Can Inactive Physicians Be Lured Back to Work?

BY DENISE NAPOLI

WASHINGTON — The availability of part time work and flexible scheduling could entice older and inactive physicians to reenter the workforce, a recent survey found.

This in turn could offer a partial solution to the nation's shortage of primary care physicians, who make up about 50% of this cohort.

"We really need to do a much better job of creating an environment that's much more flexible," Ethan Alexander Jewett said at a physician workforce research conference that was sponsored by the Association of American Medical Colleges.

"When we lose these folks, we've lost the investment that we've made in medical education. And in an era when we have a physician shortage, we could be reabsorbing that investment and the expertise of these physicians," both on a long-term basis or as needed in times of crisis.

However, he cautioned that reentering physicians will need support from employers and medical societies, given that 38% of them have not practiced medicine in 5-10 years, and 24% haven't practiced in longer than 10.

From January to March 2008, Mr. Jewett surveyed 4,975 physicians who were younger than age 65 years and who were listed as inactive in the American Medical Association's files. "Inactive" was defined as those who no longer practice, teach, research, or administer medicine.

A total of 1,520 physicians responded. Of these, 500 were truly inactive, about half of them were women. Primary care physicians comprised roughly half of this inactive group. Just over a quarter (27%) of the whole group were inactive in medicine but working in another field.

A total of 436 physicians were in fact retired—also half women. And 584 physicians were, despite their status with the AMA, currently active in medicine. This category included only about 40% women, said Mr. Jewett, a policy analyst at the American Academy of Pediatrics.

When asked what would make them return to the workplace, 58% of women and 42% of men said that the availability of flexible, part-time scheduling would be the "number one driver," Mr. Jewett said.

About 50% of the inactive physicians surveyed said that they had already explored the possibility of reentering the medical workforce. Mr. Jewett pointed out that his survey took place before the recession, so even more physicians may now be seeking to reenter the workforce.

He did not report any disclosures related to his presentation. ■

Report Details Hospital Bed, Physician Capacity Changes

BY JOYCE FRIEDEN

A new report from the Dartmouth Atlas of Health Care finds that, overall, the hospital bed supply per capita contracted from 1996 to 2006, while the numbers of hospital-based employees and registered nurses increased.

The number of staffed acute care beds dropped from 2.82 per 1,000 U.S. residents in 1996 to 2.46 per 1,000 in 2006, according to the report. However, there was great regional variation. For example, the Jackson, Miss., area had 4.44 beds per 1,000 in 2006, compared with 1.45 in San Mateo County, Calif. Not surprisingly, the areas with the most beds also had high numbers of hospital employees.

"As long ago as the 1960s, Milton Roemer described the phenomenon that a built bed was a filled bed," noted the report, which was written by Dr. David C. Goodman, Dr. Elliott S. Fisher, and Kristen K. Bronner. "Numerous studies since then have found that higher bed supply is associated with more hospital use for conditions where outpatient care is a viable alternative. This includes most medical causes of hospitalization."

Physician supply continued to expand "modestly," although numbers varied greatly by specialty, the report said. For example, the number of primary care physicians increased 11% over the study period, compared with 51% for infectious disease specialists and a whopping 198% for critical care specialists. Specialties that experienced declines included cardiothoracic surgery (–17%), pulmonology (–18%), and general surgery (–19%).

The authors made several suggestions for managing hospital capacity and physician workforce growth. To reduce "unwarranted" variations in hospital supply, "Congress could require the Centers for Medicare and Medicaid Services to use its capital payment policies to limit the further growth of hospital capacity in markets that are already overinvested," they wrote. "Although Certificate of Need programs have generally not been effective, strengthening [such] programs or statewide prospective hospital budgeting processes could be used to more wisely target future hospital growth."

