American Urological Association

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April 6, 2014

The Honorable Bernie Sanders
Chair,
Subcommittee on Primary Health and Aging
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Richard Burr
Ranking Member,
Subcommittee on Primary Health and Aging
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

Re: Urology Shortages and Hearing on Physician Workforce Shortages.

Dear Chairman Sanders and Ranking Member Burr,

The American Urological Association (AUA), founded in 1902, is the premier professional association for the advancement of urologic patient care, and works to ensure that its more than 18,000 members are current on the latest research and practices in urology. The AUA also pursues its mission of fostering the highest standards of urologic care by providing a wide range of services—including publications, research, the Annual Meeting, continuing medical education (CME) and the formulation of health policy. We noted with interest the upcoming subcommittee hearing entitled "***Addressing Primary Care Access and Workforce Challenges: Voices from the Field"*** and applaud your efforts to evaluate the severe physician manpower shortage. Clearly this shortage will only worsen as health insurance coverage is expanded to an additional 30 million Americans and the baby boomers continue to reach retirement age.

While AUA acknowledges the need to increase the number of available primary care providers, this only addresses part of the problem. Based on current estimates from the Association of American Medical Colleges (AAMC), the overall shortage will be approximately 130,600 physicians by 2025 – one-half of which, or 64,800, are specialty physicians, including urologists. And unlike primary care physicians whose residency training is only three years, specialty physicians require up to seven years of post-graduate residency training; thus we need to take steps now to ensure a fully trained specialty physician workforce well into the future.

Recent surveys have highlighted that, by 2020, urology will face a severe shortage primarily related to increased demand of the aging population[1] as well as previous resident restrictions. Correcting this workforce shortage is of vital importance in order to maintain the availability of urological services to meet the needs of our aging population, for whom the rates of obesity and chronic diseases like diabetes, rheumatoid arthritis/osteoporosis, and kidney disease continue to rise. One in every five primary care visits in the United States involves a urologic condition. Urologists

[1] http://www.physiciansnews.com/spotlight/304.html

treat many conditions that involve the urinary and reproductive tract of both men and women. We provide medical and surgical treatment for prostate cancer and bladder cancer, two of the four most common cancers diagnosed in US men and kidney cancer, the seventh most common cancer diagnosed in US men and women. We also treat men with enlarged prostate and urinary difficulties, urinary incontinence in men and women, stones of the urinary tract, infections of the urinary tract, erectile dysfunction in men, and infertile couples.

While we are aware of concerns related to a shortage of primary care physicians, we want to ensure you have key data related to shortages in urology, as well as particular training challenges that increase the costs of training. Urology has seen a greater than 10% decline in the number of urologists per capita over the past twenty years, which is amongst the greatest of all surgical sub-specialties. In 2009, there were only 3.18 urologists per 100,000 population, which marked a thirty-year low in the labor force for our field. The average age of a urologist is 51 years, with 38 percent of urologists age 55 or older.

This contracting urology workforce is impacted by an aging US population that will require more health care services. By 2030 it is estimated that nearly 20% of the population will be 65 years or older. These elderly patients will require as much as three fold the rate of surgical services that the general population consumes. To meet the demands of these population estimations, the Health Resources and Services Administration Bureau of Health Professions, in its 2008 report, projects a need of 14,000 urologists by 2015 and 16,000 urologists by 2020. Instead, several projections have estimated that the US will have less than 8,000 urologists by 2020. These data are congruent with other independent projections that show that by 2030 urology will face a 32% (3,884 urologists) deficiency in the number of providers necessary to adequately care for a projected 364 million US citizens.
Another concerning trend is the geographic distribution of urologists in the United States. In rural settings, as defined by the Office of Management and Budget Metropolitan Statistical Area census, the average age of a urologist is on average 2.2 years older than a urologist practicing in an urban setting. As of 2009, the concentration of urologists practicing in an urban setting was 7 times higher than the number practicing in a rural setting. In addition, urologists practicing in a group setting increased to 60% of the entire workforce; whereas the number of urologists in solo practice decreased to 20%. In summary, the geographic trends favor younger urologists practicing in large groups within an urban setting. Urologists in the rural setting tend to be older and in solo practice nearing retirement. These data raise concerns that a disproportionate aging urology workforce significantly threatens access to urologic care, especially in rural areas, which comprise 18% of the US population, or roughly 54 million people. The ramifications of these trends can be far reaching as there is a statistically significant higher urologic cancer specific mortality rate for people living in a county not served by a urologist.

