

Garland County is Running Out of Doctors

By Richard G. Pellegrino, MD, PhD

The question for Garland County residents is this: If you get sick in the future, are you going to be able to find a doctor in the county to take care of you? The answer might surprise you.

Garland County is losing doctors to retirement and normal attrition, and we are unable to recruit all the young doctors we need. If this continues, not only will the physician base in general be diminished, but some specialties will cease to be represented. Any action in Washington that brings more people into the system will exacerbate the problem. In addition to the effect on patient care, the economic costs of such an eventuality are staggering.

Our economy is based on small business, tourism and a constant influx of retirees from all over the country. Small business and retirees look carefully at the state of medical care in a community before they decide on a place to settle. Fewer doctors in fewer specialties will make Garland County much less attractive. In addition, the medical industry, with its many nursing, administrative and clerical positions, is responsible for 15-20% of all the jobs in the county.

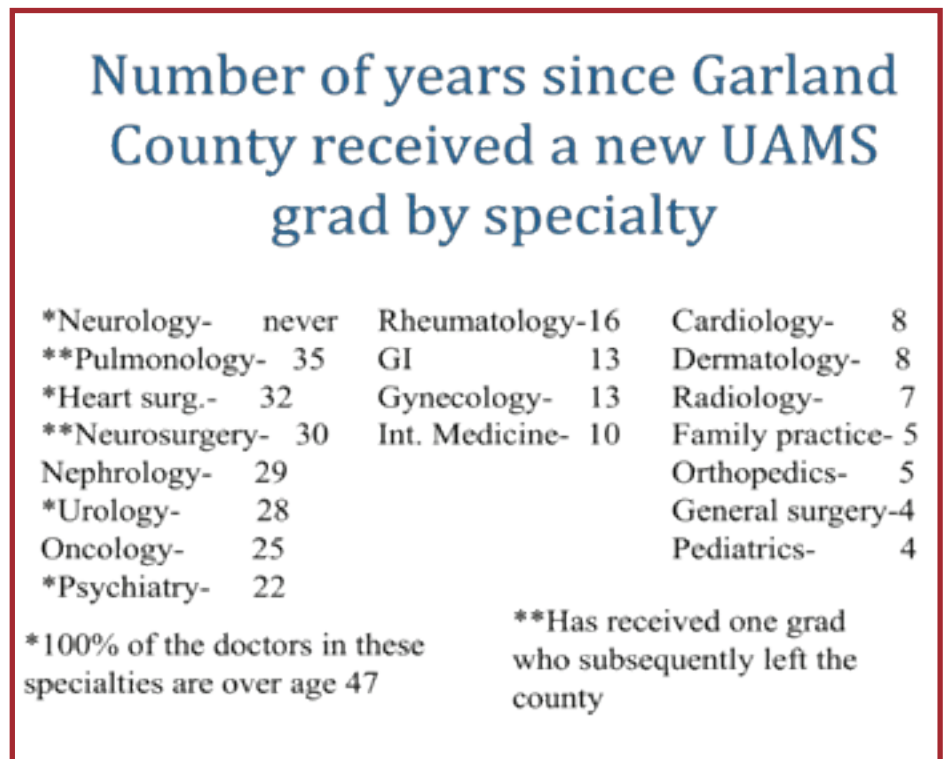
This issue has been in the back of the minds of doctors in the county for many years as many of us began to experience more and more difficulty attracting new associates to the area. Lately however, it has been more acute as more and more patients told us about their difficulty in finding a new doctor. After hearing this time and again, I decided

to do a little research. I went to the library and copied the physician section of all the phone books from 1999-2008 and from 1981-1985. Each physician name was entered into a spread sheet along with the years they appeared in the book. This was then combined with data on age, medical school, residency and several other parameters to yield some interesting facts. It should be noted that only doctors listed in the phone book were counted, so this would exclude emergency medicine, hospitalists and anesthesiologists.