To better adjust the physician workforce, "a national workforce commission with representation from the clinical professions, public health, health care purchasers, and patients would provide badly needed analyses and research to better direct funds for health workforce training and for provision of care to the underserved," the authors suggested. ■

POLICY & PRACTICE

Obama Gets Health Team in Place

President Obama now has filled several of the major positions on his health care team. They include former Kansas governor Kathleen Sebelius as Health and Human Services secretary, former New York City health commissioner Dr. Thomas Frieden as Centers for Disease Control and Prevention director, and another former New York City health commissioner, Dr. Margaret Hamburg as Food and Drug Administration commissioner. Ms. Sebelius, a former insurance commissioner, was chosen in part for her health insurance expertise, while Dr. Frieden is well-known as a crusader for various public health causes, such as decreasing the number of people who smoke and removing trans fats from restaurant food. Dr. Hamburg is respected for her work on a multi-drug resistant tuberculosis outbreak in New York. Acting FDA commissioner Dr. Joshua Sharfstein has been nominated as deputy chief of the agency.

Feds Launch Disease Program

The National Institutes of Health has launched a $24 million drug development program to produce new treatments for rare and neglected diseases. The Therapeutics for Rare and Neglected Diseases program, funded by Congress this spring, creates a drug development pipeline within NIH and is intended to stimulate research collaborations with academic scientists researching these diseases, NIH said. The NIH Office of Rare Diseases Research will oversee the program. NIH estimates that more than 6,800 rare diseases affect more than 25 million Americans, but effective pharmacologic treatments exist for only about 200 of these illnesses. In addition, many neglected diseases—uncommon in the United States but more common in parts of the world where people cannot afford expensive therapies—also lack treatments, NIH said.

Patients Want Internet Advice

Patients expect to rely on computers and other electronic technology in the future for many routine medical issues, and seem to be less concerned about privacy issues than providers are, a study in the Journal of General Internal Medicine found. The investigators convened focus groups of frequent Internet users, and then analyzed the transcripts. They found that the participants want customized health information from the Internet, and also want complete access to their own health record. In addition, they expect that in the future, home monitors and other technologies will communicate with clinicians, increasing efficiency and quality of life for patients and providers. "Patients know how busy their doctors are and they want to reserve us for what they really need us for—treating serious illness and conditions," said co-author Dr. Tom Delbanco, professor of general medicine and primary care at Harvard Medical School.

AHRQ: Quality Improving Slowly

U.S. health care quality continued to improve at a slow pace in 2008, but many Americans still do not receive recommended care, the annual quality report from the Agency for Healthcare Research and Quality found. Quality varies widely throughout the system, AHRQ found. For example, patients hospitalized with a heart attack receive 95% of recommended services, but only 15% of patients on dialysis are registered on a kidney transplant waiting list, the report found. A median of 59% of patients received needed care across the core measures tracked, AHRQ said. In addition, reporting of hospital quality measures is propelling improvement in those measures, but patient safety lags, the report said, adding that one in seven adult hospitalized Medicare patients experiences one or more adverse events. AHRQ urged more work in the area of patients' experiences, saying that "patients see problems from a personal perspective and may observe deficiencies that busy providers do not notice."

Family Medical Spending Rises

A typical U.S. family of four will account for about $16,711 in medical spending this year, up $1,162 from last year, according to a report from actuarial firm Milliman, Inc. Of the total, employers paid 59% and families 41%, according to the annual Milliman Medical Index report, which looks at the average yearly health care costs when the family of four is covered by an employer-sponsored preferred provider organization. Employer subsidies increased about $500 since last year, and employees picked up about $650 more of the health care tab, including about $500 for employee contributions toward coverage and $150 for employee out-of-pocket expenses, according to the Milliman index.

Medicaid Plans Save States Money

Medicaid health plans appear to be saving money for most states, increasing access to and quality of care, according to a study performed by the Lewin Group for insurer group America's Health Insurance Plans. Lewin analyzed 24 existing studies and found states achieved savings ranging from less than 1% to 20% after implementing private Medicaid health plans. A large part of the cost savings reported came from reducing unnecessary utilization. For example, California found that preventable hospitalizations were as much as 38% lower in health plans than in fee-for-service Medicaid, according to the report. Beneficiary drug costs in Medicaid health plans were 10%-15% lower than for fee-for-service programs.

—Jane Anderson