Mirroring this nationwide shortage of clinical urologists, a recent survey of the academic urologic workforce projected that over 369 faculty positions will need to be filled over the next five years. This fact suggests that a shortage of academic urologists, the prime educators of urology graduate medical education (GME), is even more profound than that of independent practice urologists. The

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Society of University Urologists (SUU) surveyed their membership to better understand the issues surrounding resident training. Fifty- four percent of respondents noted that their programs currently had unfunded residency positions, and sixty-five percent said that funding is an obstacle to adding new residency positions. The main financial support engines used to supplement these resident positions are hospital funds and clinical revenue, the latter of which is no longer sustainable as clinical reimbursement dollars continue to decrease.

Furthermore, the Accreditation Council for Graduate Medical Education's (ACGME) initiatives have placed many new mandated requirements on urology training programs, including specific restrictions on resident duty hours. There is now a more focused emphasis on didactic teaching and independent learning opportunities, which are provided primarily through organized proficiency training labs. These new methods have proven costly, and are not supported by existing GME funds.

The current system of GME funding for urology residency programs is not sustainable. With 10,000 seniors aging into the Medicare program every day for the next 18 years, and 30 million new patients entering the system through the Affordable Care Act (ACA), the need for the services of trained urologists will increase significantly. The severe urology workforce shortage, in combination with a cap on GME funding, have led to a very precarious situation regarding the ability to train high quality urologists in the near future. There has been a 2% decline in the number of accredited urology residency programs since 2001, and a 19.7% decline in the number of urology residents achieving American Board of Medical Specialties certification from 2000 – 2009 (2010 ABMS Certification statistics). The American Urological Association is committed to training the highest quality residents; however, the current GME funding for resident education cannot meet the requirements necessary to accomplish this goal.

Looking to the future, the AUA believes that:

- Healthcare is a public good, requiring an investment in training the physician workforce;
- Shortages in specialty medicine, such as urology, must be explicitly recognized and addressed;
- GME funding should be increased and supported by all users of the health system;
- GME funding should be expanded to the full length of ACGME accredited training;
- Current Medicare GME funding caps should be eliminated and the number of training slots should be based on projected physician workforce needs of the US population;
- Institutions should be accountable to program directors for reporting GME funding at the program level; and
- Incentives are needed to train and develop a quality urology workforce for patients in the rural setting.

Many specialties like urology are already facing workforce shortages, and projections show that the problem is only going to get worse. It takes more than twelve years to produce a specialist, and by the time a true crisis is visible, we will be unable to quickly correct it. As our nation's population ages, access to high quality and appropriate care is necessary to contain costs and effectively manage the progression of disease, chronic conditions and co-morbidities. Preparing our medical workforce and ensuring medical education continues to evolve to meet advancing medical

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knowledge is critical to maintaining the standard of health care in this country.

Given the acute shortages of specialty physicians, and the demand created for their services by an aging population and expanded insurance coverage, AUA would like to encourage you to consider the workforce shortages in specialty medicine and urology, and respectfully request that the committee hear testimony from specialty medicine in future workforce hearings.

Thank you for considering our suggestion and for your leadership on this issue. If you have any questions or would like more information from us, please contact AUA staff liaison Brad Stine at (202) 403-8503 or email him at bstine@auanet.org.

Sincerely,

Chris G. Gonzalez, MD, FACS
Vice-Chair,
AUA Health Policy Council

Raj Pruthi, MD, FACS
Member,
AUA Workforce Workgroup