Approved: :
Date : 2/1/93
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MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on January 27,, 1993 in Room 423-S of the Capitol.

All members were present except: Rep. Freeborn, excused

Committee staff present:
William Wolff, Legislative Research Department
Sue Hill, Committee Secretary

Conferees appearing before the committee: Carolyn Gaughn, Executive Director of Kansas Academy of Family Physicians
Dr. Tietz, Topeka, Kansas
Dr. Epley, Atchison, Kansas
Dr. Kellerman, Salina, Kansas
Marlen Rein, University of Kansas (answered questions only)

Others attending: See attached list:

Chairperson Flower called the meeting to order, drawing attention to Committee minutes. When members had had ample time to read the minutes, chair entertained a motion. Rep. Mayans moved to approve the minutes of January 25, 1993 as submitted, seconded by Rep. Scott. Motion carried.

Chair stated after the numerous questions asked, numerous policy issues and policy changes in HB2072 heard at the meeting yesterday, a SubCommittee has been appointed to work on these issues. She appointed Rep. Neufeld as Chair, and Rep. Wells, and Rep. Sader to serve on this SubCommittee.

Chair welcomed conferees and invited them to begin their presentation.

Carolyn Gaughn, Executive Director of Academy of Family Physicians offered hand/out (Attachment No.l) She stated three physicians would also make comments today . She indicated the interest these professionals have in the deliberations and belief in the importance of the work in the Legislature. She defined family practice; noted the continuing education requirements are no less than 150 hours of approved education every three years; detailed the certification by the American Board of Family Practice and noted the board introduced mandatory re-certification every (7) years to retain "board certified" status. Goals of the Ks. Academy of Family Physicians (KAFP), i.e., improving education programs; preserve/promote quality, cost-effective health care; maintain high standards among physicians who practice family medicine; ensure an optimal supply of well-trained family physicians; to provide responsible advocacy for patients/public in health related matters. She then detailed data regarding medically underserved areas; changes in the medical community, i.e., more women are entering the medical field; concern with the decreasing numbers overall of persons going into medicine; the need for recruitment for family physicians.

Dr. Dennis Tietz offered ((Attachment No.2), a hand/out that indicates relating health care services in Kansas. This hand/out was developed by the Kansas Health Foundation, (formerly the Wesley Foundation in Wichita).

Dr. Tietz is a lifelong Kansan. He gave some personal background, noted he has been a practicing physician for 12 years in Topeka. He drew attention to (Attachment No.3,)noting a major concern of the Kansas Academy of Family Physicians, (KAFP) has been access to quality health care for all Kansans. In September, 1992 forty family physicians from around the state met for discussions and today propose four legislative initiatives that could help provide some short-term and medium-term relief for underserved areas. (1) Expansion for the Kansas Medical Student Loan Program. He gave a detailed explanation of the proposal. (2) Increased stipends for all family practice residents. He detailed this proposal, and noted Smoky Hill has

this year, it's best-ever recruitment year as a result of the philosophic/financial support demonstrated by the 1992 Legislature. (3) Guaranteed minimum salaries for family practice faculty. He discussed the seriousness of many faculty members leaving the medical teaching profession, many because of low salaries. He detailed recommendation that the state continue to directly provide 75% of salaries for these faculty members. (4) Faculty locum tenens program. He detailed the proposal and gave rationale, calling for funding for two additional faculty positions in the Departments of Family Practice in Kansas City and Wichita.

Dr. Tietz detailed the Bridging Program, noting it needs to be amended in order to "lock-in" the resident-physician to practice in Kansas. He detailed the Federal Health Personnel Shortage Area, noting the (KAFP) would support a pilot program for medical school debt repayment for board certified grads of Kansas family practice residency programs, not otherwise eligible for the current Medical Student Loan Program.

Dr. Epley began his remarks by giving his educational background, noted he is a native Kansan now in active practice in Atchison, Kansas. He stated he has no hand/out, no prepared text, but is vitally interested in the future of access to medical care in the state. He spoke about the "prospective of a Kansas family physician. He detailed a "day in the life of ", his own, i.e., hospital rounds with 2-10 patient cases; back to the office to dictate patient files after rounds; see patients in the office; dictate for those patient files. There are 220 pregnant women active files in his office with deliveries coming frequently (many at night). He noted the typical day is, the delivery of real medicine and real primary care. There is no specialty in the state than can render the spectrum of care that family physicians render. He gave thanks to a resident physician who today is taking over for him so that he would be free to come to Topeka to speak before Committee. He conveyed the thanks of Kim Quambly, saying she is a recipient of the bridging program, and will be serving in North East Kansas in 1994 as a family physician. She is grateful for the bridging program. Dr. Epley explained the benefits of the bridging program, not only from a physician residents view, but how patients in underserved areas will eventually benefit as well. He detailed concerns about 13,000 unfilled family practice positions. He noted there now are only two physicians practicing in obstetrics in his town of Atchison. Formerly, there were seven. There is 11,000 active patient charts for two doctors and one physician's assistant, which is inadequate. Dr. Epley noted he has 220 pregnant women active charts in his office. Recruitment for more family practice physicians is vital, but not an easy task. He noted, the Academy is closer with the Medical Center on many issues than they have ever been before.

