Statement of Byron Perkins, DO
On Behalf of the
American Osteopathic Association

Presented to:

Senate Health, Education, Labor, and Pensions Committee

February 20, 2007

Senator Murkowski and distinguished members of the Committee, my name is Byron Perkins. I am a practicing osteopathic family physician in Anchorage and currently serve as the President of the Alaska Osteopathic Medical Association. I am honored to be here today representing the American Osteopathic Association (AOA). The AOA, which represents the nation's 59,000 osteopathic physicians and over 12,000 osteopathic medical students, applauds the Committee's interest in examining this very important issue. Access to physicians and other health care services for people residing in rural and other underserved communities is a serious problem. The AOA believes that access to physician services in rural and other underserved communities can be improved by increasing training and workforce opportunities along with developing new programs that aid in the recruitment and placement of osteopathic and allopathic physicians.

We recognize that many communities in the United States face limited access to physicians and physician services. This is especially true in rural and frontier communities. We applaud the efforts made by state governments, the federal government, Members of Congress, and rural communities to increase physician access for their citizens. However, like you, we believe much more should be done.

For more than 130 years the AOA and the osteopathic profession has been dedicated to educating and training the future physician workforce. Consistent with our mission, we remain committed to producing primary care physicians who will practice in rural and other underserved communities. This mission has been a tenet of the profession since it's founding in the late 1800's. Today, more than sixty-five percent of all osteopathic physicians practice in a primary care specialty (family medicine, internal medicine, pediatrics, and obstetrics/gynecology). In Alaska, there are 112 osteopathic physicians. Seventy-two of these osteopathic physicians practice in a primary care specialty, 59 are family physicians [Maps 4 and 5]. Nationwide, more than 100 million patient office visits are made to osteopathic physicians each year.

Over the past fifteen years the osteopathic profession has enjoyed tremendous growth. We are one of the fastest growing professions in health care. Since 1990 the number of osteopathic physicians has increased sixty-seven percent. Currently, there are 59,000 osteopathic physicians in the United States. The number of osteopathic physicians in the United States is projected to exceed 90,000 by 2015. Osteopathic physicians represent six percent of the current U.S. physician workforce and over eight percent of all military physicians.

Throughout our history, the osteopathic profession has placed an emphasis on primary care and rural service. Our commitment to these goals is reflected in our membership and in the mission statements of the nation's colleges of osteopathic medicine. Our emphasis on primary care and rural practice is reflected by the fact that currently twenty-two percent of osteopathic physicians practice in a designated medically underserved area (MUA) (Map 1). As our membership grows, the AOA is refocusing its efforts on our core mission—training physicians who are capable and willing to provide high quality care to our nation's neediest populations.

The issues facing our nation's rural health care system are complex. We do not suggest that there are easy answers, but we do believe that change in some policies would increase our ability to meet these needs.

The following pages outline several recommendations. These recommendations would improve the ability of the AOA and our allopathic colleagues to meet the needs of rural and other underserved communities. We believe that the implementation of these recommendations will allow the U.S. medical education system to meet its responsibilities of training physicians who will provide quality health care to all populations regardless of their geographic location.

Physician Workforce

Many experts now believe that the United States will face a shortfall in its physician supply over the next twenty years. While academic and policy experts debate the needs and expectations of the future physician workforce, the AOA recognizes that we must begin to educate and train a larger cadre of physicians, now.

The time it takes to educate and train a physician is, at minimum, seven years. This means that a student accepted in the matriculating class of 2007 will not enter the physician workforce until at least 2014. Due to the time required to educate and train future physicians, we believe a concentrated effort must be focused on increasing the nation's physician education and post-graduate training capacity over the next five years. If handled appropriately, the country could increase the physician workforce dramatically by 2020.

Reliance upon the J-1 Visa program is neither the most effective nor the most desirable way to increase physician supply in rural communities, although we recognize that the program can provide short-term relief. The J-1 program is not capable of meeting the physician workforce needs of our nation and should not be promoted for this purpose. Yes, a few states and communities have physician services as a result of the J-1 program. However, thousands of rural communities remain without physician services. The AOA supports increasing our capacity by adopting policies that encourage larger numbers of U.S. educated and trained physicians to practice in rural and underserved areas. An increase in U.S. educated and trained physicians, if properly selected and trained, will lead to a more predictable and reliable physician workforce and is more likely to produce larger numbers of physicians who will practice in rural communities.