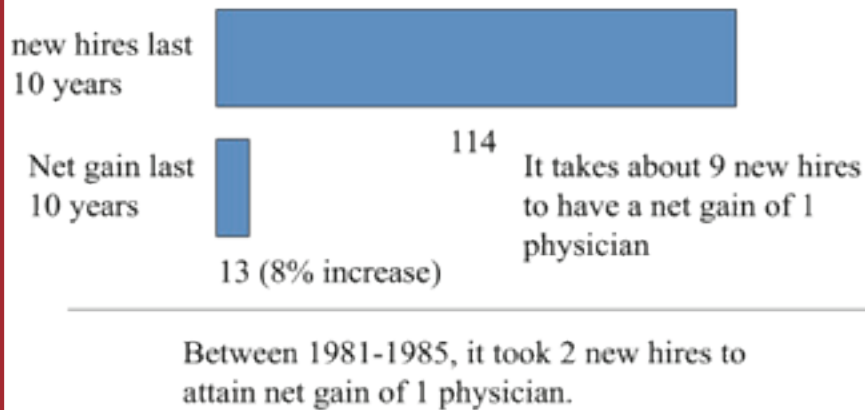
As of 2008, there were 178 doctors in the Garland County phone book. Doctors practicing in the county were found to be older than would be necessary to maintain a stable medical community. If the average doctor begins their career at 29 and retires at 65, one would expect a mean age of 47 in a perfect world where

each retiring doctor is replaced by a new one. Sixty five percent of our doctors are older than this ideal mean age of 47 reflecting the difficulty we have in recruiting new physicians. In fact, of the twenty one specialties studied, only two have an average age under 47. Fifteen have an average age over 50 and six over 55 with Urology topping the list with an average age of 63.

Approximately 60% of the practicing physicians in town either graduated from UAMS, from a UAMS residency or both. The UAMS contribution is helpful but uneven across specialties. Figure 1 is broken down by specialty and shows the number of years since a graduate of either UAMS or a UAMS residency came to Garland County to practice. Neurology has never received a contribution from UAMS and another seven specialties have not seen a



Physician turnover has increased dramatically



UAMS graduate for over two decades, sometimes three. Four of these, neurology, urology, cardiovascular surgery and psychiatry, do not have a single practicing physician under the ideal median age of 47. These specialties are in the greatest danger of disappearing from our county. Other specialties, including family practice, have received UAMS graduates in the last ten years and there are four specialties in the middle. However recruitment is not the only problem. When they get here, we can't keep them. From 1999-2008, 114 new physicians were listed in the phone book for a net gain of thirteen, so that it took almost 9 new hires for a net gain of 1 physician. (Figure 2). Of these 114 new physicians, 55 came after 1998 and left by 2008, for an approximate 2:1 turnover ratio. For comparison, I looked at the years 1981-1985. It took just two new hires for a net gain of one, and the turnover ratio was much lower. Obviously there has been a fundamental change in physician behavior.

Working with this historical data, one might say the solution is easy. If we can recruit 114 doctors in the next ten years, or 11.4 per year, we will at least sustain our current small rate of growth (8% over ten years). Not so fast. In the last ten years, 18 physicians have retired.

In the next ten years, 61 physicians will reach age 65. This is a 3.4 fold increase in probable retirements. It is recognized that some physicians may choose to work past 65. On the other hand, some physicians may choose early retirement, particularly if there are further drastic changes in healthcare. This may alter some of the numbers slightly, but would not change the conclusion of this study. In any case, if the turnover rate remains constant at approximately 2:1, and we

add in the extra 43 retirements, we would have to recruit another 86 doctors to replace those 43 additional doctors that are going to retire. When added to the normal turnover, this would work out to twenty new recruits per year!

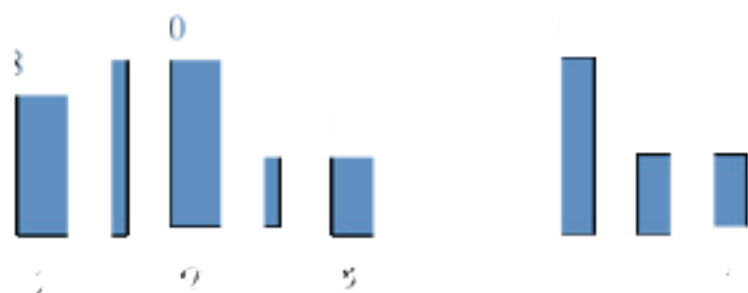
So, can we recruit twenty new doctors per year? Figure 3 shows the number of new doctors that appeared in the phone book in the five years from 2004-2008. The number is decreasing and in 2008 we were only able to attract five new physicians. Given this data, the number of doctors in Garland County has to decline and decline precipitously over the next ten years if current trends hold.

