THE IMPERARTIVE TO INCREASE PHYSICIAN SUPPLY

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OVER-ARCHING CONCEPTS and UNDERLYING TRENDS

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Powerful long-term trends indicate that the US will confront shortages of physicians in relation to the potentials for medical care, the desires of the public and the capacity of the economy.

Cooper, Federal Forecasters Conference, 2000

EARLY SIGNS OF PHYSICIAN SHORTAGES

Longer waiting times for patients
Longer referral times for physicians

Difficulty recruiting physicians; increased salaries and bonuses for new physicians

Practicing physicians report of overload and burn-out

Reports of shortages by state medical societies, hospital associations and specialty organizations

25 medical schools under development in 14 states

Policy changes from “surplus” to “shortage” by the AAMC, AMA, AAHC, AOA, AACOM, COGME

Initial attempts at Federal legislation to correct shortages

UNITS OF ANALYSIS

Communal behavior

1 Nation
50 States

306 Hospital Referral Regions (HRRs)
923 Metropolitan Statistical Areas (MSAs)
3,141 Counties

Individual behavior

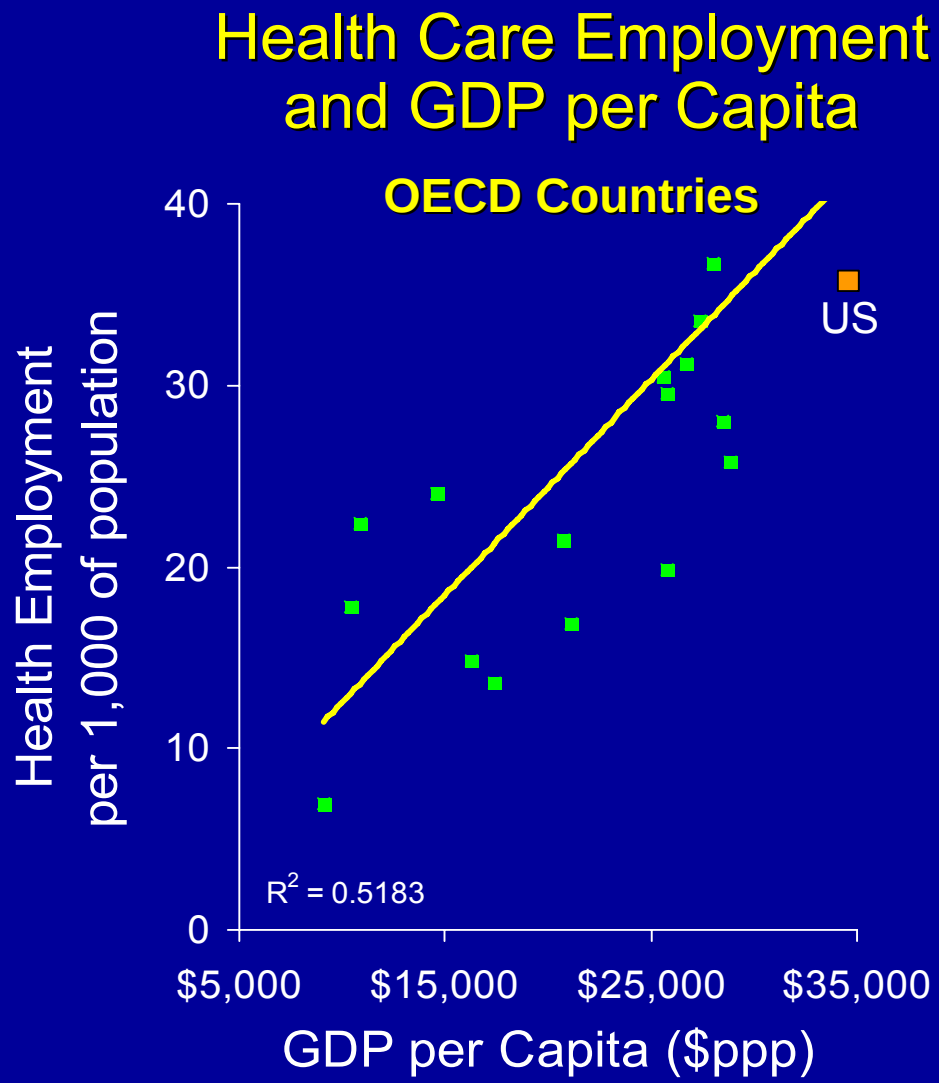
41,375 ZIP Codes
85,000 Census tracks

Units of observation must be matched to the units for which conclusions are drawn and decisions are made. *T. Getzen, HSR 2007*