Dr. Kellerman, President of Kansas Academy of Family Physicians offered hand/out (Attachment No.4), and gave an overview of Health Care in Kansas. He noted there has been a rural health problem in Kansas for a long time and now it is acute. Access to medical care problems can be divided into two categories, (1) cost issues, (2) manpower. He detailed both issues. He detailed trends that have affected physician manpower in Kansas, i.e., physicians produced by the Murphy Plan in the 1950s are retiring now and not being replaced by adequate numbers; the medical education environment does not encourage medical student interest in family practice; change in rural Kansas demographics over recent years indicates nearly a 50-50 percent split of population living in urban/rural areas; doctor and hospital reimbursement in rural verses urban areas is inequitable; paper work and regulations by government and insurance companies impacts inequitably on rural and office based physicians. Solo physicians and those in small groups have less ability to share costs and this burden may drive physicians out of rural practice; malpractice costs and the threat of liability continue to be a problem. He detailed these concerns. He noted Corporate medicine will have an increasing effect on rural Kansas; the need for more family physicians is more than a rural problem. It has been proven that family physicians are cost-effective providers of comprehensive medical care.

All conferees answered numerous questions. Mr. Marlen Rein, Kansas University also answered questions.

Chair thanked all conferees for their interesting/enlightening testimony.

Chair announced, tomorrow at 10:00 a.m., room 526-S, the Secretary of SRS will give a talk on pre-assessment screening.

Chair announced the names again of the Sub Committee Appointed on HB2072, Rep. Neufeld as Chair, with Rep. Wells, and Rep. Sader also serving.

Chair adjourned the meeting at 2:58 p.m.
Next meeting is scheduled for January 28,1993, 1:30 p.m.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Jan. 27, 1993

NAME	ORGANIZATION	ADDRESS
KEITH R LANDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS	TOPEKA
Dennis Tietze	KAFP	Topeka
Carolyn Gaughan	KAFP	Wichita
Joyce Volmut	KDHE	Topeka
Bob Wunsch	KUMC	Lawrence
Chip Wheelen	Ks Medical Soc.	Topeka
R Epps	SRS	Topeka
Marlin Rein	KUMC	KC
David Hanzlick		
Harold Riehm	KAOM	TOPEKA
David Carpenter	KHA	Topeka
Jerry Slaughter	KMS	Topeka
SHERRY CLAYTON	K-NASW	Topeka
Rick Kellerman MD	KAFP	Salina
[illegible]	KAFP	Atchison

NUTS & BOLTS OF FAMILY PRACTICE
January 27, 1993, 1:30 p.m.
Carolyn Gaughan, Executive Director
of the Kansas Academy of Family Physicians

Chairman Flower, Vice Chairman Wagle, honored members of the committee, my name is Carolyn Gaughan. I'm the Executive Director of the Kansas Academy of Family Physicians. Thank you for the invitation to appear before the House Committee on Public Health & Welfare to discuss the state of family practice in Kansas. I have brought three members of the Academy along to give you their insights, and together we hope to cover a number of issues of concern to you. As we talk you'll see that family physicians are very busy people. It's a measure of these leaders' interest in your deliberations and belief in the importance of your work that these three busy family physicians have dropped their practices for an afternoon or a day to share their perspectives with you. The one page outline being distributed gives you an idea of what we hope to cover, and the scope of our discussions. I'll start with a short explanation of the Nuts and Bolt of Family Practice, then Doctor Kellerman will give you an Overview of Health Care in Kansas, Dr. Tietze will follow him with a handout and discussion on our legislative initiatives for the year, and Dr. Haynes will conclude with a presentation on our present and ongoing relationship with the School of Medicine. Unless you'd rather take questions along the way, I'd suggest that we hold questions until the end so we'll be sure to hear from each person. We'll try to conclude leaving 15 minutes or so for questions and answers.

Definition:

Family practice is a specialty of breadth. Family physicians treat patients with diseases that cut across the artificial boundaries of age, sex or organ systems. By definition, family practice is the specialty which provides continuing and comprehensive health care for the individual and the family. It is the specialty in breadth which integrates the biological, clinical and behavioral sciences. The scope of family practice encompasses all ages, both sexes, each organ system and every disease entity. Family practice is the continuing and current expression of the historic medical practitioner and is uniquely defined within the family context.