Today, one in five medical students in the United States is enrolled in a college of osteopathic medicine. Fifty percent of the students enrolled in the nation's colleges of osteopathic medicine are women. Currently, there are 23 colleges of osteopathic medicine operating on 26 campuses (See Map 2). There are two additional colleges that will open within the next two years, bringing the total number of colleges to 25 that are operating on 28 campuses. In 2007, these colleges will graduate approximately 3,000 new osteopathic physicians. In 2008, the number of graduates will increase to 3,500. By 2013 the number of osteopathic physicians graduating from colleges of osteopathic

medicine is projected to reach 4,500. Assuming a predictable growth pattern, the osteopathic profession should produce approximately 5,000 new physicians per year beginning in 2015.

The current colleges of osteopathic medicine, and those set to open in the future, are located in regions that historically have had limited access to physician services. Currently, there are three colleges of osteopathic medicine in Appalachian region, one in Las Vegas and one developing in Denver—two of the nation's fastest growing communities, three colleges in the states of Missouri and Oklahoma, and Yakima, Washington—which aims to meet the needs of several Northwest states including Alaska. The location of current and future colleges of osteopathic medicine reflects the osteopathic profession's commitment to rural and underserved communities.

In Alaska we are especially proud of the Pacific Northwest University of Health Sciences (PNUHS) in Yakima, Washington, which will begin classes in 2008. Along with my colleagues in Alaska, I am optimistic that PNUHS will begin contributing to Alaska's physician workforce in the near future. The AOA urges the Alaska legislature to develop new programs that encourage a significant number of Alaska residents to pursue their medical education at the PNUHS College of Osteopathic Medicine.

International Medical Graduates

The U.S. health care system is widely recognized as the most advanced in the world. The rapid development of new diagnoses and treatments outpaces those in other countries. We are the world's leader in medicine and medical technology. In this role, we should share our expertise with the world. For this reason, the AOA supports the continued acceptance of international medical graduates (IMGs) into the U.S. graduate medical education system. By training international physicians, we can improve the health care delivery systems around the world by improving the quality of the physicians. However, this transfer of knowledge and skills cannot take place if international physicians do not return to their home countries.

The United States should not be an importer of physicians. The majority of international physicians should come to the U.S. to train and then return home. The "brain drain" in many countries is well documented. Many countries lose their best and brightest young physicians to the United States and other English-speaking countries. International physicians should come here to train and should not be encouraged to stay upon completion of their training. In fact, we should require that they return to their home countries and practice medicine for an extended period of time before they are eligible to petition for a visa, J-1 or otherwise.

In 2006, almost 9,000 IMGs participated in the National Residency Matching Program (NRMP). Of these applicants, approximately 6,500 were not U.S. citizens and 2,500 were U.S. citizens who attended a foreign medical school. Almost fifty percent of all IMGs match to first year residency positions. In 2006, the total number of IMGs who matched to first year positions increased to 4,382.

Of the 6,500 IMG participants who were not U.S. citizens, 3,151 (48.9%) obtained first year positions. 2006 was the fifth consecutive year that the number of non-U.S. citizen IMGs matching to first year positions increased. Of the 2,500 U.S. citizen IMG participants, 1,231 (50.6%) were matched to first year positions. 2006 was the third consecutive year that the number of U.S. citizen IMGs matching to first year positions increased. The total number of IMGs filling first year residency positions will be much higher than the approximate 4,400 who secured positions through the NRMP. Many IMGs are able to secure residency training positions outside the match.

Recruitment and Placement

Medical schools and colleges of osteopathic medicine traditionally place significant emphasis on an applicant's academic achievement—grade point average, undergraduate degree program, and scores on the Medical College Admission Test (MCAT). While we would never suggest that the academic standards required for admittance be lowered, we do recommend that the nation's medical education institutions begin evaluating "other" factors. An evaluation of the student's life, including an evaluation of where the student was raised, attended high school, and location of family members, provides an indication of where a future physician may practice. For example, an applicant from Manhattan, New York is less likely to practice in a rural community than an applicant from Manhattan, Kansas. If the two applicants are equally qualified, we should encourage our schools to matriculate the student from Manhattan, Kansas, an individual more likely to return to rural Kansas once education and training is completed.

Our medical education system must increase its efforts to promote both primary care specialties and experience in rural practice locations. Over the years, the role of the rural family physician became less glamorous than that of the urban subspecialist. Far too many medical school students want to be an "ologist" instead of a general surgeon, family physician, general internist, or pediatrician. Our nation's health care system needs specialists and subspecialists, but we need far more primary care physicians. Our medical education system must place greater emphasis on educating and training primary care physicians and general surgeons. These physicians are more likely to practice in a rural or small community hospital and are far more likely to practice in rural America.