I believe the cause of this problem is three fold.

1) Medicare

Garland County has one of the highest percentages of Medicare patients in the country and Arkansas is among those states with the lowest Medicare reimbursement rates (bottom 15% of all states). The county is rich in older, sicker patients and providers get paid the least for taking care of them. The re-

New doctors coming into the county, 2004-2008



sult is physician salaries that are among the lowest in the country. In a national market for physicians, many of whom are \$100,000-200,000 or more in debt from medical school, we fare poorly.

This low Medicare reimbursement is another example of unintended consequences getting in the way of good intentions. The point of the Medicare programs was to create a way for seniors to get quality medical care they can afford. Since different parts of the country have different costs of living, the reimbursement was adjusted to reflect this. Sounds fair, but the consequences are and will continue to be disastrous for poor areas of the country with larger, more needy elderly populations. Differential Medicare reimbursement rates artificially redistribute physician manpower to New York, for example, whose reimbursement rates are much higher. This discriminates against those very people the program was designed to help; people, by the way, who have contributed just as much in Medicare taxes as their New York counterparts. That's the bad news.

The good news is that it appears that Medicare reimbursement rates have the power to influence the distribution of physicians. Perhaps this power could be used for good. There are a number of ways to begin to level the playing field or even to find underserved areas and bring them in line with rates in more heavily served communities. One could add a new category to the Relative Value Unit (RVU) that could place a value on community physician manpower needs. The Geographic Practice Cost Index for that RVU can then be increased or decreased depending on the needs of the county or even a particular specialty in that county. Medicare does have modest bonus payments for underserved specialties in areas, but this is not working either because it is not enough or communities at risk are being identified too late. For example, the only specialty that receives the Medicare bonus in Garland County

is psychiatry. This is appropriate. There is not a single Medicare outpatient psychiatrist in the County. But what of the specialties that are at risk? The youngest Urologist is 58 years old and his four colleagues are 62, 63 and 67. The heart surgeons are 57 and 61. Neurology has four physicians, age 48, 54, 59 and 75. Must we wait until care in these areas completely falls apart?

Rather than wait until a crisis, per-

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haps areas of need can be identified by methods similar to those I employed in Garland County and adjustments can be made before things become critical. In the absence of a change in Medicare, Arkansas can try to even the playing field with incentive programs similar to those administered for primary care by the Rural Practice Board. These programs need to be expanded and need to include other specialties in areas of need.

2) The disappearance of the independent physician

As more hospitals and clinics employ young physicians, the practice of medicine is increasingly changing from a profession to a job, with doctors occupying an increasingly subordinate position in the company organization chart rather than being self employed. Faced with these realities, young doctors are behaving like corporate employees. They are accepting jobs with inflated salaries designed to help the Arkansas clinic or

hospital compete in the national market for doctors. Once their two or three year contract is over, their salary is decreased to be more in line with lower Arkansas reimbursement rates and they are on to the next contract. In the past, physicians were recruited into doctor owned practices by physicians who would eventually become their partners. There was a future in staying put in one town and building a professional life. I think this move towards “corporate medicine” contributes significantly to the increase in turnover rates that we see when we compare the early eighties to the nineties. I don't really see this trend reversing any time soon.

3) Arkansas trained doctors leave the state.

UAMS is #3 nationwide in the percentage of medical students who stay in state, but I do not have data on the number of medical residents who ultimately practice in Arkansas. I do know that the state in which you do your residency is a very important predictor of where you will eventually practice. Figure 1 shows us that the UAMS contribution to the medical community in Garland County is very uneven. Some departments, such as family practice, pediatrics and others contribute regularly and some do not. I think we need to figure out what it is that post graduate residencies on the right side of Figure 1 are doing that those on the left are not and work with UAMS to maximize its contribution to the pool of Arkansas physicians across all specialties.

I suspect that Hot Springs and Garland County are not alone here. I am currently applying the same simple methods to Jefferson County with the help of a physician who practices there. You can't tackle a problem until you have identified its extent and I will continue to look at even more counties and to work with UAMS and the legislature to identify solutions.

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