Continuing Medical Education:

Realizing that the family doctor's effectiveness depends on up-to-date information, the founders of the American Academy of Family Physicians required members to complete a minimum of 150 hours of approved continuing medical education every three years. This requirement, unique at its inception, has become a standard for an increasing number of medical associations.

Board Certification:

Likewise, the American Board of Family Practice set the standard in certification for all other medical specialty boards. The ABFP, like other specialty boards, is an autonomous organization charged with conducting examinations to measure competence

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in a particular field: family practice. Recognizing that the half-life of medical knowledge is about five years, the ABFP introduced mandatory recertification every seven years for physicians to retain the status of "board certified."

KAFP Goals:

The Kansas Academy of Family Physicians is dedicated to providing educational programs which offer quality continuing medical education. Other major goals of the organization are to preserve and promote quality, cost-effective health care; to maintain high standards among physicians who practice family medicine; to ensure an optimal supply of well-trained family physicians; and to provide responsible advocacy for patients and the public in all health-related matters.

Primary Care is Not Organ Specific:

By definition, primary care is not organ specific. I've heard representatives from the specialties of ophthalmology, radiology and psychiatry who have said that they believe their specialty is primary care "for the eye, for the mind, etc." But by definition, this cannot be true as these are organ specific specialties, creating artificial boundaries that primary care must transcend. Indeed, KAFP goes so far as to say that family physicians are the true primary care physicians. For within such primary care specialties as internal medicine and pediatrics, the movement toward procedural sub-specialization continues. These fields serve ever more often as mere prerequisites for their subspecialties. Currently 56% of internal medicine residents go on to subspecialty training, and 40% of pediatrics residents do likewise. By comparison, only 4.7% of family physicians take such a path.[1]

Numbers:

In 1990, 64 Kansas counties were underserved, 51 of them critically underserved. Two of those counties list no primary care physicians, 12 others list only one.[5] KAFP currently has 646 active members, that is practicing physicians. The age of family physicians demonstrates a bi-modal curve. There is an anticipated retirement of the first wave, estimated at 27% of physicians practicing in counties of under 10,000 population, by 1995.[2] In July of 1991, there were 7,275 residents in training in 390 approved programs. Since January 1970, 34,158 physicians have been graduated from three-year family practice residency programs.[4]

Distribution:

Areas of need greatly attract family physicians. They choose practice in rural and underserved areas twice as often as other primary care physicians. A rural Kansas community may lack sufficient population to attract and hold two internists plus two obstetricians plus two pediatricians, yet may be very well served by two or three family physicians. Nationally 46.3% of family practice residents settle in towns under 25,000 people, and 10.7% in towns of less than 2,500. In Kansas 13% of family physicians are in towns of less than 2,500, 17% are in towns of 2,500 to 10,000 population, 16% in towns of 10,000 to 25,000 in population, 7% in communities of 25,000 to 50,000 and 47% in cities of more than 50,000. Internists by contrast, settle in cities of less than 50,000 only 11% of the time.[1]

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Changing Demographics in Medicine:

Women are entering medicine in ever greater numbers. In 1989, one in six physicians were women, showing continued growth in representation since 1970. In 1989, 73 percent of women physicians were under age 45, a higher percentage than in earlier years. Enrollment patterns at medical schools indicate that the number of women physicians will continue to grow.[3] Family practice is no exception. As more women enter the field, recruitment patterns for communities to attract female physicians and their spouses, will need to be different. At the same time, the population is aging, and family physicians, who deal with the entire family will be in more demand to help with higher numbers of seniors.

Health Care Reform Measures Depend on Primary Care:

As you consider measures to reform health care in Kansas, bear in mind the need for one physician who coordinates the health care, treats the entire person, handles 90% of a person's health care problems and utilizes the services of a limited specialist when needed. I'm talking, obviously, about a family physician. Without sufficient numbers of family physicians in Kansas a health care reform measure is doomed to failure, be it "pay or play," managed care or a national health plan. We must have enough trained family physicians to provide access to care for all. KAFP believes that every Kansas has a right to health care and that each Kansan should have a personal family physician. When Kansas says we need more physicians, we are really saying we need more family physicians.

Bibliography

1. "Who Will Take Care of Our People?" North Carolina Academy of Family Physicians' Report Health Care Manpower Crisis Task Force, March 1991.

