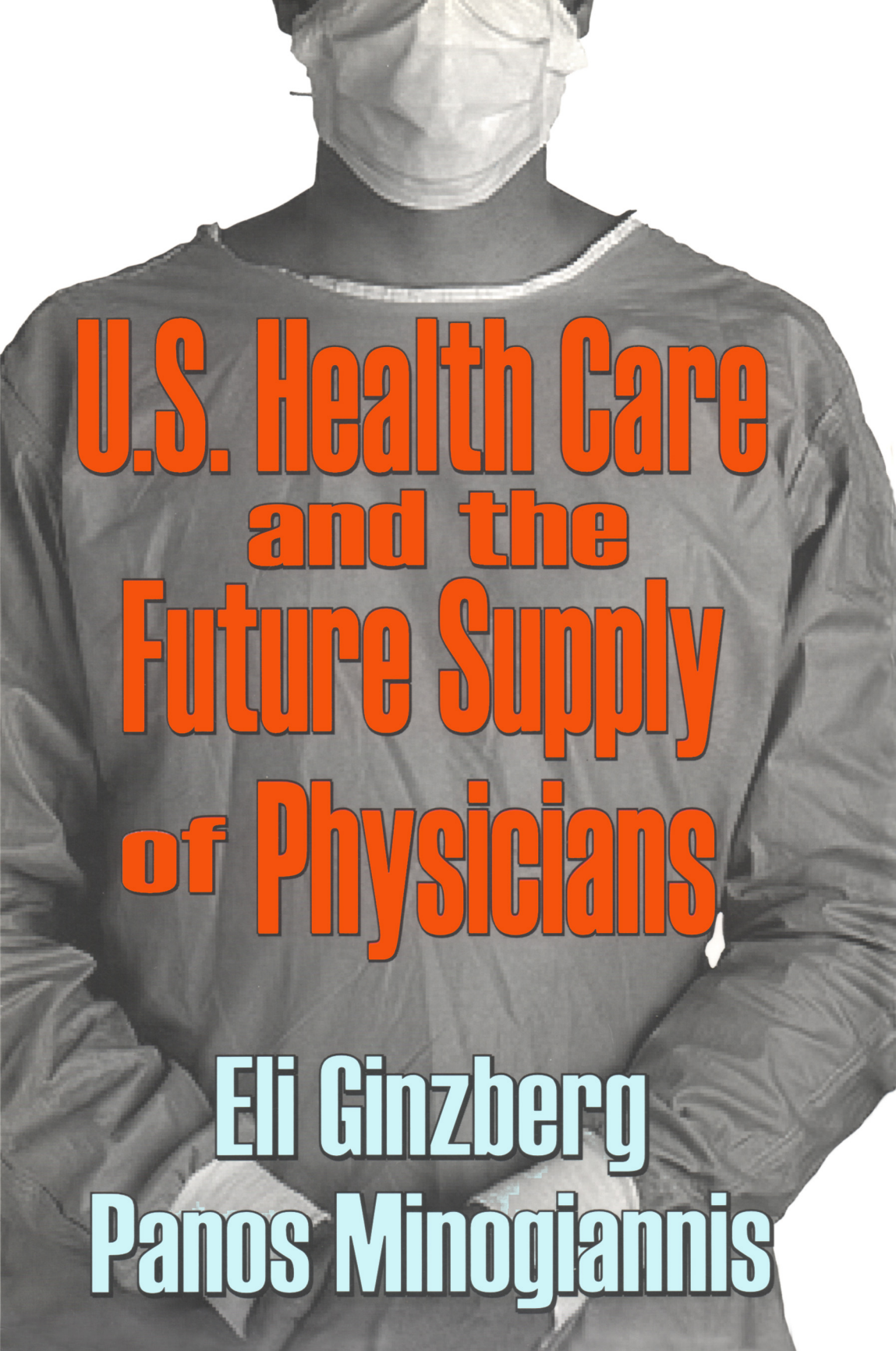

U.S. Health Care and the Future Supply of Physicians

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Introduction: The Problem and Its Setting

This introduction will provide the reader with some critical insights into how this book came to be written; its sponsoring foundation; and the nature of the collaboration between the senior and the junior author. It will also elaborate on some defining characteristics such as the doubling of the U.S. population of the elderly by 2030 and the likely consequences of this development on the care and treatment of the much enlarged number of the chronically ill elderly whose numbers are expected to double from around 35 million to over 70 million.