The AOA believes that programs funded and operated under Title VII of the Public Health Services Act are essential to achieving the goals outlined above. Over the past five years, Title VII programs have seen a dramatic decrease in both support and funding. We urge Congress to reverse this trend and place a greater emphasis on these important programs.

Increase Training Capacity

Currently, there are approximately 96,000 funded residency positions in the United States. The number of funded residency positions has been static since the late 1990's when Congress, as part of the Balanced Budget Act of 1997, placed a limit or "caps" on the number of funded residency slots any existing teaching program may have.

The residency caps were established at a time when the general consensus was that the country had an adequate supply of physicians. We now recognize this is not correct. The residency caps established by the BBA limit the ability of teaching hospitals to increase training programs, thus preventing responsible growth capable of meeting our future physician workforce needs. The AOA encourages Congress to either remove or increase the caps on the number of funded graduate medical education training "slots" as established by the Balanced Budget Act of 1997.

This past week, Senators Harry Reid and Bill Nelson introduced the "Resident Physician Shortage Reduction Act of 2007." This legislation authorizes the Secretary of the Department of Health and Human Services (HHS) to increase the number of residency cap positions for which Medicare payments will be made if certain criteria are met. The increases or cap adjustments target teaching hospitals in eligible states where there is a demonstrated shortage of resident physicians. States would be considered to have a shortage of resident physicians if its ratio of allopathic and osteopathic physicians training in ACGME or AOA approved residency and/or fellowship programs is below the national median number per 100,000 population. According to current statistics, the national median number of resident physicians per 100,000 population is 25. Teaching hospitals in twenty four states would be allowed to increase their FTE cap under the proposed formula.

The AOA supports this legislation and urges all Senators to cosponsor this important bill. Furthermore, we call upon the Senate to approve this legislation this year.

Improve Rural Training Programs

There is an old saying in medical education circles that physicians will practice within 100 miles of where they train. While the validity of this saying either in a world that is limited to the United States' borders or alternatively in an era of globalization is unproven, its message rings true. Physicians are more likely to practice in settings where they have the most experience. While a majority of physician training takes place in the hospital setting, it should not be limited to this setting. We need to do more to expose medical students and resident physicians to different practice settings during their training years.

A valuable component of graduate medical education is the experience of training at non-hospital ambulatory sites. These sites include physician offices, nursing homes, and community health centers. Ambulatory training sites provide an important educational experience because of the broad range of patients and conditions treated and by ensuring that residents are exposed to practice settings similar to those in which they ultimately may practice. This type of training is particularly important for primary care residency programs since a majority of these physicians will practice in non-hospital ambulatory clinics upon completion of their training. This training also is essential to improving access to care in rural communities.

Congress has long recognized that a greater focus should be placed on training physicians in rural and other underserved communities. In the 1990s, Congress began to fear that the current graduate medical education payment formula discouraged the training of

resident physicians in ambulatory settings. This opinion was based upon the fact that the payment formula only accounted for the resident training time in a hospital setting.

Through the Balanced Budget Act of 1997, Congress altered the payment formula, removing the disincentives that existed for training in non-hospital settings. We accomplished this goal by allowing hospitals to count the training time of residents in non-hospital settings for the purpose of including such time in their Medicare cost reports for both indirect medical education (IME) and direct graduate medical education (DGME) payments.

This change in the payment formula was designed to increase the amount of training a resident physician received in non-hospital settings, enhance access to care for patients in rural and other underserved communities, provide an additional education experience for residents who are considering practicing in rural communities, and provide a recruitment mechanism for rural and underserved communities in need of physicians.

The program appeared to be working as intended. However, in 2002 the Centers for Medicare and Medicaid Services (CMS) began administratively altering the rules and regulations in respect to this issue. As a result, CMS intermediaries began denying the time residents spent in non-hospital settings. In many cases, hospitals were forced to repay thousands of dollars as a result of this administrative change in regulations.

Many Members of Congress urged CMS to work with interested parties to resolve this issue by developing new regulations that clarify the appropriate use of non-hospital settings. Unfortunately, these conversations have not produced policies that meet the original intent of Congress as established in 1997. As a result, hospitals are being forced to train all residents in the hospital setting, eliminating the valuable educational experiences offered in non-hospital training sites. Additionally, some teaching hospitals may be forced to eliminate residency programs entirely as a result of current CMS policies.

Allowing hospitals to receive payments for the time resident physicians train in a non-hospital setting is sound educational policy and a worthwhile public policy goal that Congress clearly mandated in 1997. Additionally, it is good for rural communities.