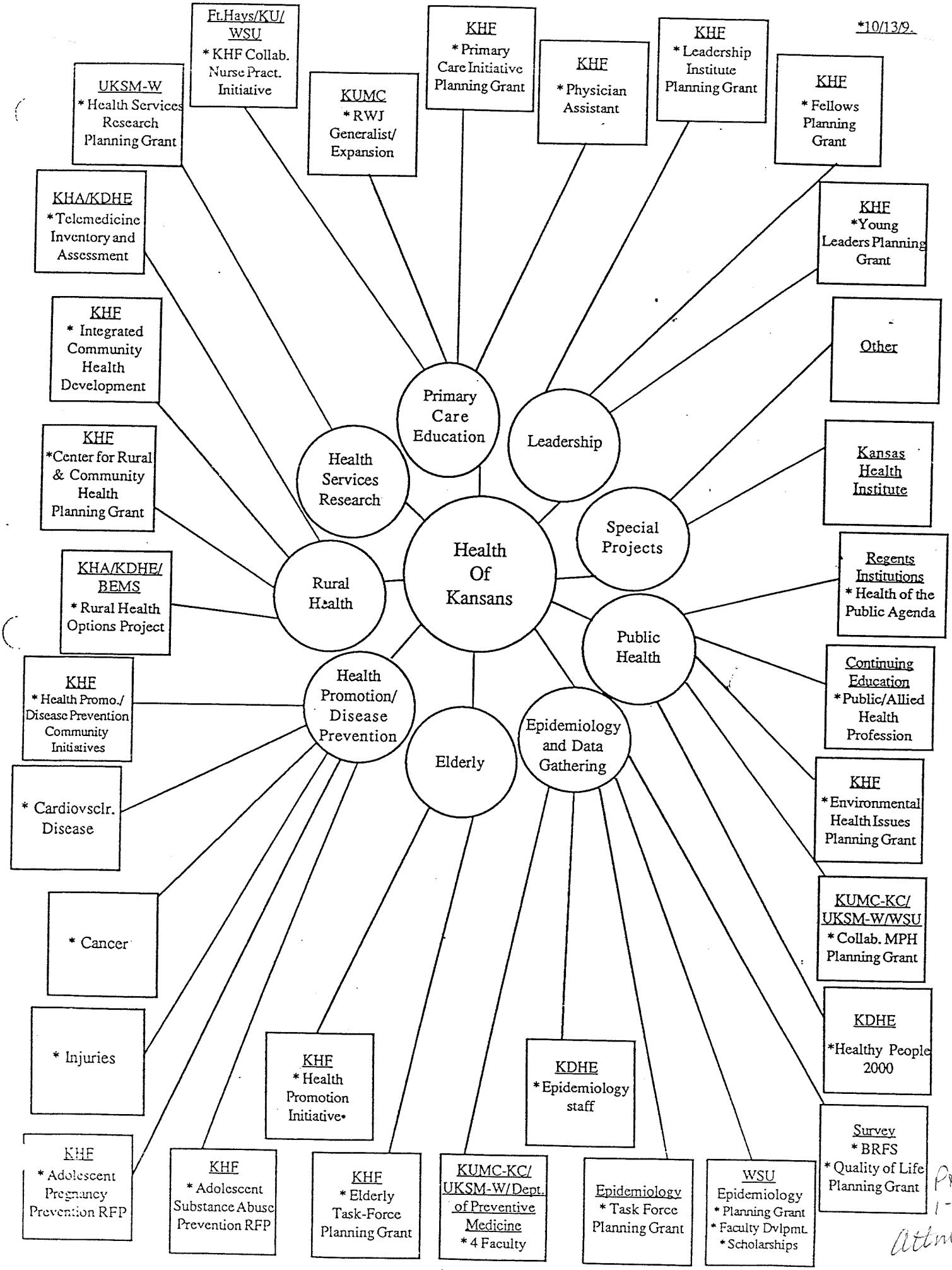
2. Report of the Council on Medical Education "Educational Strategies for Meeting Rural Health Physician Shortages", American Medical Association, 1990.

3. Health Personnel in the United States, Eighth Report to Congress, 1991, U.S. Department of Health & Human Services, Public Health Service, Health Resources and Services Administration.

4. AAFP Reprint 304. American Academy of Family Physicians.

5. 1990 Kansas Medically Underserved Areas Report.

*10/13/9.



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Kansas Family Physician Supply
Initiatives of the Kansas Academy of Family Physicians
January 1993

The Kansas Academy of Family Physicians (KAFP) is a group of 650 practicing family physicians from all corners of our state, urban and very rural. The major concern of the KAFP has been access to quality health care for all of the citizens of Kansas. Ultimately, the KAFP would like to see each and every Kansan have their own family physician.

Kansas family physicians are disturbed by the medical manpower crisis in our state, especially in rural and inner city areas.
Simply stated: when Kansas asks for "more doctors", Kansas is really asking for more family physicians.

