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The U.S. Presidential Election and Health Care Workforce Policy

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Abstract

The candidates for the 2008 presidential election have offered a range of proposals that could bring significant changes in health care. Although few are aimed directly at the nurse and physician workforce, nearly all of the proposals have the potential to affect the health care workforce. Furthermore, the success of the proposed initiatives is dependent on a robust nurse and physician workforce. The purpose of this article is to outline the current needs and challenges for the nurse and physician workforce and highlight how candidates' proposals intersect with the adequacy of the health care workforce. Three general themes are highlighted for their implications on the physician and nurse workforce supply, including (a) expansion of health care coverage, (b) workforce investment, and (c) cost control and quality improvement.

Keywords

nursing; health care workforce issues; regulation of nursing practice; electoral/campaign activity; coverage/access

America's workforce of nurses and physicians is the linchpin of its health care system. During the past decade, critical shortages of nurses have developed, and projections suggest that these shortages will progressively worsen (U.S. Department of Health and Human Services, 2002). Inadequacies in the supply of physicians are only a few years away, with the emergence of critical pockets of shortage during the past several years and with projected shortages approximately equal (in percentage terms) to those projected for nurses (Cooper, 2004; Cooper, Getzen, McKee, & Laud, 2002; Council on Graduate Medical Education, 2005). In both cases, shortages vary in geographic distribution and are most severe among inner-city and rural populations, but they are spreading to affect the entire population. It seems certain that these shortages will negatively affect health outcomes across the United States. They also will limit the options for making planned structural changes to the health care system.

During the 2008 presidential campaign, candidates have offered a range of proposals that would effect changes in health care. Although few would directly affect the workforce of physicians and nurses, most have implications for the health care workforce. The candidates' proposals have followed three general themes: (a) expansion of health care coverage, (b) workforce investment, and (c) cost control and quality improvement. Although most candidates have ended their campaigns since the start of party primaries in January, the proposals of all candidates remain relevant because they have informed the still-fluid discussion of health care

issues in the 2008 campaign. In addition, many of the candidates no longer running will still retain some degree of political influence as elected officials or as advisers to the next administration.

We review the candidates' proposals with a focus on the adequacy of the health care workforce. At the conclusion, we offer recommendations consistent with the positions of the Council on Physician and Nurse Supply, cochaired by authors Aiken and Cooper, which could be taken up by a presidential candidate to address the health care workforce issues highlighted in this review.

The Nurse Workforce: Current Challenges and Needs

The Bureau of Labor Statistics, U.S. Department of Labor (2007), has estimated that, during the 10 years from 2006 to 2016, 587,000 additional jobs for registered nurses (RNs) will be created, among the largest number of new jobs for any occupation. According to the U.S. Department of Health and Human Services (DHHS; 2002), the United States already lacks more than 120,000 nurses, and the average nurse vacancy rate in hospitals is 8.5%. Furthermore, DHHS predicts that by 2010, the shortage of nurses nationally will more than double, to 275,000, a shortfall of 12%, and if remedial actions are not taken, these shortages are expected to balloon to between 350,000 and 800,000 (11% to 24%) by 2020. Moreover, these projections are limited to nurses working in institutional sites (hospitals, doctors' offices, nursing homes, etc.), and the total shortages will be even greater.

A number of factors contribute to these shortages of nurses, including an aging workforce, unfavorable work environments, low relative earnings, and more-satisfying alternative job opportunities. However, the major underlying factor is a growing demand for health care, which affects not only the nurse workforce but the physician workforce as well (Cooper et al., 2002; U.S. Department of Health and Human Services, 2002). Attenuating the projected shortages of nurses will require that nurse graduations increase by at least 25% annually (Aiken, 2007). Unfortunately, schools of nursing are not currently able to meet such demands because of insufficient numbers of faculty, inadequate financial resources, and limited physical capacity (American Federation of Teachers, 2005; Berlin & Sechrist, 2002; Kuehn, 2007). However, the availability of qualified applicants does not appear to be a problem. Indeed, nearly 31,000 qualified applicants for baccalaureate degree programs alone were turned away in 2007 because of the limited opportunities in the nation's nursing schools (American Association of Colleges of Nursing, 2007).