Development of New Teaching Hospitals

In addition to expanding the training capacity at existing teaching hospitals, we desperately need to create new training programs at new hospitals. Currently, a majority of allopathic and osteopathic residency training programs exist in or near the major metropolitan cities on the east coast, west coast, and Great Lakes region. While the current programs continue to excel at producing high quality physicians, they do not adequately distribute physicians to communities across the nation.

As we outlined previously, it is well documented that physicians establish practices near the location of their training program. Assuming this to be true, the nation desperately needs new training programs in many states, especially those in the Midwest, Southwest,

Northwest, and Rocky Mountain regions. By providing greater number of residency training programs in these areas, the physician workforce shortage could be reduced greatly for many states.

A major obstacle often preventing the establishment of new residency training programs are the costs associated with the creation of such programs. Under current law, a hospital starting a new residency program is not eligible for direct graduate medical education (DGME) or indirection medical education (IME) funding until they have filed their initial cost-report with the Centers for Medicare and Medicaid Services (CMS). Initial cost-reports are filed following the completion of the first year the residency program is in operation. The first payments from CMS to hospitals with new residency programs typically occurs around 16 to 18 months after the program is started. This financing arrangement presents challenges for hospitals that operate on narrow margins, especially community hospitals that lack adequate reserve funds to offset the financial commitments associated with starting a new residency program.

The AOA is working with Members of Congress to develop a new program that would assist community and rural hospitals in their efforts to establish new residency training programs. Under the "Physician Workforce and Graduate Medical Education Enhancement Act," the Secretary would be directed to establish an interest-free loan program whereby hospitals committed to starting new osteopathic or allopathic residency training programs could secure start-up funding to offset the initial costs of starting such programs. Congress would be asked to allocate adequate money to establish and fund the program.

To be eligible, a hospital must demonstrate that they currently do not operate a residency training program, have not operated a residency training program in the past, and that they have secured preliminary accreditation by the American Council on Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Additionally, the petitioning hospital must commit to operating an allopathic or osteopathic residency program in one of five medical specialties or a combination of these specialties: family medicine, internal medicine, emergency medicine, obstetrics/gynecology, or general surgery.

A hospital may request funding to assist in the development of a residency training program. We suggest that the financing be limited to no more than one million dollars. Funding could be used to offset the costs of residency salaries and benefits, faculty salaries, and other costs directly attributable to the residency program.

Hospitals securing a loan under the program would be obligated to repay the total sum, without interest, to the Secretary. Hospitals would have two repayment options—repayment in full or repayment through a financing mechanism. The AOA looks forward to working with Members of the United States Senate on this concept and is optimistic that this type of a program would enhance the disbursement of physicians to communities in need.

Expand Programs That Provide Incentives for Rural Practice

There are numerous existing programs that provide scholarships and loan repayment for physicians who choose to practice in rural communities. These programs include the National Health Service Corps, Public Health Service, Indian Health Service, and many programs operated by state governments. The AOA supports these programs and encourages Congress to continue funding them at levels that facilitate greater numbers of physicians practicing in rural and other underserved communities.

Additionally, we believe that some consideration should be given to allow physicians to participate in the programs on a part-time basis. There are numerous communities that need physician services, but they may not need them full time. We believe that modifications should be made to federal loan repayment and scholarship programs that allow participants to repay on a part-time basis in exchange for a longer term of service. For example, if a physician participates in the National Health Service Corps and agrees to a three-year commitment in a rural community—why not allow the physician the option of committing to 4 or 5 year's service on a part-time basis. We believe this would encourage more physicians to participate in these valuable programs without jeopardizing the underlying mission.

The AOA also proposes a change in the tax code that would provide physicians practicing in designated rural communities with a tax credit equal to the amount of interest paid on their student loans for any given year that they practice in such a community, or until their loans are paid in full. Under current law, individuals may deduct up to $2,500 in interest paid on student loans from their federal income taxes. However, the income thresholds associated with this provision often prevent physicians from qualifying. Our proposal would provide a direct link between practice location and the tax credit. A physician practicing in a rural Wyoming who pays $8,000 in interest on her student loans in year one would get an $8,000 tax credit for that year. The program would continue until the physicians had retired her student loan debt or when she departed the rural community. We believe that this proposal provides a direct incentive to young physicians and would assist in the recruitment and retention of physicians in rural communities.

Improve the Economics of Medicine

The current practice environment physicians face is challenging. Over the past decade escalating professional liability insurance premiums, decreasing reimbursements, and expanded regulations have made the practice of medicine more frustrating for all physicians. These issues are compounded in rural communities where physicians are often in solo practice or small group practices, unable to benefit from economies of scale that larger group practices in urban areas enjoy.