Although the U.S. health care system is the technologic envy of the world, it has structural and financial barriers that hinder access to the primary health care services provided by family physicians. The foundation of our health care system should have a broad base of family physicians who provide quality comprehensive care to the Kansas public. During the last 25 years, however, the health care system has favored physicians who practice in highly subspecialized fields. This has created what some call "an inverted pyramid": physician specialty maldistribution where a small base of primary care-givers support a system top-heavy with doctors who have highly subspecialized and narrowed fields of interest. The inverted pyramid has led to fragmentation of care, excessive cost, and the unmet general medical needs of large segments of the population.

The medical manpower crisis is complicated by the inadequate percentage of medical students who enter family practice residencies. In recent years four of the five family practice residencies in Kansas have consistently had unfilled positions in the National Residency Matching Program. During the 11 year period between 1980 and 1991, 17.9% of University of Kansas medical students entered family practice residencies, ranking K.U. 22nd in the nation in medical students entering family practice.

Small towns, large city HMO's and group practices alike go begging for family doctors. One physician recruiter has asked, "if there is a doctor surplus, why do you need a physician recruiter to find family physicians?"

In September, 1992, 40 family physicians from around the state met at a KAFP sponsored Long-Range Planning meeting. This working group proposed four legislative initiatives that will help provide some short-term and medium-term relief for underserved Kansas. Those initiatives were subsequently unanimously endorsed by the KAFP Board of Directors. The following is an outline of those four initiatives.

1. **Expansion for the Kansas Medical Student Loan Program.** As a result of collaborative work between the Kansas Legislature, the KU Medical Center and the KAFP, the Kansas Medical Student Loan Program underwent improvement in 1992. Medical student stipend support was improved and the definition of underserved area was broadened. Subsequently, medical student interest in the Loan Program now exceeds funding authorized by the Legislature.

   A Post-Legislative Audit in 1992 was supportive of the Loan (previously Scholarship) Program as a way to improve the supply of physicians in underserved Kansas. Significant is the fact that 72% of medical students who entered family practice after taking the loan have subsequently fulfilled or are in the process of fulfilling their Kansas Medical Student Loan obligations.

   The KAFP now supports additional legislative funding for the Medical Student Loan Program with priority given to medical students who demonstrate interest in family medicine.

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2. **Increased stipends for all family practice residents.** Kansas receives multiple benefits by training family practice residents. Not only do residencies train the supply of future family physicians for the state; historically, family practice residents serve as primary care-givers to those patients who are disenfranchised in the current medical care system due to their financial situation or multiplicity of medical and emotional problems. It is in the best interest of the state to have all family practice residency positions filled with quality resident-physicians.

In 1992, only 23 of 39 available family practice residency slots in Kansas were filled by U.S. graduating medical students in the National Residency Matching Program (NRMP). Some of these slots were later filled in the "post-match scramble". However, it is generally accepted that "filling through the Match" is preferable.

Preferential salaries for family practice residents in Kansas would help our residency programs attract resident-physicians, demonstrate to medical students that the state government is serious about support for family medicine and help equalize financial inequalities between family medicine and other specialties.

This concept is not new. There is medical education support for this concept from Robert Petersdorf, M.D. of the Association of American Medical Colleges (New England Journal of Medicine, February 6, 1992) and Congressional support from Senator Nancy Kassebaum (S.1149, 102nd Congress. 1st Session, May 23, 1991).

There is precedent in Kansas by virtue of additional resident salary allocations made to Salina's Smoky Hill residents by the 1992 Kansas legislature. Smoky Hill is now enjoying its best-ever recruitment year as a result of the philosophic and financial support demonstrated by last year's legislature.

The KAFP supports legislative authorization of funds to increase the stipends of all family practice residents in Kansas.

3. **Guaranteed minimum salaries for family practice faculty.** The manpower situation at the Department of Family Practice in Kansas City and salary levels of all family practice faculty were a serious topic of discussion at the Long Range Planning Meeting. It is difficult to recruit qualified, experienced faculty when salaries are low. Quality faculty role models are critical to medical students whose specialty choices are influenced by the mentors they observe.

The KAFP is not privy to the inner workings of the university foundation system, but the tenuous financial state of the family practice foundation has been mentioned in public forum. The KAFP does understand that it is increasingly difficult for family physicians (in academic or private practice) to generate income that offsets ever-rising expenses. Due to the current medical reimbursement scheme, procedural services are inequitably rewarded compared to the cognitive services provided by family doctors.

The KAFP recommends that all family practice faculty be guaranteed salaries that are, at least, at the American Association of Medical Colleges (AAMC) 50th percentile for region and rank. Current salaries of University of Kansas Medical Center family practice faculty average at the AAMC 35th percentile.

The KAFP also recommends that the state continue to directly provide 75% of these salaries.

