

Public Policy: Shaping Physician Workforce Trends

An impending shortage of specialists must be addressed as the prevalence of age-related diseases increases.

BY ROBERT A. COPELAND JR., MD

After nearly 3 decades of growth, the physician-to-population ratio in the United States is leveling off, and a decline in the physician workforce is projected.¹ It is expected that there will be a shortage of approximately 90 000 physicians by the end of the decade and a shortage of 136 000 to 159 000 physicians by the year 2025.² These trends undoubtedly prompt the question, "What is the driver of this deficit of physicians?" This article discusses the key factors in public policy that will continue to influence the supply and demand of physician services.

AGING POPULATION YIELDS INCREASED DEMAND

The aging population in the United States is growing. The US Census Bureau has estimated that between 2006 and 2025 there will be an increase of anywhere from 50 million to 350 million individuals in the United States. As the population grows, we know that approximately 39% of individuals will be 65 years or older by 2020. By 2030, 79% of the population will be 65 years or older. Approximately 10 000 individuals per day will turn 65 years or older for the next 19 years.

These numbers clearly indicate that the aging population will be growing, and an increase in the prevalence of age-related diseases will be coupled with it. Because of that, there will be an increased demand for physician services, especially for specialty services. However, the specialty services will be in dire need because they have not grown at the same level as primary care doctors. To understand why this has happened, it is crucial to look at how public policy has influenced physician workforce trends in the United States.

THE EFFECTS OF PUBLIC POLICY

In 1910, the Flexner Report on medical education was published. This report maintained that there was a sur-

plus of medical schools in America and that too many doctors were being trained, leading to the reform of medical education, subsequently affecting the per capita supply of physicians.² Much legislation has been enacted since the Flexner report, and the trends have not always been consistent; however, there are 3 particular public policies that have played significant roles in the current problem facing specialists.

GMENAC

In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) conducted a study to evaluate the US physician supply in response to concerns that efforts to increase the number of trained physicians during the 1960s and 1970s would create a physician surplus. The committee concluded that by 1990 there would be a surplus of 70 000 physicians, and, by 2000, of 145 000 physicians. In response to this report, the federal government reduced general funding for medical schools.

COGME

The Council on Graduate Medical Education (COGME), formed in the 1980s, was created with the mandate to provide advice and recommendations to the US Congress on the supply and demand of physicians. In 1994, COGME released a report projecting that there would be a deficit of 35 000 primary care physicians and a surplus of approximately 115 000 specialists. Coupled with the GMENAC study, the COGME findings influenced a trend in medical school training in which primary care was emphasized and training in specialties was de-emphasized.

Balanced Budget Act

The third piece of legislation affecting physician workforce trends was the Balanced Budget Act of 1997, which was designed to balance the federal budget by 2002. This act capped Centers for Medicare & Medicaid Services'

funding for general medical education at 100 000 residency slots.

LEVELING THE PLAYING FIELD

The GMENAC, COGME, and Balanced Budget Act of 1997 have all contributed to a decrease in specialty training. Currently, there are approximately 16 000 active ophthalmologists in the United States; for the US population, this equates to about 5.5 ophthalmologists per 100 000 individuals.

In a 2007 study³ conducted by Paul P. Lee, MD, JD; H. Dunbar Hoskins, MD; and David W. Parke, MD, it was found that a decision to increase the number of ophthalmology training positions by 20% would take more than 2 decades to effect a 10% change in the number of practicing ophthalmologists. So, even if there was an increase in training, there would still be a shortage of ophthalmologists, leading to the current issue: How are we going to have specialty training, and how are we going to level the playing field?

A report² compiled in 2008 by the Association of American Medical Colleges (AAMC) states the answer to this query quite clearly: The workforce will have to change. In its report, the AAMC makes a total of 12 recommendations, 2 of which are germane to ophthalmologists. The first is that we need to increase graduate medical education by 30%. In addition, there must be a 30% increase in postgraduate training to accompany those increases in medical school training. Also, we would like to see a rescinded 10% cut over 10 years by the current administration to the training of graduate medical education.

CONCLUSION

In short, it is a dire need that we increase the number of medical specialists in the United States. Going forward, it is necessary that the emphasis on training specialists get equal footing with the training of individuals who choose to go into primary care. ■

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2. Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections Through 2025. 2008. Available at <https://www.aamc.org>. Accessed June 19, 2013.

3. Lee PP, Hoskins HD, Parke DW. Access to eyecare: eye care provider workforce considerations in 2020. *Arch Ophthalmol*. 2007;125(3):406-410.