According to a 2004 Health Affairs study, more than half of all practicing physicians are in practices of three or fewer physicians. Three-quarters are in practices of eight or fewer. They face the same economic barriers as every other small business in America. Costs associated with staff salaries; health and other benefits, basic medical supplies, and technology, all essential components of any business, continue to rise at a rate that far

outpaces reimbursements. When facing deep reductions in reimbursements at the same time that their operational costs are increasing, it is safe to project that most businesses will not be able to continue operation. While most businesses increase, or have the ability to increase, their prices to make up the differential between costs and reimbursements, physicians participating in Medicare cannot.

Physician Payment—Since 2001, Medicare physician payment rates have fallen greater than 20 percent below the government's measure of inflation in medical practice costs. In 2002, physicians' payments under Medicare were cut 5.4 percent.

If the projected cuts are implemented, the average physician payment rate will be less in 2007 than it was in 2001. Additionally, two provisions included in the Medicare Modernization Act (MMA), which provide increased reimbursements for physicians in rural communities, will expire over the next two years.

In 2002, physician payments were cut by 5.4 percent. Congress acted to avert payment cuts in 2003, 2004, 2005, 2006, and 2007 replacing projected cuts of approximately 5 percent per year with increases of 1.6 percent in 2003, 1.5 percent in 2004 and 2005, and 0 percent in 2006 and 2007. Even with these increases, physician payments fell further behind medical practice costs. Practice costs from 2002 through 2006 were about two times the amount of payment increases. The long-term projections are even more startling. Under the current formula, physicians face cuts of greater than 30 percent over the next eight years.

Since its inception in 1965, a central tenet of the Medicare program is the physician-patient relationship. Medicare beneficiaries rely upon physicians for access to all other aspects of the Medicare program. This relationship has become compromised by dramatic reductions in reimbursements, increased regulatory burdens, and escalating practice costs. These projected cuts come at a time when the number of Medicare beneficiaries is projected to grow from the current 43 million to more than 71 million. Additionally, since many health care programs, such as TRICARE, Medicaid, and private insurers link their payments to Medicare rates, cuts in other systems will compound the impact of the projected Medicare cuts. Medicare cuts actually trigger cuts in other programs.

Additional cuts in Medicare physician payments threaten Medicare beneficiaries' ability to access to physician services. These access problems are compounded in rural communities where the loss of a single physician can equate to no access for beneficiaries in that community. These problems will only increase if additional cuts are implemented.

Furthermore, reduced payments hamper the ability of physicians to purchase and implement new technologies in their practices. According to a 2005 study published in *Health Affairs*, the average costs of implementing electronic health records was $44,000 per full-time equivalent provider, with ongoing costs of

$8,500 per provider per year for maintenance of the system. This is not an insignificant investment. When facing deep reductions in reimbursements, it is safe to project that physicians will be prohibited financially from adopting and implementing new technologies.

Physician payments should reflect increases in practice costs. Now is the time to establish a stable, predictable, and accurate physician payment formula that reflects the cost of providing care.

Congress must act to reform the Medicare physician payment formula. Continued use of the flawed SGR formula will have a negative impact upon patient access to care. Additionally, Congress should act to extend expiring provisions that provide incentives to physicians in rural communities. The Medicare Modernization Act (MMA) altered the Medicare physician payment formula by establishing a 1.0 floor for the work geographic practice cost indices (GPCI) under the Medicare physician fee schedule and created a 5 percent add-on payment for physicians practicing in recognized Medicare physician scarcity areas. The MMA reversed years of inequities in payments between rural physicians and those in larger urban communities. Congress extended the 1.0 floor for the work GPCI as part of the "Tax Relief and Health Care Act of 2006" (H.R. 6111). However, both the GPCI and Medicare scarcity provisions expire on December 31, 2007 unless Congress acts. We believe that these are essential and positive Medicare payment policies that should be extended, if not made permanent. Both provisions will enhance beneficiary access and improve the quality of care available.

Medical Liability Reform—As you know, the nation's medical liability system is broken. In recent years physicians across the nation have faced escalating professional liability insurance premiums. According to the National Association of Insurance Commissioners (NAIC), between 1975 and 2002 medical liability premiums for physicians increased, on average, 750 percent. These premium increases are related directly to an explosion in medical liability lawsuits filed against physicians and hospitals and the rapid increase in awards. The Government Accountability Office (GAO) confirms this. In a 2003 report, the GAO stated that losses on medical liability claims are the primary driver of increases in medical liability insurance premiums.

