

AN IMPERFECT FORECAST:

Is today's waiting-room inconvenience tomorrow's physician shortage? // Is the current crop of med students too sparse to cope with an aging population? // Or does the entire system need to change?

Are We Running Out of Doctors?

■ BY LINDA KESLAR

When Rosemarie Peelle learned it would be eight weeks before she could see her neurologist about her nagging neck pain, she knew what to do. Peelle asked her husband, Kenneth, president of the Massachusetts Medical Society, to pull a few strings. He called the doctor, who agreed to see Peelle the next day.

That's how it's sometimes done. But for patients lacking connections, it has become increasingly difficult to schedule an office visit or even to find a doctor. A survey by Merritt, Hawkins & Associates, a physician search firm, found that new patients in 15 cities waited an average of more than three weeks for a gynecological checkup. According to a 2006 study in the *Journal of the American Academy of Dermatology*, the mean wait time for new patients to get a changing mole checked in Boston was 73.4 days. It even has reached the point at which having an in may not get you in. "Even for physicians and trustees, it's increasingly difficult to get primary care appointments for family and friends," says internist Brit Nicholson, chief medical officer of the Massachusetts General Hospital (MGH) in Boston.

Many experts worry that such reports, though anecdotal, foretell an impending crisis, a national shortage of physicians that will worsen just when an aging population most needs ready access to medical care. At least one estimate predicts the

physician shortfall could reach 200,000 by 2020, almost a quarter of the 850,000 doctors now practicing in the United States.

Of particular concern are the 30 million people who live in areas designated by the federal government as medically underserved. In Alaska, which has a third fewer physicians than it currently needs, demand will nearly double during the next two decades, according to one study. "It takes about four months for a new patient to see me," says internist Ross Tanner, president of the Alaska State Medical Association, who runs one of only four diabetes clinics in the state.

This wasn't supposed to happen. A generation ago, the worry was that there would be too many doctors, not too few, and schools began limiting enrollment to reduce the glut. Yet now there are fewer physicians each year relative to the rising population, and a disproportionate number of doctors are nearing retirement, to be replaced by young physicians, who seem disinclined to work the slavish hours put in by old-timers.

To counter projected shortages, there's a proposal to graduate a third more doctors in the coming decade, and a push to increase residency training slots. But these plans raise a host of issues. Upping medical school enrollment will take a while, and there's no guarantee the additional physicians won't gravitate to high-paying specialties and geographic regions that have plenty of doctors. Already, the lure of lucrative specialties





has cut the number of graduates choosing family medicine by 50% since 1997. “We can create all the jobs we want, but the incentives aren’t there for young doctors to take them,” says Rick Kellerman, president of the American Academy of Family Physicians. Moreover, adding training slots in any specialty raises the question of where the money will come from at a time when Congress is bent on cutting the budget for Medicare, which funds most residency training.

That points to another problem. Health care costs are projected to increase from today’s 16% of the gross domestic product to 20% by 2015, and to keep growing much faster than the overall economy. Even if administrators and policymakers had the will and the way to increase the doctor supply, they may be feeding a system that ultimately can’t be sustained. “Any debate over the size of the physician workforce is a distraction from the major work we need to do to address more important issues of quality and efficiency,” says David Goodman, a pediatrician and professor at Dartmouth Medical School.

Yet even as experts wrangle about the shape tomorrow’s health care system should take, growing wealth and medical advances continue to fuel demand for services—and, by extension, for more physicians, particularly specialists. Regardless of whether that’s desirable, it’s happening, and that gives rise to a more basic question: Can academic discussions and bureaucratic tinkering really change what’s happening on the ground?

Until the early years of the twentieth century, there were plenty of physicians to go around. Many earned their stripes as apprentices, just as a plumber or butcher might train, while others studied at for-profit medical colleges owned by doctors. Still others got their degrees from a relative handful of university medical schools modeled on European institutions. Then, as the twentieth century dawned, scientific advances led to calls for a more standardized, rigorous medical education, and in 1908 the recently formed Council on Medical Education asked educator Abraham Flexner of the Carnegie Foundation for the Advancement of Teaching to evaluate the American way of training doctors. During the following 18 months, Flexner visited every one of North America’s 155 medical schools, and in 1910 he delivered his report, a landmark study that decried the poor quality and broad variation characterizing much of the continent’s medical training. In the wake of the Flexner Report, dozens of medical schools, mostly diploma mills that required no university training, were forced to shut down.