4. **Faculty locum tenens program.** This proposal calls for funding of two additional faculty positions in the Departments of Family Practice in Kansas City and Wichita. These faculty would provide medical practice coverage for rural family physicians attending continuing medical education meetings or

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participating in medical education exchange programs at the University of Kansas. The KAFP feels this proposal would have immediate impact, providing relief for rural family physicians.

The KAFP is concerned about the "isolation factor" of family doctors in rural Kansas. It is difficult for rural Kansas physicians to take time away from their 24 hour per day commitment to their home communities. Although there are private locum tenens programs available on a nationwide level, their typical charges preclude their use by rural family
doctors. In addition, quality of care rendered by itinerant locum tenens is of uncertain quality.

The locum tenens program focuses on physician retention in small communities and addresses the "burn-out" factor common to overworked rural physicians. The KAFP believes this program is in the public interest and should receive high priority.

In addition to these four initiatives, two other problems have recently surfaced involving the Kansas Bridging Program and criteria for loan repayment in federally designated Health Personnel Shortage Areas in Kansas. Those problems and possible solutions follow:

Kansas Bridging Program. The KAFP Executive Committee has become aware that the Kansas Primary Care Bridging Plan needs to be amended. Under the current law, a resident-physician must designate a specific community in order to enter the Bridging Program. The KAFP recommends allowing resident-physicians to enter the program prior to designating a specific community. This would "lock-in" the resident-physician to practice in Kansas. Actually, this is how the original Wesley Foundation pilot program worked and had proven to be successful.

Federal Health Personnel Shortage Area. In order to remain viable, Kansas family practice programs have had to sign on resident-physicians from other states who have high medical student debt load that can be forgiven by the National Health Service Corps (NHSC) loan repayment program. Due to the federal formula used to designate federal Health Personnel Shortage Areas for NHSC loan repayment, rural Kansas receives low priority. The federal formula places emphasis on infant mortality (Kansas is relatively low) and disregards the percentage of population over the age of 65 (where Kansas is relatively high). Kansas family physicians have asked Senator Nancy Kassebaum and Representative Pat Roberts to address this problem but the pending legislation appears to have stalled at the federal level.

The KAFP would support a pilot program for medical school debt repayment for board certified graduates of Kansas family practice residency programs who are not otherwise eligible for the current Medical Student Loan Program. At the current time, a KU medical student on the loan program receives a total package worth approximately $25,000 a year for 4 years with agreement that they will practice in an underserved area of the state when they complete residency 7 years later. It has been suggested that the Kansas legislature take a similar amount of money for 4 years to help defray the debt obligations of new graduates of our family practice residency programs as an incentive to attract them to underserved Kansas. This proposal could have immediate effect. It would not be available to graduates on the Kansas Medical Student Loan Program.

Conclusion: The KAFP recognizes that physician supply is only one part of the equation in health care access. But in rural Kansas it is a significant part of the equation.

Because of the "inverted pyramid", any attempt to structurally reshape the health care system, must address the current shortage of family physicians who provide primary care. In the final analysis, plans promoted by national and state policy makers for cost containment, national health insurance, pay-or-play, or universal access are doomed to failure by a shortage of family doctors.

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The KAFP would ask the legislature, when it considers any kind of health care legislation, to ask: "What impact will this have on family physicians in Kansas?". Already saddled with an inequitable reimbursement system, the constant threat of malpractice litigation, the frustrating paperwork demands of insurance companies and government bureaucracy, and the overwhelming public demands for our services, Kansas family doctors require some help in order to serve the Kansas public. The KAFP's ultimate concern is the comprehensive healthcare needs of our patients whether they be newborn, elderly, or any age in between. These KAFP proposals will increase the number of family physicians in the state and thereby improve access to care for the residents of Kansas.

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AN OVERVIEW OF
HEALTH CARE IN KANSAS

PRESENTED TO THE

KANSAS HOUSE OF REPRESENTATIVES

PUBLIC HEALTH AND WELFARE COMMITTEE

TOPEKA, KANSAS

JANUARY 27, 1993

BY

RICK KELLERMAN, M.D.

PRESIDENT

KANSAS ACADEMY OF FAMILY PHYSICIANS

HEALTH CARE IN KANSAS

To start my presentation on "An Overview of the Health Care Situation in Kansas," I would like to quote the following two sentences from a December 7 editorial in the Pratt Tribune:

"It isn't too far fetched to say that rural areas in a few years may find themselves back where their pioneering grandfathers were as far as access to medical care is concerned. The old doctors are passing and the young doctors are tending to congregate in larger centers."