NATIONS

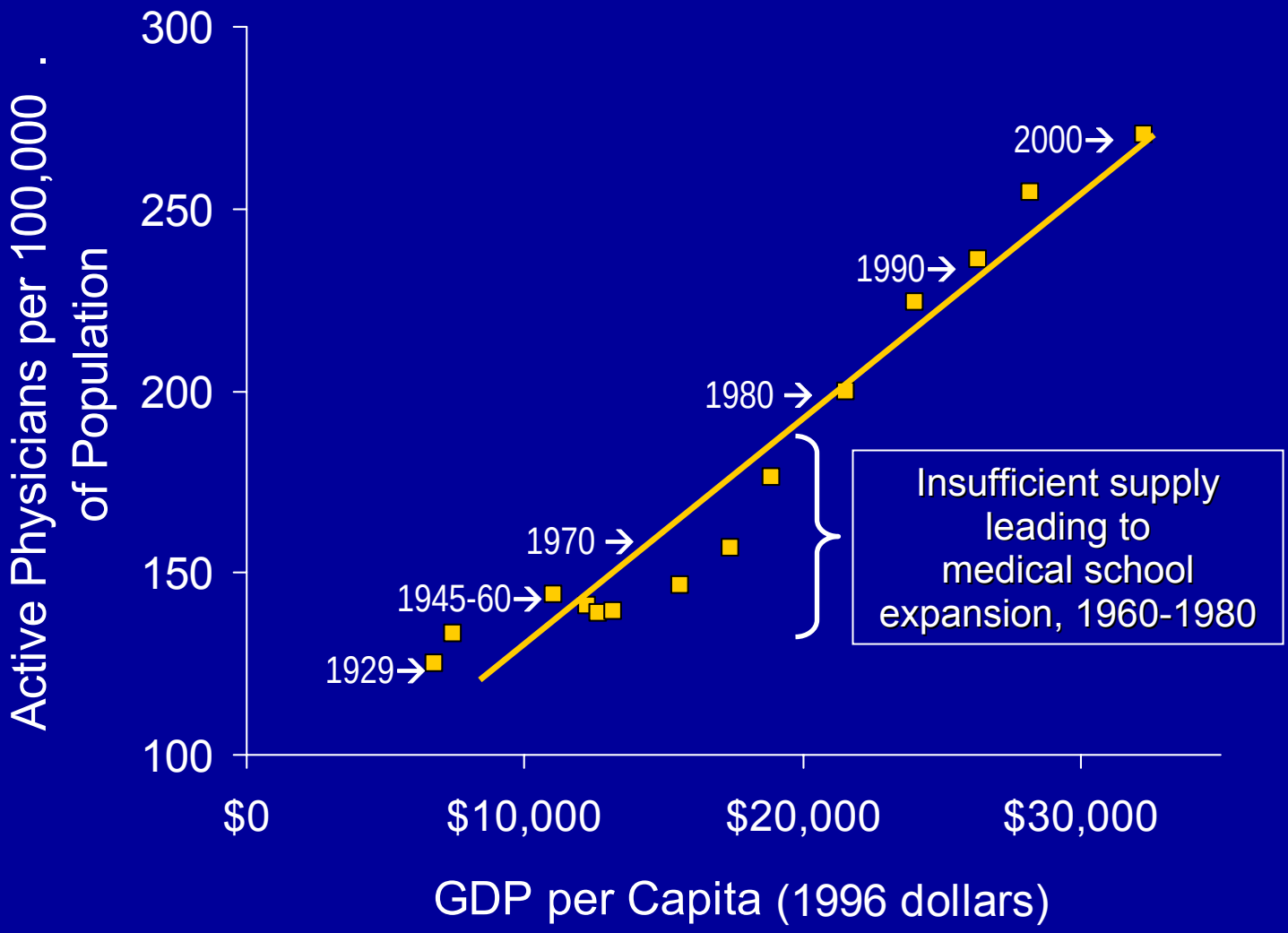
At the level of nations, economic status correlates directly with health care.

Wealth fosters the creation of health care resources, and wealth finances the utilization of health care services.