The nursing shortage is a matter not only of total numbers but also of the level of nurses' education. The fastest growing demand for nurses involves increasingly complex decision making and an ever-widening scope of knowledge and expertise. The American Organization of Nurse Executives (AONE; 2005) has adopted a position that the educational preparation of the nurse of the future should be at the baccalaureate level. The evolving physician shortage will escalate demands for nurses in expanded clinical and decision-making roles. It is nurses with a bachelor of science degree in nursing (BSN) who constitute the pool from which are drawn all advanced-practice nurses, managers and executives, and faculty, categories that are in great demand. Indeed, as mentioned above, one of the foremost limitations on expanding RN education is an inadequate number of nurses who are qualified to serve in faculty roles. But at present, more than 65% of new nurses entering the workforce are associate degree graduates, and only small proportions go on to obtain a baccalaureate degree or higher. The size of the pool of baccalaureate nurse graduates is simply not large enough to meet multiple demands. Therefore, the emphasis in expanding nursing education must be at the baccalaureate and graduate levels.

The Physician Workforce: Current Challenges and Needs

In parallel with the nursing shortage, the nation is in the throes of deepening shortages of physicians. Patients are reporting greater difficulty in obtaining appointments with both specialists and primary care physicians. It also has become more difficult to recruit physicians, a task that now engages 8,000 recruiters, one for every three graduating residents (Cooper, 2007a). Reports of shortages have been issued by more than 20 state medical societies and hospital associations and an equal number of medical specialty organizations, often with the word “crisis” in the title, and both the American Medical Association (2007) and the American Association of Colleges of Osteopathic Medicine (2007) have called for an expansion of medical education.

Several factors have contributed to these shortages. Foremost are an aging patient population, which has higher levels of acuity and complexity, and a continued growth in medical technology. At the same time, changes in physicians’ practice patterns, associated with more women in the workforce with child and family demands and lifestyle decisions among both younger and older physicians, are decreasing the hours available for practice (Evans & Sarani, 2002). Duty hour restrictions that were recently applied to residents are reducing their work effort, a significant factor because one in seven patient care physicians is a resident (Philibert, Friedmann, Williams, & ACGME Work Group on Resident Duty Hours, 2002). Finally, small but increasing numbers of physicians are leaving practice, citing concerns about administrative burdens and medical malpractice liability (Coile, 2003).

Projections based on economic and demographic trends indicate that, if the production of physicians is not increased, shortages will exceed 200,000 physicians, 20% of the physician workforce, within the next 15 years (Cooper, 2004). Even using minimalist assumptions concerning economic growth and demand, the Council on Graduate Medical Education (2005) and the Association of American Medical Colleges (2005) have projected shortages of almost 100,000 physicians. Responding at either level will require substantial increases in both medical school education and graduate medical education.

Although the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine have both called for increasing the output of medical students, inadequate numbers of faculty, inadequate space, and inadequate opportunities for clinical education limit growth—and these problems also exist in nurse education. As a result, although increases in enrollment by 30% to 50% have been proposed, current efforts to expand medical school education are unlikely to achieve even a third of that goal (Association of American Medical Colleges, 2005; Cooper, 2004, 2007a).

Even greater challenges exist for graduate medical education (Cooper et al., 2002). Because residency education in the United States is a prerequisite for practice, for both U.S. medical graduates and international medical graduates (IMGs), the supply of physicians is directly linked to the output of residency positions approved by either the Accreditation Council on Graduate Medical Education or the American Osteopathic Association. It has been estimated that 40% more entry-level residency positions will be required during the next 15 years, raising the total number from 25,000 today to 35,000 by 2020 (Cooper, 2007a). Whether through new programs or the expansion of existing ones, this growth will require accredited residency positions with the necessary faculty supervision and quality of education at hospitals and alternative sites.

During the 35 years from 1960 to 1995, the number of entry-level residents increased by 3% to 4% per year, a growth rate that kept up with the demand for physicians (Cooper, 2007a). For most of those years, growth was fueled by increased enrollment in U.S. medical schools, and after enrollment was voluntarily frozen in 1980, IMGs contributed more to the total.

However, in 1997, fearing a physician surplus, Congress capped Medicare's funding for graduate medical education positions at their 1996 levels (Cooper, 2007a). Because Medicare is a principal source of financial support for graduate medical education, this act sharply curtailed further growth in residency education.