Fewer medical schools meant fewer doctors, and in the years that followed the national ratio of physicians to population declined to about 125 per 100,000 people, compared with almost 240 per 100,000 today. But with supply constrained, demand soared, and so did doctors’ incomes. Then, in the late 1950s, policy experts projected a shortfall of nearly 40,000



physicians by 1975. Congress increased funding for medical schools and helped finance the establishment of new ones, and the number of graduates gradually rose to today's level of nearly 16,000 annually.

This push to increase the supply of physicians was such a success that, before long, experts began to wonder whether it had worked too well. In 1980 the Graduate Medical Education National Advisory Committee (GMENAC), a group of health care policy analysts, academics and physicians, produced a study predicting that the United States would have 145,000 more physicians than it needed by the turn of the twenty-first century. Subsequent studies predicted an even greater excess. In 1997, in response to this information, Congress limited the number of residencies Medicare would fund to about 80,000 each year. Although another 20,000 residencies are financed by the Veterans Administration and Medicaid, and teaching hospitals pay for a small number without government assistance, the Medicare spending freeze effectively capped the physician workforce.

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The year 2000 came and went, and a physician surplus never materialized. “Physicians were still working as doctors, not driving cabs,” says internist David Blumenthal, director of the Institute of Health Policy at the MGH and a professor at Harvard Medical School. “Everyone started wondering what was wrong with the models.”

One thing that was wrong was that the GMENAC analysts had failed to anticipate changes in medical practice that would affect which specialties doctors chose and how many physicians the system could keep gainfully employed. Two lucrative branches, cosmetic surgery and sports medicine, began attracting large numbers of physicians. An explosion in new imaging technologies has meant many more jobs for radiologists. But the popularity of particular specialties can turn on a dime, confounding predictions of surplus or shortage. Twenty years ago, residencies in cardiac surgery were among the most coveted, but with reduced compensation and a migration toward less-invasive heart procedures done by cardiologists, these days there are more slots available than there are applicants.

Richard Cooper, professor of medicine and senior fellow at the Leonard David Institute of Health Economics at the University of Pennsylvania, had always been skeptical of studies projecting a physician surplus. “They reflected a political objective—that to contain health spending you had to constrain the supply of health care,” Cooper says. “But physicians don’t drive medical costs; demand does.”

On the demand side of the equation, wealth plays a role, according to Cooper’s research. As per capita income increases, so does a country’s use of health care services—and at a faster rate than the growth in affluence, Cooper says. During the past 70 years, the demand for medical services in the United States has grown half again as fast as the gross domestic product, a trend Cooper expects to continue.

“Baby boomers and their offspring will tap health care services more than prior generations have because they’ve grown up in an era of unprecedented wealth and medical advances,” he says. Based on these and other assumptions, Cooper calculates the physician shortage could rise to 200,000 by 2020. “We’ve lost 10 to 15 years of training physicians because of surplus projections, and now we’re in a real predicament,” he says. “The medical profession has been seriously damaged.”

A somewhat less dire projection comes from the Council on Graduate Medical Education, which anticipates a shortfall of

some 85,000 physicians by 2020. Yet others question whether there is a physician deficiency at all, or whether somehow coming up with tens of thousands of new physicians would even be desirable. Dartmouth's Goodman contends that anecdotal reports of shortages merely reflect a combination of inefficient health care systems and recruiting problems in some geographic areas and specialties. There's evidence to support that view: A 2006 survey by the U.S. Government Accountability Office indicates that, from 2000 through 2004,

no more than 7% of Medicare patients nationwide reported problems finding a doctor.