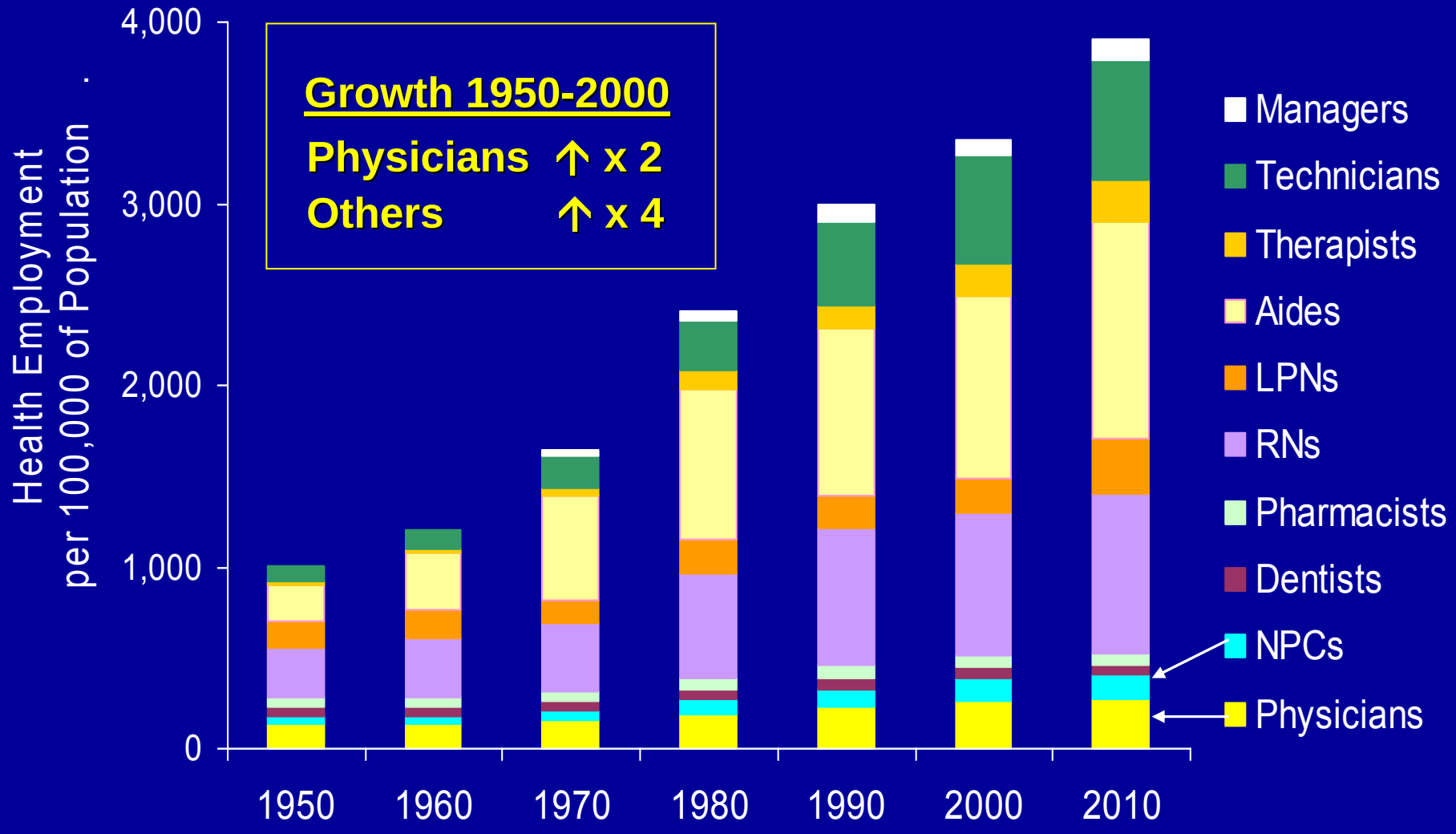


OECD 2000

NATIONAL PHYSICIAN SUPPLY TREND
1929-2000

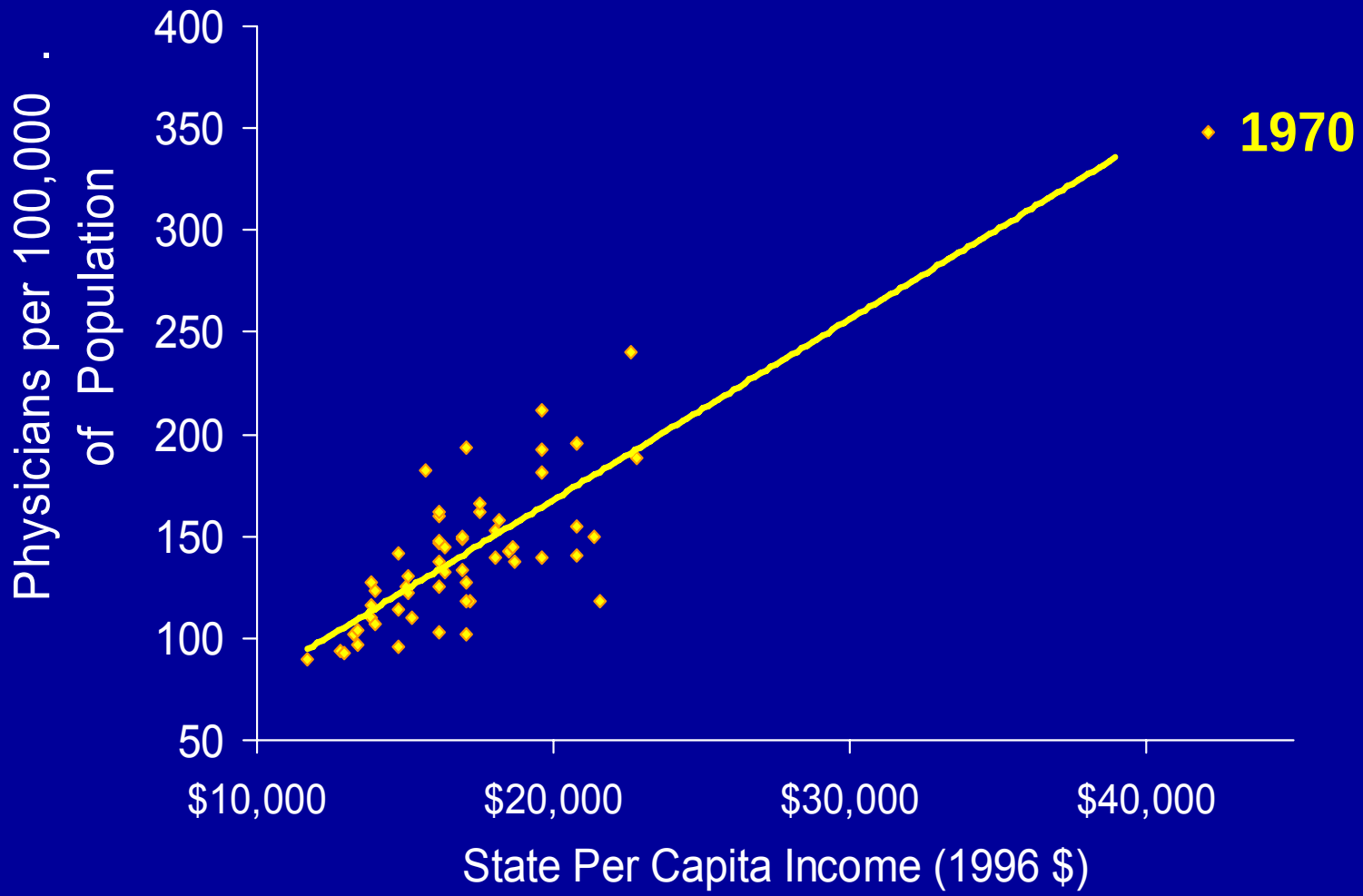


NATIONAL HEALTH CARE LABOR SUPPLY
1950-2000