A few markers of events starting in 1980: National Health Expenditures (NHE) for that year had risen to around $245 billion, up from $41 billion in 1965 when Medicare and Medicaid were first enacted. Ronald Reagan was elected president in November 1980 by a comfortable margin, but the country was entering a serious recession. After several decades of increases in the number of patients admitted to acute-care hospitals, the early 1980s saw a marked decline (about 20 percent), which was not recaptured in the following years except for the steep acceleration in the number of patients admitted and treated and discharged on the same day from the hospital.

With employers facing double-digit annual premium increases for their employee health insurance policies, the steep decline in inpatient hospital admissions in the early 1980s provided them an opportunity in selected market areas, such as Southern California, the Twin Cities, and a few other locations with large established managed-care arrangements to seek lower health insurance renewal rates in exchange for a higher number of enrollees. By the mid-to-late 1980s a considerable amount of new financing had become available to encourage the rapid growth of managed-care companies to a point where, by the early 1990s, the earlier long-term trend to double-digit increases in health insurance premiums had finally been ar-

rested with most workers having been shifted out of fee-for-service coverage into an HMO or PPO arrangement.

But the end of the 1990s saw a rising discontent from both insured patients and their physicians. Many patients resented having to revisit their gatekeeper generalist physician before returning to their specialist who was overseeing one or more of their chronic illnesses and treatments; and more and more physicians resented having their decisions overridden by managed-care officials. By the late 1990s, many enrollees with the support of their physicians and with further support from their employers secured health insurance coverage that provided more freedom of choice to the enrolled even though it was slightly more costly. Managed-care plans suffered considerable drops in enrollments.[1]

In early 2000, the Eisenhower Center of Columbia University was informed by June Osborne, the recently appointed new president of the Josiah Macy Jr. Foundation, that the foundation trustees with whom the Eisenhower Center at Columbia University had had relations since the early 1970s, had granted our request for a year's support to prepare a volume on U.S. Health Care and the Future Supply of Physicians. My junior colleague, Panos Minogiannis, who completed his doctorate at Columbia's Mailman School of Public Health with special distinction before returning to his country, Greece, to complete his period of military service. His dissertation, entitled *European Integration and Health Policy: The Artful Dance of Economics and History,* was published by Transaction Publishers, New Brunswick, New Jersey, in 2003.[2]

The remainder of this introduction will deal first with the critical health policy issues that confronted the United States in the last decade of the twentieth century, and, secondly, will call attention to the challenges that the United States will confront by 2030 when the nation's elderly, those above 65 years of age, will have doubled from 35 to 70 million, with the predominate number living at home, many of whom will be suffering from one or more chronic illnesses.

At the beginning of the 1990s, the American Association of Medical Colleges launched a program, "3000 by 2000," which aimed to enlarge the number of students of African American background who were admitted to the nation's allopathic medical schools. Regrettably, after a good start, the program fell far short of its goals.

On the other hand, the underrepresentation of women in U.S. medicine, who as late as the latter 1960s accounted for no more than

8 percent of the nation's total number of physicians in training, had been almost totally eliminated with women accounting for almost 48 percent of the entrance class in 2002, a six-fold gain. Challenges remain with respect to an enlarged role for women physicians in leadership positions in academic medical centers, and the odds favor a slow but continuing correction.

For the better part of the two last decades, if not longer, the United States has confronted conflicting views about the appropriate proportions of generalists to specialists in training. At the peak of the managed-care expansion in the 1990s, the proportion of generalists in training increased but more recently the ratio has declined, and with more than 80 percent of the U.S. population urban based, the dominance of specialists is likely to continue.

The leadership of U.S. medicine—the AAMC, the AMA, the leaders of Osteopathic Medicine—have collectively advised Congress to cut back the number of foreign-born International Medical Graduates (IMGs) admitted under special immigration regulations to pursue residency training in the United States to no more than 10 percent of the number of U.S. graduates. However, to date Congress has not seen fit to follow this advice because of its awareness of the fact that IMGs treat disproportionate numbers of the under-served urban and rural low-income population that U.S. graduates tend to avoid.

In 1995, a PEW Commission on health personnel under the chairmanship of former Governor Lamm of Colorado recommended the closure of twenty U.S. medical schools by 2005, a recommendation that has been disregarded by all groups concerned with the future of U.S. health personnel.

