enough doctors.

\textsuperscript{14} GBPW, 2013 Medical School Graduate Survey

\textsuperscript{15} GBPW; Snapshot of GME in Georgia; 2013 Academic Year
RECOMMENDATIONS

1. The House of Representatives should pass an Urging Resolution to Congress, expressing the necessity of a reallocation or increase in the number of Medicare funded GME residency slots. New slots should be, at a minimum:
   a. Located in states with growing populations;
   b. Proffered to those states that did not receive additional slots in the previous reallocation;
   c. Allowable for established teaching hospitals.

2. The current GBPW funded medical school scholarships should be eliminated and their funding should be redirected to loan forgiveness programs in rural areas or critical shortage specialties.

3. GBPW and/or the Board of Regents, Center for Health Workforce Planning an Analysis should undertake a feasibility study for the creation of a medical school debt low-interest loan fund, similar to that established for technical college students.

4. The General Assembly should use any additional state funds available to back-fill austerity cuts to the GBPW Capitation program, and hold current slots harmless by maintaining a per slot floor at FY2015 levels.

5. GBPW and the Board of Regents, Center for Health Workforce Planning and Analysis, should explore additional public private partnerships with established training sites to fund “over-the-cap” residencies or clinical fellowships.
   a. Given that Medicare GME funding will not be readily available to support these positions, the state should only fund new slots on the basis of these considerations:
      i. Private partners with the most ‘skin in the game’ will be preferred.
      ii. Only critical shortages should be addressed via this means.