Adapted from Kendix and Getzen and the Bureau of Labor Statistics

STATE
Physician Supply and Per Capita Income



1970 data from Reinhardt, 1975

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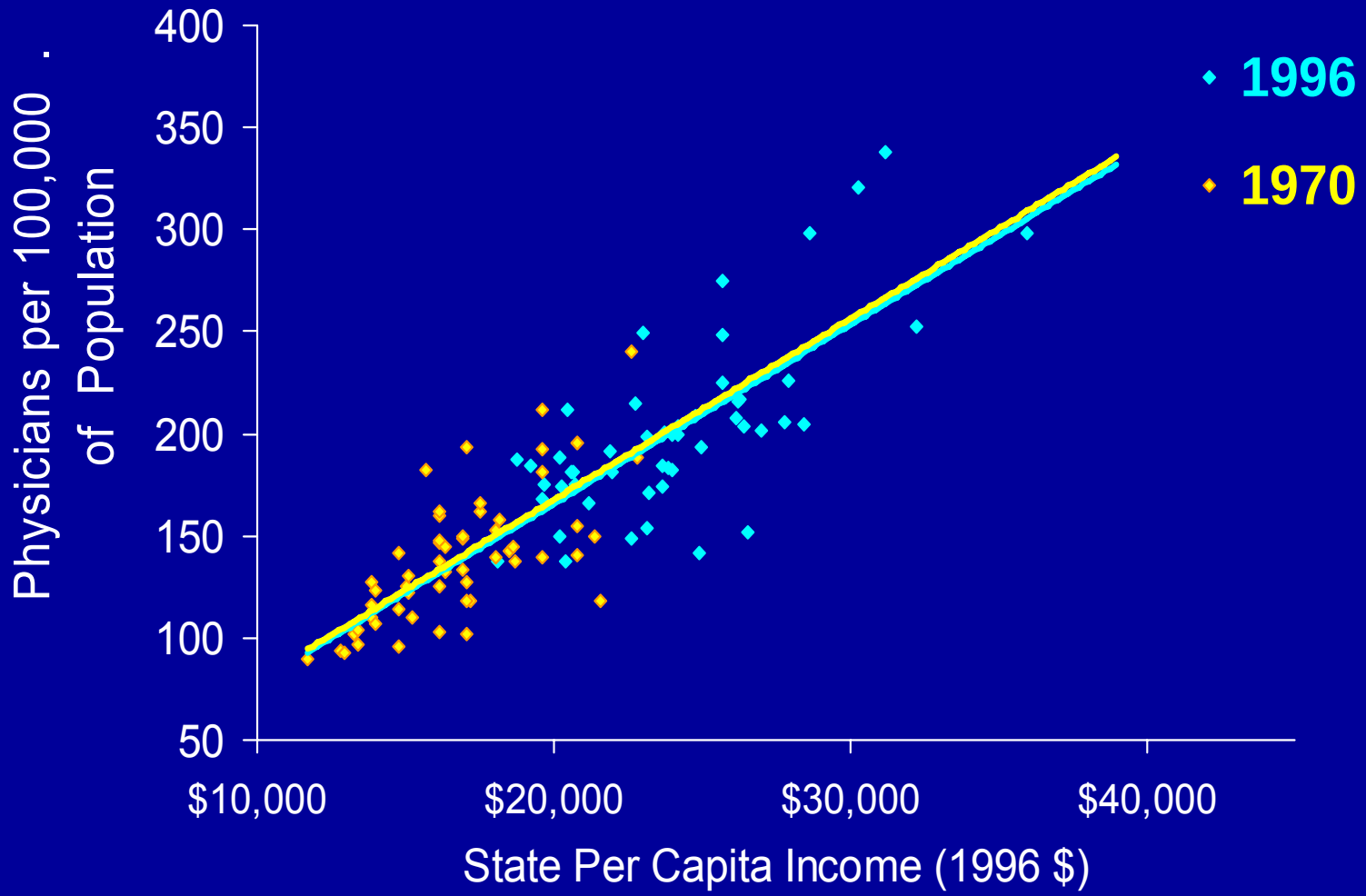