Health Care Coverage Reform

Left unaddressed, the projected shortages of physicians and nurses will exacerbate the already severe problems of health care access for many Americans. Therefore, as the nation approaches a presidential election, it is important to examine how the health care system reforms proposed by presidential candidates will affect the demand for physicians and nurses and how the availability of physicians and nurses will influence the success of proposed reforms.

Significant attention in the run-up to the presidential election has focused on addressing the needs of the uninsured. More than 45 million Americans are uninsured, at least for part of a year (Henry J. Kaiser Family Foundation, 2007). Most uninsured are in households headed by someone who is working (Henry J. Kaiser Family Foundation, 2007). They are much more likely to postpone needed care, utilize emergency rooms as their usual source of care, and experience preventable illnesses and hospitalizations, a pattern that is replicated among poor patients regardless of insurance source (Hadley, 2003, 2007). Current insurance mechanisms for low-income individuals, such as Medicaid and State Children's Health Insurance Programs (SCHIP), only partially fill the gap (Bovbjerg, Hadley, Pohl, & Rockmore, 2002; Hadley & Holahan, 2004).

A related issue that various candidates have proposed to address through health care insurance reform is the problem of underinsurance. A growing portion of the population is underinsured (Schoen, Doty, Collins, & Holmgren, 2005). Although having some form of health insurance or coverage, people in this group face challenges in accessing the health care system adequately to fit their health needs because of financial impediments, preexisting condition preclusions, and other barriers.

All the candidates have endorsed some mode of health care insurance reform. However, the Republican and Democratic candidates have subscribed to two differing approaches. Democratic candidates Joe Biden, Hillary Clinton, Chris Dodd, John Edwards, Mike Gravel, Dennis Kucinich, Barack Obama, and Bill Richardson have tended to support more-direct and immediate reforms that include an expansion of public programs, insurance pooling, and/or employer mandates or subsidies. Approaches proposed by the Democratic candidates have varied from a single-payer federal plan (Kucinich) to mandated coverage through an expanded employee-sponsored insurance system and large government-subsidized risk pooling options (Clinton, Edwards, Dodd, Richardson). A key component of various candidates' plans involves expanding the existing Medicaid and SCHIP programs (Clinton, Edwards, Obama). Funding for expanded coverage has generally been proposed without an increase in taxation (with the exception of Gravel and Kucinich), although a rollback of the Bush administration tax cuts, particularly for the wealthiest Americans, plays a key role in a number of the candidates' plans (Biden, Dodd, Edwards, Obama).

Market-based plans have dominated the Republican candidates' proposals, which emphasize a privatized system with increased consumer choice. Candidates Fred Thompson, Rudy Giuliani, Mitt Romney, John McCain, Mike Huckabee, and Ron Paul have supported limitations on regulation in order to increase competition and personal choice of health insurers and providers in the market. Tax policy approaches that involve increasing tax deductions, tax credits, and health savings accounts have also been advocated as means of making health insurance affordable for everyone, particularly in market-based plans (Henry J. Kaiser Family Foundation, 2008; John McCain 2008, 2007; Mike Huckabee for President, 2007; Romney for

President, Inc., 2008). Funding for the Republicans' plans has generally been proposed to come through tax cuts, cost containment measures, and increased market competition.

Regardless of the mechanism, coverage expansion has implications for the health care workforce. It has been projected that to provide health care in response to the increased demand created by universal coverage would require an additional 40,000 nurses, a number that seems an underestimate to us, and 35,000 physicians (Whelan, 2007). It is vital to recognize that, unless the physician and nurse workforce shortages are addressed, access to health care for many Americans will be compromised, and the problem of access for the uninsured and underinsured will continue regardless of the coverage reforms that are implemented—indeed, it will worsen.