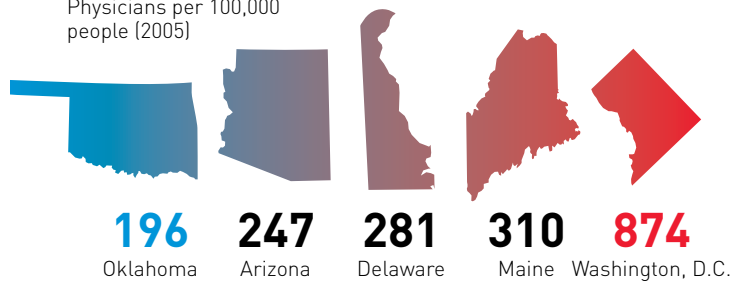
"It's what physicians do that's important, not how many there are," says Goodman. Some health care systems are much more efficient than others and require many fewer physicians to serve their population. Moreover, having a larger supply of doctors isn't necessarily beneficial, says Goodman, whose research suggests that regions and states with very high supplies of specialists have a lower quality of care and no difference in survival rates.

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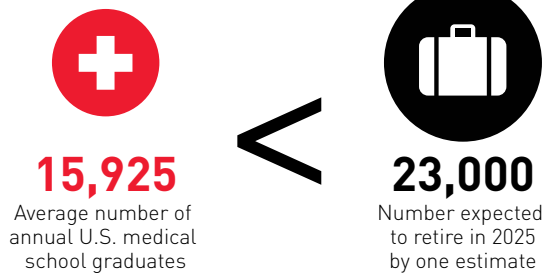
Prescription for a Crisis //

ALTHOUGH SOME AREAS HAVE PLENTY OF DOCTORS, GEOGRAPHIC DISTRIBUTION IS FAR FROM EVEN.

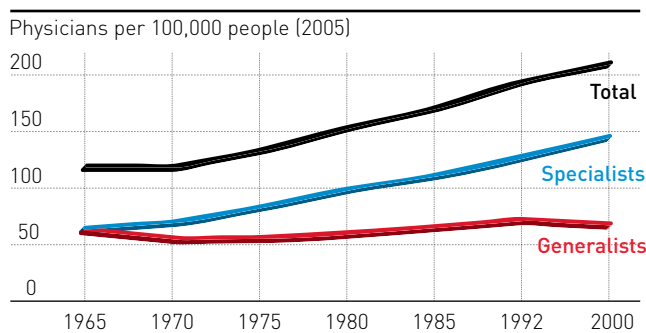
Physicians per 100,000 people (2005)



WHEN RETIRING PHYSICIANS OUTNUMBER NEW ONES, THE OVERALL SHORTAGE COULD WORSEN.



THE FADING POPULARITY OF PRIMARY CARE IS ALREADY CAUSING BIG PROBLEMS.



SOURCES: AMERICAN MEDICAL ASSOCIATION; ASSOCIATION OF AMERICAN MEDICAL COLLEGES; COUNCIL ON GRADUATE MEDICAL EDUCATION

Finding a way to get the right number of physicians, in an appropriate mix across specialties and geographic regions, is an extraordinarily tall order. To the extent that there may be a coming shortage of doctors, the most straightforward solution would be to mint more. The Association of American Medical Colleges has called for a 30% increase in U.S. medical school enrollment by 2015, a change that could add 5,000 physicians annually, and new medical schools are being planned in about two dozen states, according to Cooper. "Still, creating a school is a huge financial undertaking, and some of these schools may never materialize," Cooper says.

Then there's the question of where new doctors would train. Many policy experts want the federal government to lift the 1997 cap on the number of residencies it pays for through Medicare. A U.S. Senate bill, introduced in February, would expand residency programs in 24 states facing critical physician shortages, increasing national training slots by 1,222. There's also a House of Representatives version, but neither bill seems likely to advance quickly.

Further complicating matters is the role of foreign medical school graduates, who today fill one in four residency slots. Some experts argue that the United States should stop importing such a big percentage of its doctors. "Our continual reliance on the rest of the world for a major portion of our physicians creates a drain on the global workforce, especially for the poorest countries," says Fitzhugh Mullen, a professor of pediatrics and health policy at George Washington University in Washington, D.C. If medical school enrollments increase, even without lifting the federal spending cap on residencies, Mullen wants U.S. graduates to fill most of the existing training slots. But others, including the MGH's Blumenthal, question whether it would be possible to increase the overall number of physicians practicing in the United States while also reducing the number of foreign medical school graduates.