As a result of a broken medical liability system patients face reduced access to health care, the overall costs of health care increases, and the future supply of physicians is threatened. Many physicians no longer provide services that are deemed high-risk, such as delivering babies, covering emergency departments, or performing certain surgical procedures. This crisis also impacts primary care physicians, especially those in rural areas who are often the only physician practicing in a community. As a result, patients have seen a decrease in the availability of physician services. Additionally, the medical liability crisis has a significant impact upon the career choices of future physicians. In a recent poll conducted by the AOA, eighty-two percent of osteopathic medical students stated that the cost and availability of medical liability insurance would influence their

future specialty choices, while 86 percent stated that it would influence their decision on where to establish a practice once their training was complete. This trend in career choices is disturbing and will have a long-term impact upon the health care delivery system in the years ahead.

Summary

Again, the AOA appreciates the opportunity share our views on this important issue. We remain committed to working with Congress to enact legislation that will ensure access to quality physician services for all Americans, regardless of where they reside. In closing we would like to highlight five recommendations made in our testimony that we believe will lead to improved access to physician services, increase the availability of U.S. trained physicians, improve the quality of training for future physicians, and improve the recruitment and retention of physicians in rural communities.

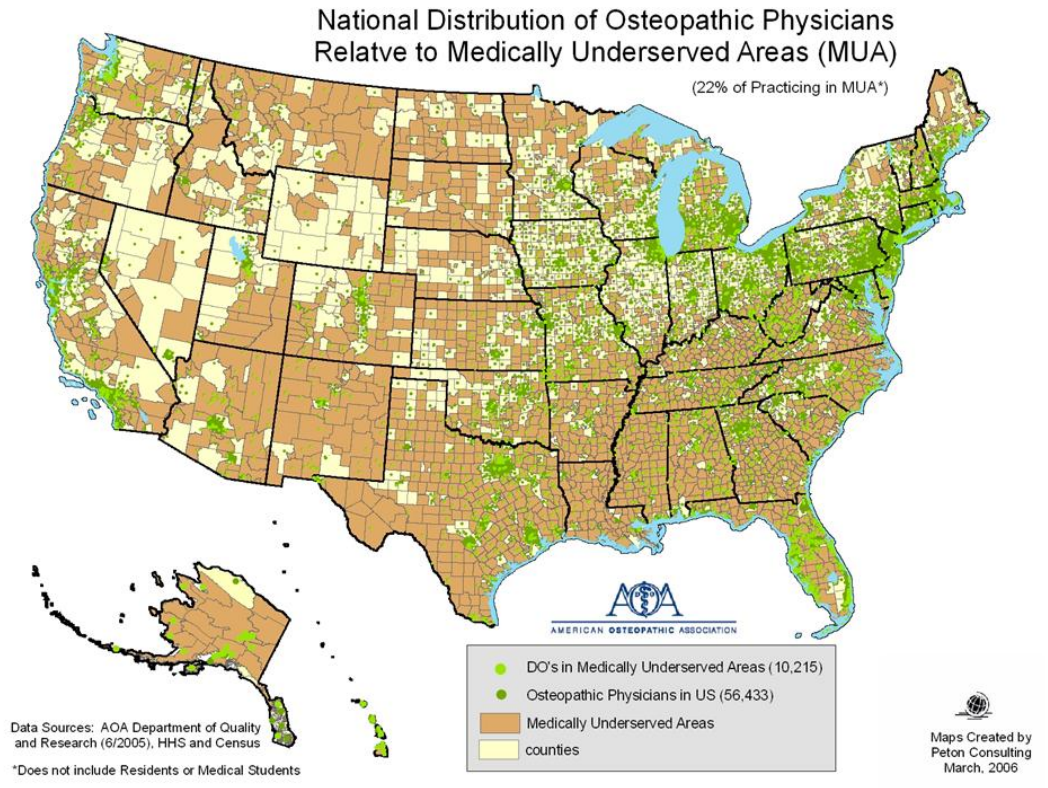
1. Congress should consider eliminating the cap on available and funded residency positions in the U.S. This cap hinders the ability of osteopathic and allopathic medical schools to educate and train larger numbers of physicians. To meet the health care needs of our growing population we must have the capacity and financing to train a larger number of physicians. The AOA supports the "Resident Physician Shortage Reduction Act of 2007" and urges the Senate to approve this legislation in 2007.

2. Congress should establish and fund a new interest free loan program to assist in the creation of new residency training programs at hospitals that have not operated teaching programs previously. By expanding opportunities to new hospitals, Congress can facilitate the training of physicians in new geographic regions that currently have limited access to physicians.

3. Congress should enact legislation that would establish, in statute, clear and concise guidance on the use of ambulatory non-hospital sites in graduate medical education programs. If enacted, it will preserve the quality education of resident physicians originally envisioned by Congress in 1997.