If I told you that this quote is from the December 7, 1992, issue of the Pratt Tribune you would not be surprised. However, if I told you that the quote is from the December 7, 1945, issue of the Pratt Tribune (47 years ago), you might be surprised. There has been a rural health problem in Kansas for a long time. It is particularly acute right now, and we are going to continue to have problems in the future.

During this overview, I am going to review some Kansas medical history, explain the Murphy Plan that has guided rural health care in Kansas for the past 40 years, explain current trends that are affecting health care delivery in our state, and explain how family practice fits into the equation of health care reform.

Access to care problems can be divided into two broad categories: (1) Cost issues: problems of the uninsured and under insured, appropriate use of expensive technology, the costs of medications and hospital care, etc. (2) Manpower issues.

Though cost and manpower issues overlap, most of my comments will emphasize the

medical manpower maldistribution problem in Kansas, because that addresses an immediate question for many small towns in Kansas: "How do we recruit doctors to our community?" The majority of counties in Kansas can be classified as underserved.

Let us review some Kansas medical history. In 1948 faced with editorials like that from the Pratt Tribune, requests from over half of the counties in the state for physicians, an increasingly angry farm lobby, an increasingly concerned medical society and an increasingly frustrated legislature, a health care delivery plan was developed by Dr. Franklin Murphy, who was then Dean of the Kansas University Medical School. Dr. Murphy's plan had two main provisions.

First, the Medical School would expand its classes to produce more general physicians. Second, rural communities were responsible for providing young physicians with the facilities, such as hospitals and offices, that they would need to practice medicine. Federal dollars called Hill-Burton funds were used to finance construction of hospitals. Small town practice was strongly recommended to young physicians in Kansas. My former partner says he was actively encouraged to go to a rural area. Now in his seventies, he retired last year after serving the same Western Kansas community for 40 years. The Murphy Plan has been the guide for rural health care delivery in Kansas for the last 40 years, and its effect is still evident. However, the halcyon days of the Murphy plan are over.

There are three premises I have about rural health care in Kansas. (1) A health care delivery system is essential to a rural community's economic infrastructure. (2) Quality health care delivery to rural areas depends on the availability of residency trained family physicians. (3) When asking for "more doctors," rural Kansas is really asking for "more family physicians."

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That leads to the first and second of ten current trends that have affected physician manpower in Kansas:

Trend number one: Those physicians produced by the Murphy Plan in the early 1950s have, or will soon, retire.

Trend number two: Retiring physicians produced by the Murphy Plan in the 1950s are not being replaced in adequate numbers by new physicians.

During the last few years, there has been a decrease in interest among medical students in family practice as a career and we have had problems filling our family practice residency training programs in Kansas. This is a pattern that must be reversed if we are to have any hope of meeting our state's health care needs in rural and underserved areas. The Kansas Department of Health and Environment testified to this committee last year that "upwards of 40 new doctors a year" will be required between now and the year 2000 just to keep pace with rural physicians who retire or relocate.

Trend number three: The current medical education environment does not encourage medical student interest in family practice. Dr. Steven Schroeder, President of the Robert Wood Johnson Foundation puts it this way: "Academic medical centers have responded to the incentives of society as they see them. You can argue that they have responded very, very well. . . .Financial incentives to practice technology-intensive specialty care are one factor. Payment for high-tech care is much higher - sometimes 10-, 20-, or 30-fold. . . .The major source of research funds in academic medicine is the National Institute of Health. The NIH tends to look at it's funding as organ-system specific - depth, not breadth. So the values of family medicine as a specialty do not fit well with the values of academia. . . .Academia tends to put generalism on the lower rung of the intellectual ladder. So the desire to be a generalist fades as students move

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from the first to the fourth year of medical school." (Medical Economics, December 21, 1992.)

The fact is that the needs of our state for health care services may not run parallel to the values of an academic tertiary care medical center.

Trend number four: There has been a change in rural Kansas demographics. The State of Kansas is now almost evenly split with 50% of the population living in urban areas and 50% living in rural areas. The care of the aging population in rural Kansas will be of increasing importance during the next decades. Over 20% of the population in many rural Kansas counties are over the age of 65. Geriatric patients are less mobile and have more difficulty picking up and driving to the next town for their medical care. But if 20% of the population is over 65, then 80% is under the age of 65. That age group is the work force, the children, and the childbearing families of rural Kansas.

Trend number five: Doctor and hospital reimbursement in rural versus urban areas is inequitable. Rural physicians charge less, are reimbursed less and have less ability to share costs with a multitude of partners. There is less "economy of scale" in rural areas. But practice costs are the same in rural and urban areas. The cost of Band-Aids, tongue blades and Xerox machines are the same in urban and rural areas.

