

State of the Nation's Health Care
Vineet Arora, MD, MA, chair of Council of Associates of ACP
Oral Remarks

Thank you Dr. Hedberg.

I am an Instructor of Medicine in the Section of General Internal Medicine at the University of Chicago, where I did my internal medicine residency. We deliver primary care to the residents on the South Side of Chicago; 85 percent of these patients are African American and the majority is over age 65 and covered by Medicare. I also serve as the Associate Program Director for the Internal Medicine Residency Program and the Assistant Dean for the Pritzker School of Medicine at the University of Chicago.

I am a member of ACP's Board of Regents, and chair of ACP's Council of Associates, which represents physicians who are being trained in an internal medicine residency program or who have gone on for additional training in a subspecialty medicine fellowship program. *We are the new generation of physicians that the elderly and disabled members of our society will be counting on for their primary care.*

Unfortunately, there won't be enough of us. A combination of high student debt and an unfavorable economic environment is causing many of us to choose careers other than general internal medicine or family practice—the two specialties that aged and disabled patients most depend on for their primary care.

There is growing evidence that shortages are developing for U.S. physicians, particularly in general internal medicine and family practice. Current projections indicate that the future supply of primary care physicians will be inadequate to meet the health care needs of the aging U.S. population, especially as Baby Boomers are beginning to reach retirement age in 2011. In 1998, 54 percent of graduating internal medicine residents planned to practice general internal medicine compared with 27 percent in 2003. Strikingly, in 2003 only 19 percent of all internal medicine residents planned to pursue careers in general internal medicine. In my own program, I was one of only two of our nearly 30 graduating residents that did not enter a subspecialty training program.

The reasons why medical students and young physicians are turning away from primary care are complex and multifaceted. But based on my own experience, and from my conversations with my peers, I can say with confidence that that the dismal economic practice environment associated with primary care today is the major barrier.

We learn early in our medical training about the importance and joy of having a continuous, ongoing and personal relationship with a patient, which is the hallmark of general internal medicine and family medicine. Unfortunately, we also learn that primary care is under-reimbursed compared to other specialties, and that many primary care physicians are struggling to keep their practices open at a time of escalating practice costs, excessive paperwork requirements that take time away from patients, and reimbursement from

Medicare and other payers that does not keep pace with their rising costs. It is so bad that many of the excellent role models in primary care that we meet in our training programs go as far as to counsel us *not* to go into primary care. Why? Because they tell us that there is no economic future in primary care.

Today, a physician entering practice has on average accumulated more than \$100,000 in student debt. The median indebtedness of medical school students graduating this year is expected to be \$120,000 for students in public medical schools and \$160,000 for students attending private medical schools. About 5 percent of all medical students will graduate with debt of \$200,000 or more. Unfortunately, many of those young graduates facing the highest debt burden are of modest means and diverse backgrounds, and they are underrepresented in medicine: exactly the types of physicians we want to recruit to provide primary care for our increasingly diverse population.

In addition, many of us are entering practice at the same time we are getting married, buying homes, and starting families. Several weeks ago, I was visiting my friend, a new mom, who is completing her family medicine residency in New Hampshire. She is married to another medical trainee and together, they have nearly \$400,000 in medical school debt, and another baby on the way. When interviewing for jobs, she realized that she could not accept a job in office-based primary care, and expect to pay for child care while continuing to pay off their debt. And there are countless others like her. Is it any surprise that more and more of us have concluded that we simply cannot afford to support our families and also practice primary care?

Reversing this decline will require immediate action by policymakers. The long pipeline of medical education and training and the retirement and career changes of older physicians necessitates that the nation have a constant influx of new students embarking on medical careers. As the population ages, and larger numbers of patients encounter chronic and more complex illnesses, the need for general internists and family physicians will increase. The need for primary care physicians, who can provide first contact and comprehensive continuing care for adults, will continue to increase as the population ages and its health care needs increase, and as the demand for acute, chronic and long-term care increases. Unfortunately, unless there is action now, many of those who are already in practice will be forced to retire or limit how many Medicare patients they will see.

Again, I represent physicians who are being trained in an internal medicine residency program or who have gone on for additional training in a subspecialty medicine fellowship program. *We are the new generation of physicians that the elderly and disabled members of our society will be counting on for their primary care.*

Now I'd like to have Bob Doherty talk about some of the implications of the program we're putting forth today.