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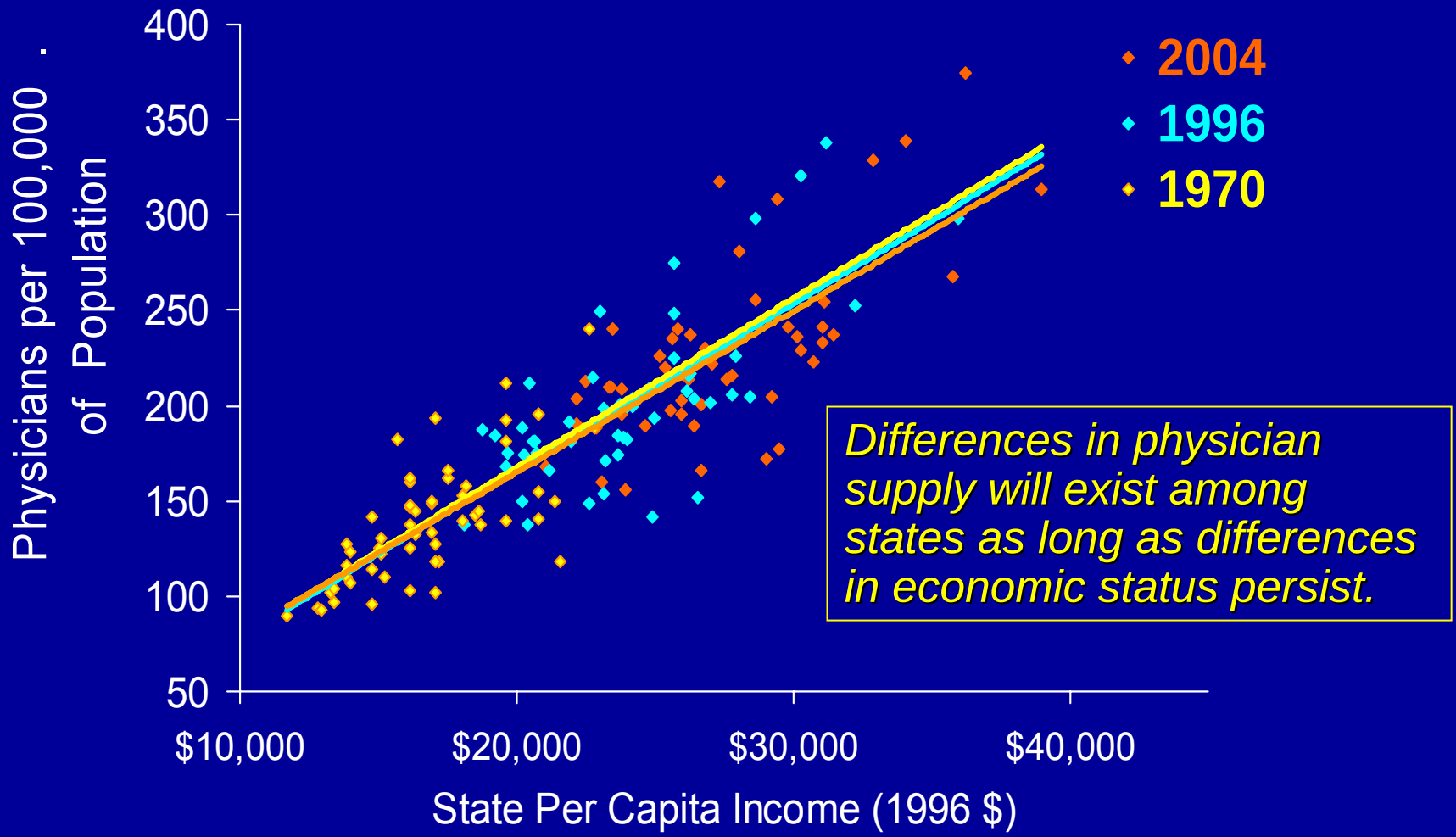
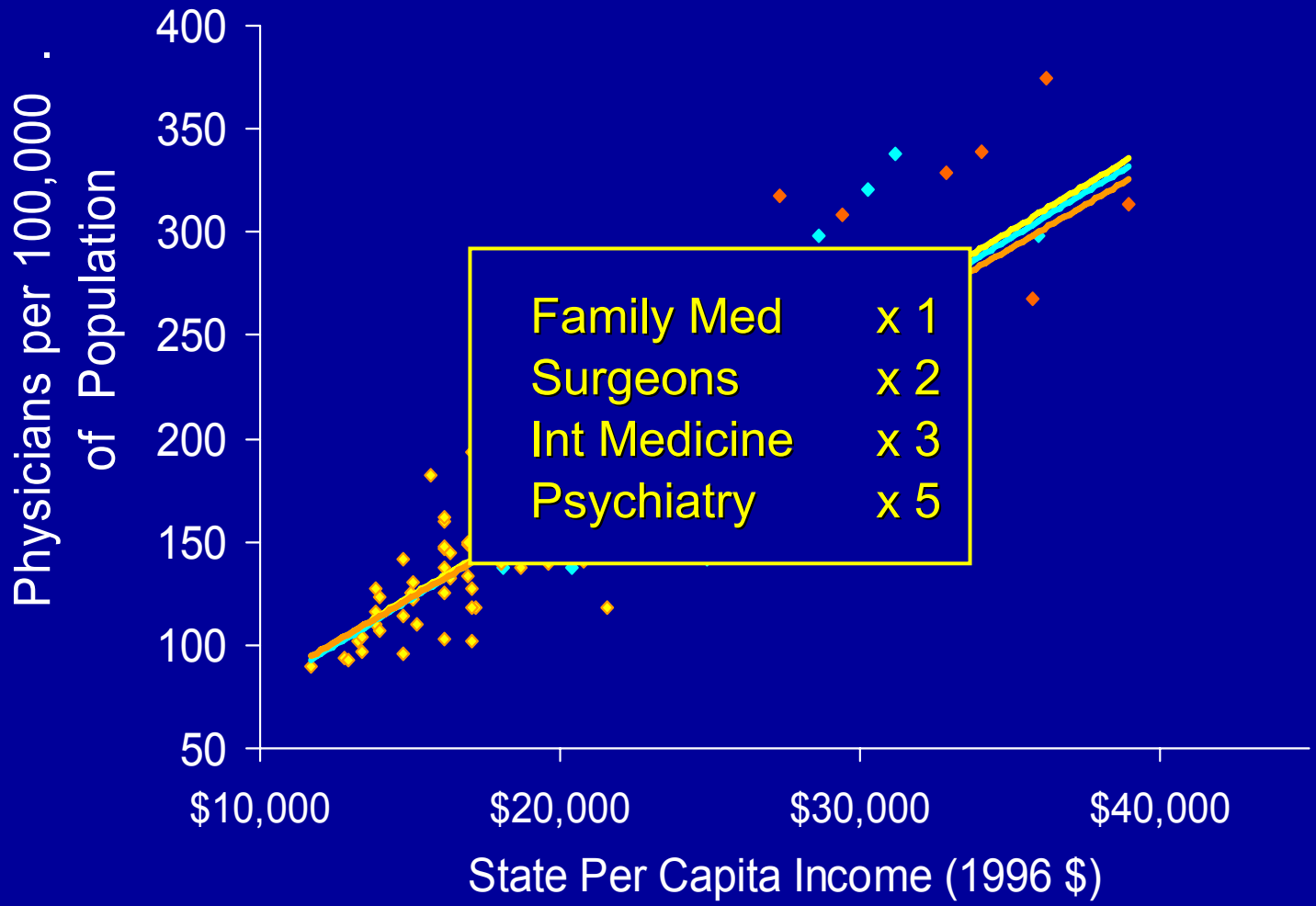