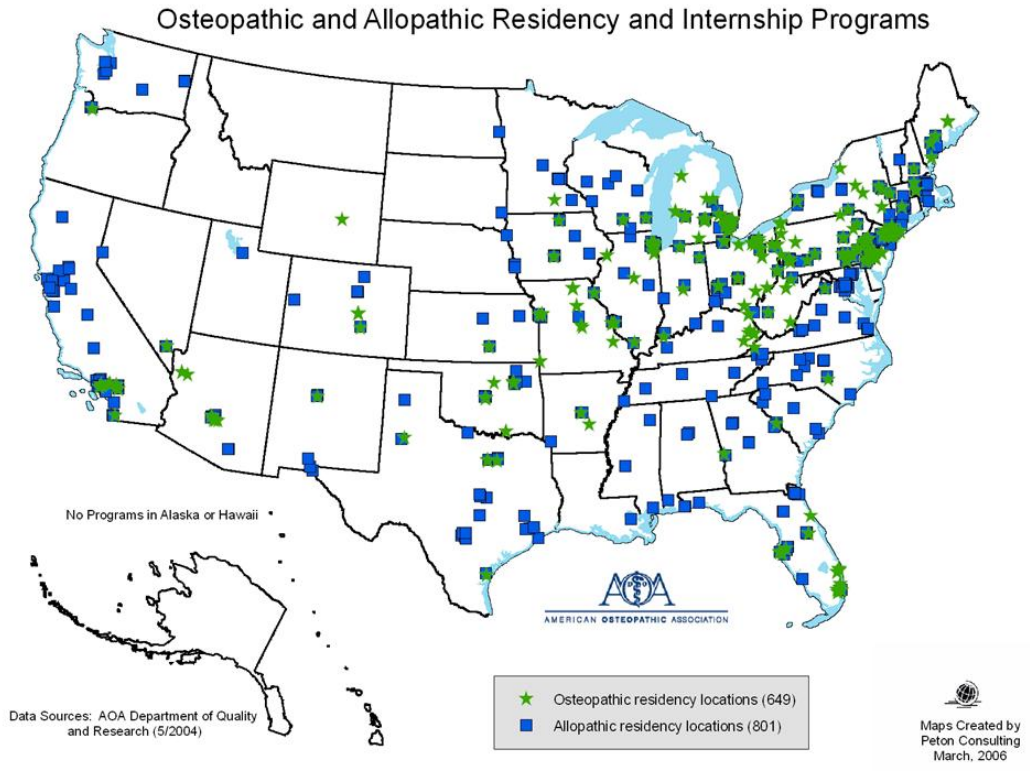
4. Congress should amend the tax code to allow physicians practicing in rural communities an annual tax credit equal to the amount of interest paid on their student loans. We believe that this proposal provides a direct incentive to young physicians and would assist in the recruitment and retention of physicians in rural communities. Additionally, Congress should revise current scholarship and loan repayment programs to allow physicians to fulfill their commitment on a part-time basis.

5. Congress should reform the Medicare physician payment formula by eliminating the sustainable growth rate and replacing it with a more equitable and predictable payment structure. Additionally, Congress should make permanent provisions that establish a floor of 1.0 for the work GPCI and provide a 5 percent add-on for services provided by physicians in recognized Medicare scarcity areas.