As of the beginning of the twenty-first century, we have clear evidence that physicians are not playing more than a marginal role in looking after the chronic elderly patients living at home and there is little reason to anticipate any marked changes in the decades ahead in their practice mode. The bulk of the care that these patients require and receive comes from non-physician clinicians, primarily RNs, nurse practitioners, physician assistants, and selected non-physician therapists. Odds are that these groups will continue to provide most of the home-care services required by the chronically ill. Several challenges remain: the desirability of increasing the opportunities for physicians in training to share some training experiences with non-physician clinicians; the possibility that the United States will imitate the recently adopted innovation introduced by the Ger-

man government to provide financial support for families that commit themselves to care for one or more homebound elderly; with the experiment expanded to include neighborhood daycare clinics for the care of many of the homebound.

The United States needs to take advantage of the larger part of the decade that remains to experiment with improved care for the about-to-double homebound chronically ill.

Notes

1. These are the parameters that set the working environment for the nation's physicians. Admittedly, it is one of volatility and when one realizes that 14 percent of GDP is spent on health care, one has to wonder where that money goes and perhaps, more importantly, whether there are changes that can be introduced into the system in order to control the rise of expenditures. An area, perhaps the most important in which one could potentially intervene is in the supply of health care personnel. This has been one the long-term interests of the staff at the Eisenhower Center for the Conservation of Human Resources. Therefore, it is only fitting that the final project of the Center should focus on this subject.
2. Prior to that, we collaborated fruitfully on a number of projects over a period of four years.

1

Why Focus on Physician Supply?

The simplest answer to the rhetorical question that provides the title to this opening chapter emphasizes that the availability of physicians is the key determinant of whether all of the nearby inhabitants in an area will be able to access a physician if and when they need to do so. A further point: since most physicians still continue to practice in the United States as independent practitioners, the decisions that they make about the diagnosis and treatments that their patients should receive affects both their own earnings as well as playing a key role in determining the expenditures of the health care sector. And thirdly, the manner in which physicians practice, solo or as members of a smaller or larger group of colleagues; office or hospital-based; in close association or not with a group of non-physician clinicians and medical technicians will determine to a marked degree the efficiency and effectiveness of the health care services that they provide to the patients who come to them for advice and treatment. In short, while many different sectors of our modern society, from government to health insurance companies, managed care organizations, academic health centers, the pharmaceutical industry and still other groups, exercise varying degrees of influence on how the nation's health care system operates with particular reference as to the availability of medical access for the population, to costs, and to the quality of the care provided, the physician remains the key to the efficiency and effectiveness of the health care services that the public receives. It is the licensed physician alone who is authorized by law to provide a wide range of treatments that, if mishandled, can result in injury or even to the premature death of the patient rather than to his or her recovery and future well-being.

Put differently, physician supply has historically been the approach to address larger questions that face U.S. health care policymakers.

These questions include: How can we provide equitable access? How can we provide quality care? How can we accomplish these ends within a reasonable cost? The centrality of the physician supply in the U.S. health care system is the connecting link to these broader questions. How many doctors we have, what kind, what ethnicity/gender, from what schools, where they practice, how they practice—all these questions and many more are important because of their potential to affect the system's financing, access to it, and the delivery modes. This is why focusing on physician supply is important and this is why it should be studied within this broad context.

Looking back to the U.S. policy experience, there are three kinds of policies that have affected physician supply: (1) policies that directly targeted physician supply, (2) broader health care reforms, (3) other societal reforms. Furthermore, they have been initiated by both government and private sector as well as by the profession itself. A brief review of selective policy initiatives can be rewarding. It is by no means exhaustive, but nevertheless indicates that (1) there are many actors involved in this arena, and (2) their actions interact with one another, often in ways that would have been difficult to predict beforehand.

Policies That Target the Physician Supply

In the early-to-mid-1960s, more specifically between 1963 and 1965, the federal government took the lead to double the output of U.S. medical schools on the assumption that the 140 physicians per 100,000 population, the national ratio as of 1960, was grossly insufficient to meet the future needs of the American people, more specifically because of their increasing affluence and the steady advances that were being made by "high-tech" medicine with respect to diagnosis, treatment, and rehabilitation. After thirteen years of liberal federal funding, further increased by state and private sector funding, Congress declared in 1976 that the prior existing physician shortage had been eliminated. At that point, Congress appointed a Graduate Medical Education National Advisory Committee (GMENAC) to assess and report on future trends in the supply and specializations of U.S. physicians. In 1980 and 1981, after detailed studies to meet the Congressional charge, GMENAC reported that the United States would face in 1990 an excess of almost 70,000 physicians and by century's end an excess of 145,000—or of the order of 20 percent, too many physicians in the year 2000. Because