Workforce Recruitment, Retention, and Investment

Nurse Workforce Investment

Several candidates, including Democrats Biden, Clinton, Edwards, and Richardson, have explicitly noted direct investment in the expansion of the nursing workforce (see Table 1). For example, Edwards proposed initiatives to retrain 50,000 nurses leaving the profession and the recruitment and education of 50,000 new nurses. Edwards planned to increase support for nursing schools and for partnerships between these schools and hospitals in order to increase enrollments in nursing schools by 30% during 5 years. This would be a positive step but would require a corresponding investment in nursing faculty. Edwards also proposed paying tuition for nursing students who agree to serve where they are needed most, such as rural hospitals and urban public hospitals. Similarly, Hillary Clinton has proposed providing \$300 million to increase enrollment in nursing schools, establish mentor programs for recent graduates, and recruit more minorities into the profession (Hillary for President, 2007b). Joe Biden put forward a plan for educating 100,000 new nurses in the workforce during the next 5 years through bolstering the Nurse Student Loan Program, funding academic institutions to establish doctoral nursing degree programs where none exist, and establishing various pilot projects to promote nursing education and faculty development (Biden for President '08, 2007). Bill Richardson has stated broadly that he will work to fix the nursing shortage by expanding education, scholarship, and loan repayment programs (Richardson for President, 2007).

Although Republican presidential candidates have supported increasing access to health care through market mechanisms, none has offered an explicit proposal for increasing the nurse workforce. John McCain has proposed using the market to encourage an expanded role for nurse practitioners (NPs; John McCain 2008, 2007).

Another mechanism for supporting and promoting nursing is through improving the environments in which nurses work. For instance, Edwards offered a plan to improve workplace conditions for nurses through federal challenge grants to support magnet hospitals with better work environments. Loss of hospital-based nurses due to the burnout, stress, and fatigue associated with an unfavorable nursing practice environment has been well documented (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). Furthermore, initiatives such as the magnet hospital program aim to recruit and retain nurses by having a favorable environment in which to practice (Havens & Aiken, 1999; McClure, Poulin, Sovie, & Wandelt, 1983). Obama has proposed a requirement for hospitals to collect and publicly report measures of health care costs and quality, including nurse staffing ratios (Obama '08, 2007). Though it would provide consumer information, the utility of a report card system in spurring staffing improvements in an environment of workforce shortages with limited federal funding is questionable.

Many of the candidates' workforce development and recruitment proposals have offered investments into areas similar to those offered by the Nurse Reinvestment Act of 2002. What remains to be seen is whether any presidential candidate's proposal, when put into action, would overcome the shortcomings of the Nurse Reinvestment Act, which include severe underfunding and inadequate attention to expanding baccalaureate education and nursing faculty development (Sochalski, 2003).

All the proposed plans to increase the number of nurses fail to meet the need in two important ways. First, their targets fall short on the number of new nurses that would be educated, falling far short of the 120,000 new graduate RNs that will be needed per year (Aiken, 2007).

Second and foremost, all the plans are silent on the matter of BSN nursing. Although they propose ways to increase the number of RNs overall, the particular need to increase nurses at the baccalaureate level has not been addressed.

Physician Workforce Investment

Among the original group of candidates, only one, Senator Biden, has directly addressed the physician workforce supply issue (see Table 1). Senator Biden was a cosponsor of the Resident Shortage Reduction Act of 2007, which would allow Medicare funding for additional residency positions in states where the ratio of graduate medical education positions to population is below the national average. Because expanding this critical choke point in the pipeline of physician supply is the key to addressing the demand for physicians, this policy would provide some relief, particularly in states with a growing population, such as Florida and Nevada, where the need for physicians is great. However, it must be noted that this legislation alone would be inadequate in meeting the projected shortfall in physicians, which is anticipated to reach more than 200,000 physicians by 2025.

Nurse Immigration

As noted above, immigrant physicians may not directly enter practice in the United States, as they may in most other developed countries. Rather, IMGs must undertake residency education in the United States, which makes the number of residency positions the "gatekeeper" of physician supply. The same is not true for nurses. Indeed, one method of meeting the demand for nurses is the recruitment of international nurses.

The mechanisms through which international nurses are able to immigrate and attain licenses to work as RNs have changed during the past 20 years. Currently, before an occupational visa can be issued, international nurses must undergo a credentials review, demonstrate English language proficiency, and pass a test of entry-level competence (Aiken, 2007; U.S. Department of State, 2007).

The number of internationally educated nurses has tripled since the early 1990s, and the United States imports more internationally educated nurses than does any other country (Aiken, 2007; Buerhaus, Staiger, & Auerbach, 2004). The debate over immigration policy has highlighted tension between the desire of some to recruit additional nurses from outside the United States and the desire of others to limit immigration.