Boosting physician supply is also complicated by the impending departure of a large segment of the current pool. A third of physicians practicing in the United States are older than 55 and likely to retire during the next 20 years. Their

exodus could have a profound impact on the availability of medical services, particularly because the new generation of doctors tends to look at its role differently. “Generation Xers are more in tune with their families and personal lives than I was, and they value their time off,” says David Nichols, 59, who notes that his younger colleagues at Whitestone Family Practice, near Virginia’s Chesapeake Bay, log much shorter workweeks than he did at their age. “I don’t fault them for it, but you just don’t get the same work ethic these days.”

What’s more, many new doctors are women, who made up just 10% of practicing physicians in 1980 but make up half of today’s medical students. That is also affecting the workforce, because young female physicians, even more than their male colleagues, seem determined to balance careers with family life. Jane Gudakunst, a family practitioner, ultimately gave up clinical practice in favor of a part-time position in hospital education in Clarion, Pa. Gudakunst knows firsthand the hours older physicians worked, having watched her father toiling for years in his own small-town practice. “It would take two or three physicians today to keep pace with what my father did,” she says. “That’s not what I want for my life.”

Yet despite such attitudes, or perhaps because of them, Gudakunst and other young physicians are a prized commodity. With a recent survey by the American Hospital Association finding significant workforce shortages at nine of 10 hospitals, most hospitals and medical practices across the country are actively recruiting physicians, and often it’s an uphill battle. Not long ago, according to the MGH’s Nicholson, the hospital had 10 qualified applicants for every open primary care position. During the past two years, however, there were only 30 qualified applicants to fill 20 slots. For the first time the hospital has hired a physician recruiter, and it is considering sweetening incentive packages, Nicholson says.

Most estimates of future medical personnel needs assume that spending on health care will continue to grow much faster than the overall economy. But Dartmouth’s Goodman, among many others, doesn’t think the country can afford an endless expansion of health care spending. Rather than race to produce additional doctors who will order still more services for their patients, he wants to reform what he believes is a dysfunctional system. “Almost everyone working on the problems of health care considers the system unsustainable in terms of quality and costs,” Goodman says. “Rather than spend more resources on training more physicians, we should be building more efficient delivery systems.”

Instead, medicine could move toward using caregivers who aren’t physicians, particularly in primary care. The MGH’s John D. Stoeckle Center for Primary Care Innovation, for example,

is exploring the concept of team medicine, in which each patient will be assigned a corps of nurse practitioners and doctors, allowing doctors to spend more time with patients who need extensive or specialized attention. The increased use of electronic health records could also help ease the doctor crunch, says Stoeckle Center executive director Susan Edgman-Levitan, by reducing the time team members spend tracking down files and specialists’ notes. “There has been a lot of discussion about the need to pay primary care physicians more and change the reimbursement model, but a lot less has been said about how to redesign the actual delivery of care in a way that remains safe but is also more efficient,” she says.

Yet even with changes in how care is provided, solving the physician supply issue is likely to remain an elusive goal. Determining how many doctors are actually needed, and where, is an inexact science at best, and medical advances, if their effect is to keep people alive even longer, could mean demand for medical services will increase at an even faster rate in coming decades. But federal policymakers, who control the purse strings, seem disinclined or unable to fund a perpetual expansion of the system. Still, to sit tight and let medical economics take its course risks putting more pressure on an already overtaxed health care system. ■

→ DOSSIER

1. “New Steam From an Old Cauldron—The Physician-Supply Debate,” by David Blumenthal, *The New England Journal of Medicine*, April 22, 2004. A comprehensive analysis of the revived debate about the physician workforce, analyzing methodology, ideological and social underpinnings, and how policymakers may approach solutions.
2. “End-of-Life Care at Academic Medical Centers: Implications for Future Workforce Requirements,” by David Goodman et al., *Health Affairs*, March/April 2006. Groundbreaking study that challenges those who argue that the physician workforce needs expanding and that contends states with the most medical specialists and general internists have lower quality of care than those with fewer.
3. *Will the Last Physician in America Please Turn Off the Lights?: A Look at America’s Looming Doctor Shortage*, by James Merritt et al. (MHA Group, 2004). Data, surveys and analysis provided by a leading physician-recruiting firm that support the growing doctor shortage based on such workforce measures as appointment waiting times, practice profiles and recruiting-package incentives.