



# Workforce trends and access to surgical care:

*We need your  
perspective*

by

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**O**ur nation's ability to maintain an adequate surgical workforce in the current socioeconomic climate is in serious doubt. The U.S. population is expected to surge to 325 million in 2020, and 400 million in 2050. At the same time, senior citizens, who consume a disproportionate share of health care resources, will comprise 20 percent of the total by 2020.<sup>1</sup> Meanwhile, the total number of physicians produced per year remains stable at about 24,000. In addition, medical societies in California, Massachusetts, New Jersey, Ohio, Pennsylvania, and Washington State have reported increasing numbers of early retirements. They attribute this situation to higher liability costs, decreased reimbursement, and unfunded mandates, such as the privacy standards under the Health Insurance Portability and Accountability Act.<sup>2</sup>

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Complicating the picture is our inability to determine what constitutes an adequate surgical workforce to meet the demands of a growing population. Such assessments are hampered by a substantial gap in real data about surgeons' practices, the number of years they expect to remain active, the patients they serve, and the intensity of their work.

We are concerned that, in the not-too-distant future, patient access to prompt surgical care will very likely be threatened by a workforce that is simply strained beyond its limits. We believe that policymakers need to understand the urgency for congressional action that creates a climate that promotes an adequate supply of surgeons who will be prepared to respond to the needs of our nation's growing population.

Hence, the Health Policy Steering Committee of the American College of Surgeons is asking for your help identifying indicators that will assist us in determining whether there is an impending shortfall of surgeons in coming years and how access to surgical care problems are beginning to emerge and affect patients.

### **Lessons from abroad**

Work-hour limitations in Europe have resulted in a significant restructuring of health care delivery by residents and practicing surgeons.<sup>3</sup> Foreign residents faced with limited work hours, smaller populations, and less varied cases than in the U.S. found that it takes longer to acquire the experience needed to meet the requirements for board certification.



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A recent issue of *Surgery* explores how restrictions in these countries resulted in higher levels of specialization, less availability of broad-based capabilities, a tendency toward standardized hours, and more difficulty securing evening and emergency coverage. Some of these requirements also limit the surgeon's ability to acquire critical care and trauma experience and reduce the availability of comprehensive surgical care in some communities.<sup>3</sup>

In this country, there already are indications that the workforce is working harder and longer, and that it is barely able to care for the patients who need services today. With the intensity of practice increasing, many surgeons feel they cannot spend enough time with their patients. Some of them are narrowing the scope of their practices and now perform only specific procedures or treat selected disease states.<sup>4</sup>

### **Socioeconomic climate**

Socioeconomic factors complicate delivery of surgical care. Recent Centers for Medicare & Medicaid Services data indicate that the U.S. health care budget will rise to \$3.1 trillion by 2011, growing at an annual rate of 7.3 percent during the forecast period of 2002-2012.<sup>5</sup> This is up from only \$1.3 trillion in 2000. And, as the current state of the economy drives spending, budget deficits, and health care decision making, the resulting increases create significant challenges for appropriate resource allocation in the U.S. With the cost of health care services growing to almost 18 percent of the gross domestic product, employers and payors are placing greater emphasis on the documentation of the net value and benefit of that investment. Members of Congress, and society overall, feel pressure to appropriately prioritize the kinds of care provided in order to control costs.

The medical liability crisis further compounds the problem with surgeon supply. A recent study by the Agency for Healthcare Research and Quality showed that states with limits on noneconomic damages in medical malpractice lawsuits have about 12 percent more physicians per capita than states without caps.<sup>6</sup> By 2000, states that had enacted caps had a significantly higher number of physicians per 100,000 county residents compared with states without caps. In contrast, in 1970, there was no statistically significant difference between states and their per capita supply of physicians.


Another factor in surgeons' willingness to continue practicing is the net impact of substantial payment inequities. From 1992 to 2003, the Medicare Economic Index—or Medicare's inflation rate—increased almost 30 percent, while the physician fee schedule conversion factor lagged significantly behind, with a cumulative increase of only 18.7 percent for the same period. The rate of payment increases simply has not kept up with the rate of inflation—or with the true cost of delivering services.<sup>7</sup>

Increased demand, coupled with decreased reimbursement and a shortage of surgical capacity, creates a perverse form of rationing that limits the patient's ability to secure needed care. Recent reports by the Center for Health System Change suggest that wait times for nonemergency care have increased, resulting in treatment delays. The same study found that fewer physicians are accepting new Medicare or Medicaid patients, and even fewer are able to provide uncompensated or voluntary care.<sup>8</sup>

All indicators suggest that a shortage in the surgical workforce will present a significant access problem for patients. Given the length of training required, it will become more difficult to reverse this decline and fill the surgical workforce gaps. In light of these pressures, how do we foster the entry of more surgical talent and encourage more senior surgeons to continue practice to meet the needs of the aging population? Changing desires in lifestyles coupled with payor efforts to control costs of care, the uncertainty of medical liability premiums, and the challenge of running a complicated business, could also be driving experienced physicians from practice.

### **We need information**

It is incumbent on the profession to actively promote the value and importance of a career in surgery to promising young surgeons and students. However, surgeons also need to help policymakers understand that government policy, as it affects surgeons' practices, is undermining efforts to improve access. Unfortunately, incomplete data regarding surgical capacity make it difficult for the College to show policymakers how their actions are causing these problems. They need information from practicing surgeons so they can truly understand the problems their constituents are beginning to encounter.

We are asking Fellows to visit <http://www.facs.org/ahp/workforcesurvey/index.html> to take a short survey and help us collect data on how market forces and legislation are affecting patient access to care (or you can fill out and fax the copy of the survey on pages 20-21). Your frontline experience with patients and practice can help legislators understand the unintended consequences of problematic policies. We also welcome personal stories about patients and local community issues that illustrate these troublesome trends, which may be forwarded by e-mail to [ahp@facs.org](mailto:ahp@facs.org). 

### **References**

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