1970 data from Reinhardt, 1975

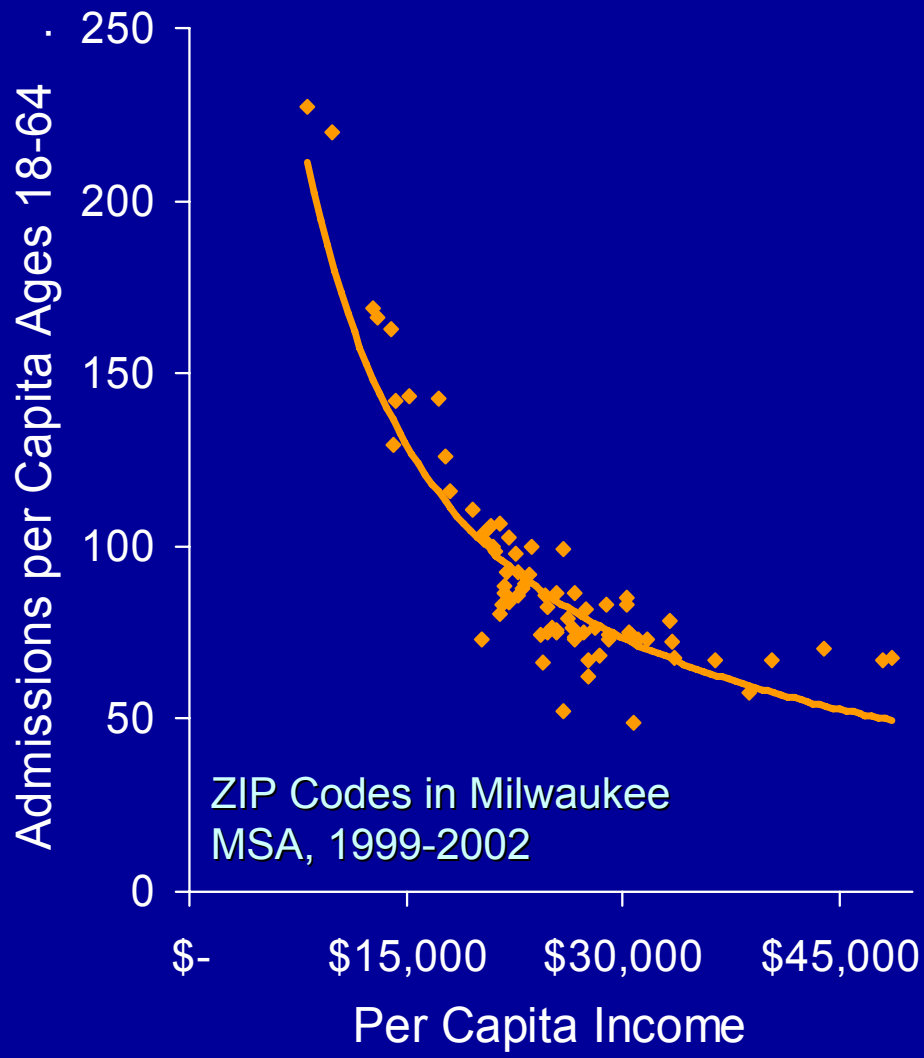
STATE
Variation in Specialist Density



INDIVIDUALS
ZIP Codes, Census Tracks

At the level of individuals, (as measured by ZIP Codes or Census Tracks), economic status correlates inversely with health care utilization.

Poor individuals consume more health care. ("*Ethnic dualization*")



COUNTER-CLINICAL CONCLUSION

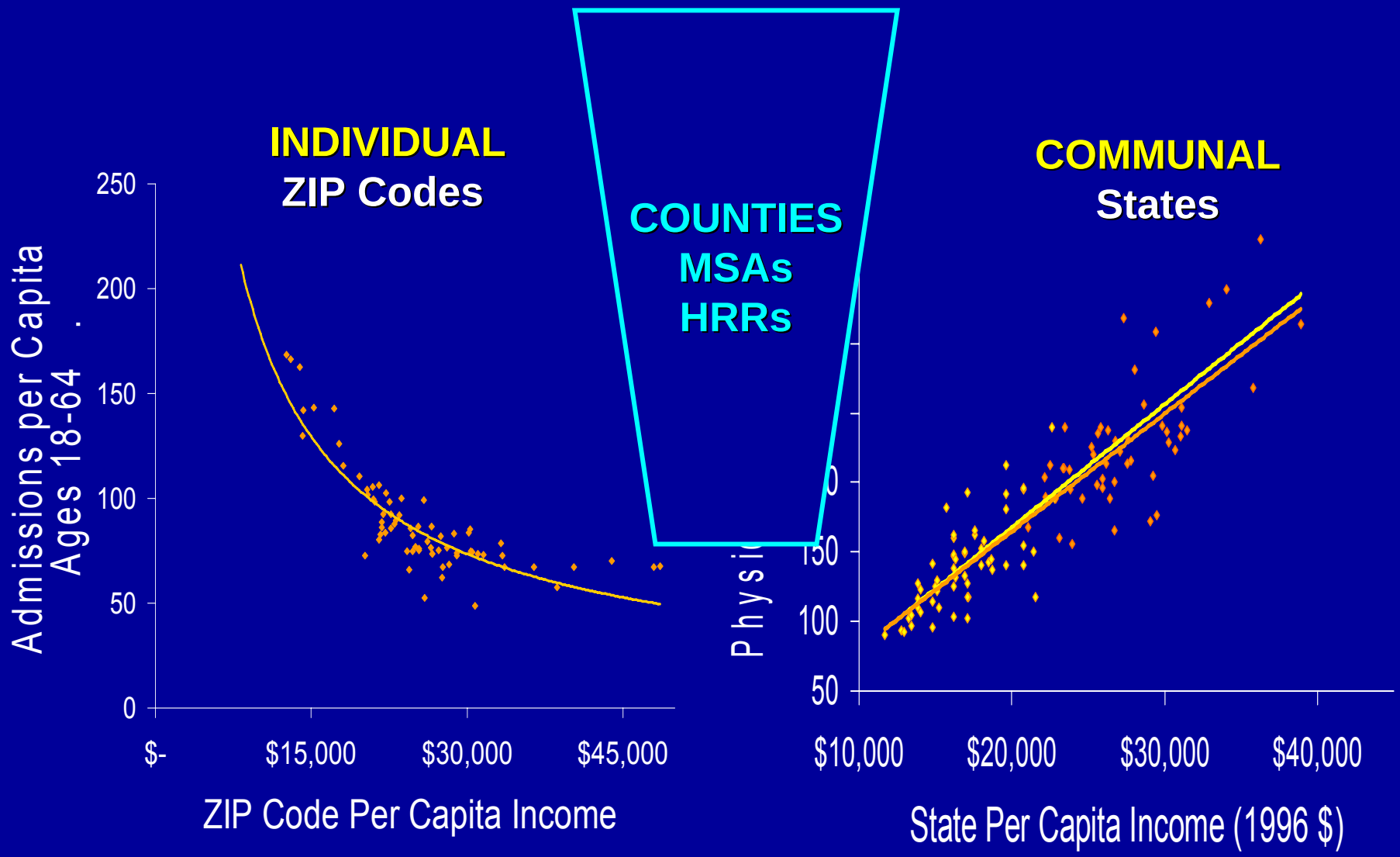
More care by more highly skilled practitioners yields better outcomes, but…