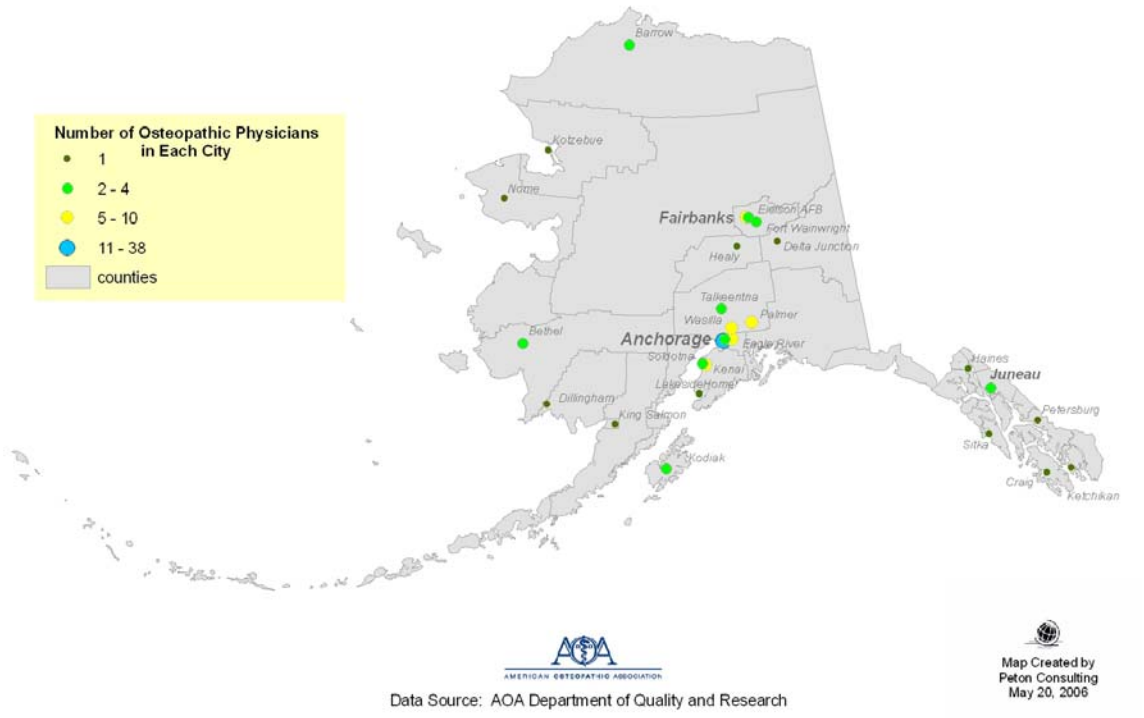


[Map 1] National Distribution of Osteopathic Physicians Relative to Medically Underserved Areas

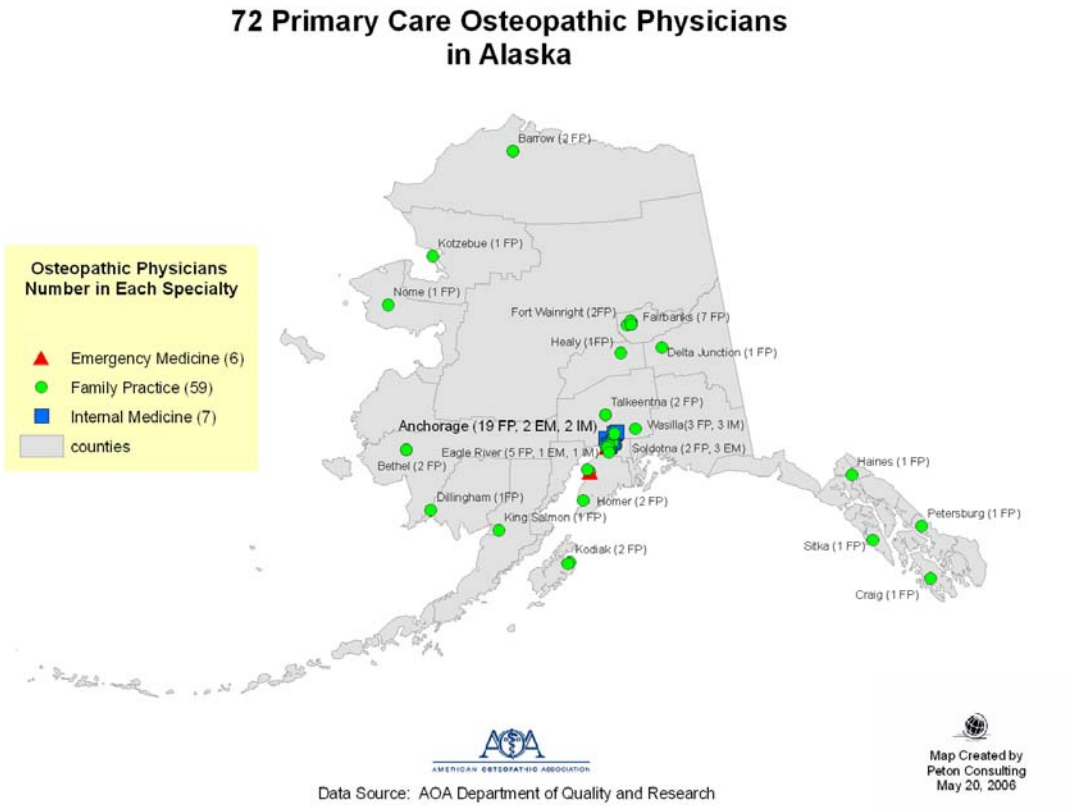
[Map 2] Colleges of Osteopathic Medicine



[Map 3] Osteopathic and Allopathic Residency and Internship Programs



[Map 4] Osteopathic Physicians in Alaska



[Map 5] Primary Care Osteopathic Physicians in Alaska