Evidence suggests that reliance on internationally educated nurses is not likely to relieve the shortage because the size of the shortage in the United States is too great to solve through immigration for practical reasons of limited visas and ethical concerns of depleting the nursing resources of other countries (Aiken, 2007; Ross, Polsky, & Sochalski, 2005). Immigration remains a stopgap measure that has helped some hospitals, particularly in urban areas, alleviate nurse shortages. However, no presidential candidate has specifically addressed the issue of international nurses and their role in health care reform or the nursing shortage.

Physician Immigration

Physician immigration is limited because of the requirement that all physicians educated at non-U.S. or Canadian medical schools must complete a U.S. residency program. Physician immigration is further limited by the interplay of two visa programs, J1 and H1-B. J1 is an educational visa that requires visa holders to leave the United States after education. However, a waiver program allows J1 visa holders to remain and eventually qualify for a green card if they serve for 3 years in underserved areas. This has been an important source of physicians in such areas, particularly rural areas. In the past, most IMGs entered in this way. However, an alternate route is available through the H1-B program, which allows employers to sponsor skilled international workers whose jobs are difficult to fill domestically. This route is being used increasingly by teaching hospitals as a means of attracting better qualified IMGs. The H1-B program does not include the service requirement that the J-1 visa does but draws from the same pool and undercuts states' ability to fill J-1 spots to meet the needs of underserved areas. As a result, there are too few J1 visa holders to fill all of the waiver positions, which has created a crisis for many rural areas. Although all the candidates have spoken about immigration, none has addressed the complexities of how immigration policy affects the physician workforce and, in particular, the provision of service in underserved areas.

Chronic Care Management and Preventive Care

A consistent theme for most candidates is the need to reduce the rate of spending on health care. Projections put the percentage of gross domestic product spent on total health at 18.7% by 2014, up from 15.3% in 2003 (Heffler et al., 2005). A number of cost control and quality improvement mechanisms, including chronic and preventive models of care, health information technology, and malpractice reform, have been integrated into the candidates' health plans to control spending. The area of chronic care management and preventive care is reviewed here in particular for its impact on the physician and nurse workforce.

Many candidates have focused on preventive care and chronic disease management as a focus for potential cost savings. This focus is appropriate because chronic disease care accounts for more than 75% of the U.S. health care budget (Centers for Disease Control and Prevention, 2005). However, only 1% of health care spending is devoted to promoting health and preventing illness (Gerberding, 2005). Yet most policy analysts agree that, although it is beneficial for the population, prevention will not decrease health care expenditures (Cohen, Neumann, & Weinstein, 2008).

Among the changes in practices proposed to increase the focus on chronic disease management and preventive care, some candidates have emphasized the importance of the "medical home" concept. The medical home emphasizes a consistent source of coordinated and available primary care that acts as the point for integrating a patient's health care. Characteristics of the medical home include a consistent health care provider (usually a primary care provider) who coordinates a team approach to patient-centered care, enhanced access to care through expanded hours and open scheduling, an emphasis on evidence-based practice and quality outcomes, and utilization of technology to improve service delivery (American College of Physicians, 2006). This concept as applied to adults arose from concerns about fragmentation of medical care for children with special health care needs (American Academy of Pediatrics, 2004). Implementation of the medical home has resulted in improved effectiveness of care and, when implemented among a population of uninsured, in increased satisfaction and fewer emergency room visits (Gill, Fagan, Townsend, & Mainous, 2005; Starfield & Shi, 2004). Clinton, Edwards, and Obama have integrated the concept into their health reform plans (Hillary for President, 2007a; John Edwards '08, 2007; Obama '08, 2007). Obama also supported the idea when sponsoring the Minority Health Improvement and Health Disparities Elimination Act (Westenskow, 2007).

Although the medical home model has merit, the reality of workforce shortages is that there will be too few primary care providers “in the home.” Indeed, the evolving shortages are disproportionately affecting primary care providers, not only primary care physicians but also NPs and physician's assistants (PAs) who provide primary care. Thus, although the current workforce of primary care physician has been characterized as “in crisis,” the even greater shortages of specialists are drawing more young physicians away from primary care education and into the specialties (Garibaldi, Popkave, & Bylsma, 2005). With inadequate total numbers of physicians being educated, this gradient of education is likely to continue. Similarly, NPs and PAs, who traditionally have served primary care roles, are increasingly being drawn on to fill important gaps in arenas of specialty care (Cooper, 2007b). Thus, to meet the needs of the “medical home,” investment cannot be directed simply toward educating a larger primary care workforce but rather must be directed toward educating a larger physician and nursing workforce overall.