A physician who performs a service in Kansas City is reimbursed by Medicare at a rate higher than a physician in Greensburg, even though the services they provide are identical. The physician in Greensburg has a much higher percentage of Medicare patients in his practice. Elderly patients have more multi-system problems and take longer to see than younger, healthier patients. So the rural family doctor is economically penalized for taking care of elderly patients.

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Statistics from a KAFP survey last year show that Kansas family doctors in rural areas see Medicaid patients in their towns as a community service. There are no alternative sources of care in rural areas so the local doctor must care for the indigent on a daily basis. For a routine hospital visit, Medicaid reimburses $8.40 a day, barely enough to pay the insurance clerk who files the claim.

Family doctors tend to provide cognitive and diagnostic services instead of higher income procedural services.

Although most reimbursement policies are set at the federal level and by insurance companies, this inequitable reimbursement pattern is one that this committee must understand.

Trend number six: "Hassle factors." The amount of paperwork and regulation by Government and insurance companies impacts inequitably on rural and office based family physicians. Solo physicians and physicians in small groups have less ability to cost share and hire business managers, insurance clerks, and other ancillary personnel to stay current and up-to-date on the various regulations of Medicare, Medicaid, federal agencies, state agencies, and a multitude of insurance companies. Physicians are trained in medicine, and the time and cost factors of the "small business" aspects of medical practice take time away from patients and our own families. This burden may drive physicians out of rural practice.

Trend number seven: Malpractice costs and the threat of liability continue to be a problem in Kansas. Although not the issue it was in 1988, many feel the malpractice problem is cyclic and are waiting for the pendulum to swing back. The societal and economic costs of "defensive medicine" that physicians must practice is receiving close inspection by health planners as health care costs skyrocket.

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Trend number eight: Corporate medicine will have an increasing effect on rural Kansas. When Atwood, Kansas, is trying to recruit a physician, its competition is not Oberlin. Rather, Atwood's competition for a new family practice graduate is a Minor Emergency Center or Walk-In Clinic in Kansas City or Wichita. These clinics provide excellent salaries, 9 to 5 schedules with little call or business responsibilities.

Trend number nine: Family, social and professional lifestyle issues impact on rural physicians. Social and professional isolation of rural physicians continues to be a problem, what I call the "24 hour 7 day per week 365 day per year On-Call Syndrome." It is oftentimes not just the number of patients seen and stress of practice, but rather the stress of constant availability that is a problem for many rural physicians.

Trend number ten: Every major health reform measure has called for the production of more family physicians.

The need for more family physicians is more than a rural problem. Every health care reform plan, whether it is national health insurance, pay-or-play, or managed competition, recognizes that patients in urban areas should have a family doctor who handles 90% of a person's health care problems on an on-going basis, who treats the "entire person", who recognizes when the specialized services of a limited subspecialist are necessary (and when they are unnecessary).

Family physicians have proven to be cost-effective providers of comprehensive care. Every health care planner recognizes that. The pressure for more family doctors - above and beyond the need to replace retiring physicians - will intensify as the health care system changes.

Is Kansas prepared to meet the needs for more family doctors?

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Let us talk about family practice training in Kansas because if Kansas is to meet it's needs for new physicians, it will take the work of our family practice residency programs. Family practice is a specialty of breadth. Family practice physicians treat patients with problems that cut across the artificial boundaries of age, sex or organ system. As an example, it is unreasonable to think that Tribune, Kansas, will recruit a geriatrician, pediatrician, and gynecologist to their community. But Tribune has a superb family physician, Bob Moser, M.D., working overtime to serve Greeley county's needs. We have five accredited family practice residencies in Kansas: one in Kansas City at the Medical School, three in Wichita (St. Joseph's, St. Francis and Wesley), and the Smoky Hill Family Practice Residency in Salina.

What is a board certified family physician? After completion of medical school and after receiving a medical degree, new physicians enter residency programs. Family practice residencies are three years in length, the same as internal medicine and pediatrics. After completion of three years of training, our residents take a comprehensive, two day board examination. We retake and pass that test every six years to remain board certified. In Kansas, all a physician has to do to get a license to practice is a one year internship. But family physicians feel that completion of an accredited residency and continued Board Certification is one way of insuring physician quality.

Kansas receives multiple benefits by training family practice residents. Not only do residencies train the supply of future family physicians for the state; historically, family practice residents serve as primary care-givers to those patients who are disenfranchised in the current medical care system by virtue of their financial situation or multiplicity of medical and emotional problems. It is in the best interest of the state to have all family practice residency positions filled with quality resident-physicians.

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In conclusion, the health manpower problem in Kansas is complicated. It is complex. There are no easy answers. There is no quick fix. Health care reform is in a state of flux and many of the trends I've presented, must be dealt with at the federal level. But I am convinced that no matter which kind of plan is eventually adopted, it will require the production of more family doctors.

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