Conclusion

Addressing the workforce shortages will require political will and financial investment. The key to solving the nurse shortage is investment in nursing school faculty and education infrastructure to draw down the long waiting list of qualified applicants to BSN programs. This approach would not only educate nurses at a high level but also create the necessary cadre of nurses who could proceed to graduate education that would qualify them for advanced practice and teaching. Public financing to allow for a minimum of a 30% expansion in nursing school enrollments, with the incremental growth accomplished by fostering expansion at the BSN level, is recommended as the essential focus for the next president.

Alleviating the deepening shortage of physicians will require an expansion of both medical schools and graduate medical education. Like nursing education, graduate medical education capacity will need to be increased by at least 30%. Achieving the needed growth for graduate medical education will, at a minimum, require removing the current caps on the number of residents who can be funded through Medicare. Future changes in funding will have to be addressed within the context of a comprehensive reassessment of the appropriate financial roles of government and the private sector. There must also be an investment in more clinical training sites and more clinical preceptors in both nursing and medical education.

Demand for health care services will increase whether or not significant changes are made to America's health care delivery system. However, because of the evolving shortages of nurses and physicians, the health care system is not positioned to accommodate this demand. The 2008 presidential election, with its focus on health care reform, affords an opportunity to address this imbalance. The incoming president will face formidable challenges in health care, which will be difficult to address without an adequate workforce of physicians and nurses. To that end, the Council on Physician and Nurse Supply (2008) has called on the incoming administration to convene a White House Conference on Physician and Nursing Education.

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Biography

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Table 1**Presidential Candidates' Plans to Address Physician and Nurse Workforce Supply**

Candidate	Plans to Address Physician Workforce Supply	Plans to Address Nursing Workforce Supply
Joe Biden (Democrat)	Increase funding for graduate medical education (was cosponsor of the Resident Shortage Reduction Act of 2007, which would expand residency positions). Support initiatives to prepare physicians to practice in specialties to meet impending needs of Americans, especially geriatrics, family medicine, and emergency care.	Train and put 100,000 new nurses in the workforce in the next 5 years by increasing yearly student loan amounts, explicitly including accelerated-degree nursing students in the Nursing Student Loan Program; providing funds to establish doctoral nursing degree programs in states that lack even one such program; and establishing projects between health facilities and academic institutions to allow nurses to stay in their jobs while also attending school to earn a graduate degree and eventually teach.
Hillary Clinton (Democrat)	No direct reference to physician supply.	Provide federal funding to address nursing and nurse faculty shortages and nurse retention issues by establishing innovative training and mentoring programs.
Chris Dodd (Democrat)	No direct reference to physician supply.	No direct reference to nurse supply.
John Edwards (Democrat)	No direct reference to physician supply.	Improve work conditions to bring back 50,000 nurses who have left the profession and recruit 50,000 young people into nursing and support their education. Eliminate mandatory overtime.
Mike Gravel (Democrat)	No direct reference to physician supply.	No direct reference to nurse supply.
Rudy Giuliani (Republican)	No direct reference to physician supply.	No direct reference to nurse supply.
Mike Huckabee (Republican)	No direct reference to physician supply.	No direct reference to nurse supply.
Dennis Kucinich (Democrat)	No direct reference to physician supply.	No direct reference to nurse supply.
John McCain (Republican)	No direct reference to physician supply.	Support innovative delivery systems and greater market flexibility in permitting appropriate roles for nurses and nurse practitioners.
Barack Obama (Democrat)	No direct reference to physician supply.	Require hospitals to collect and publicly report nurse staffing ratios.
Ron Paul (Republican)	No direct reference to physician supply.	No direct reference to nurse supply.
Bill Richardson (Democrat)	Rebalance the supply of physicians to encourage practice in primary care and underserved rural areas by expanding training, scholarship, and loan repayment programs.	Work to fix the nursing shortages by expanding training, scholarship, and loan repayment programs.
Mitt Romney (Republican)	No direct reference to physician supply.	No direct reference to nurse supply.
Fred Thompson (Republican)	No direct reference to physician supply.	No direct reference to nurse supply.