…patients who receive the most needed care have

- more measured burden of disease
- more unmeasured burden of disease
- and worse outcomes.

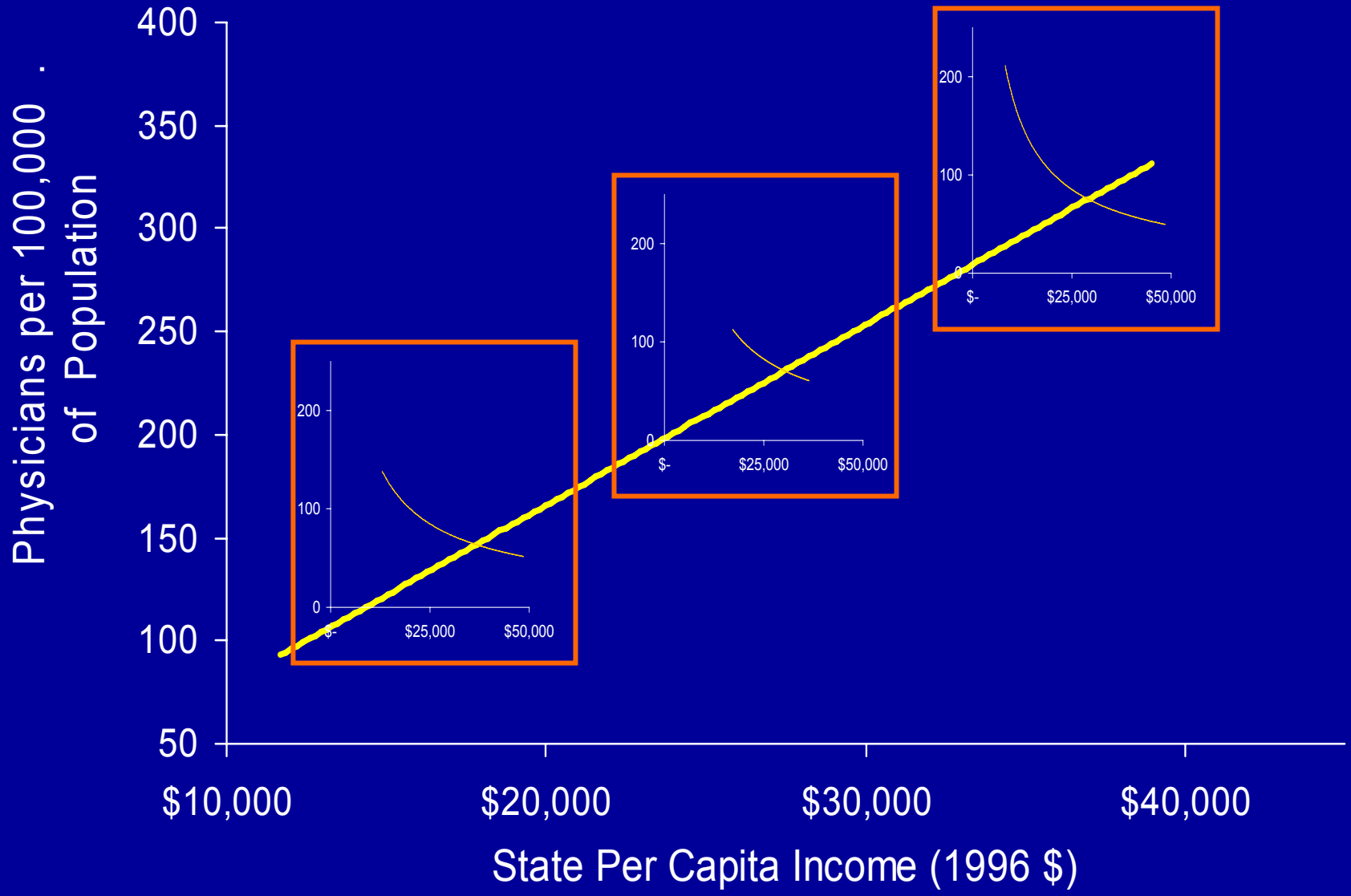
Kahn, et al. HSR Feb 2007

*Outcomes among **SMALL AREAS** are influenced by countervailing individual and communal trends*



SMALL AREAS

Aggregate wealth in states determines resources, while individual economic status influences utilization



EFFICIENCY vs. EQUITY

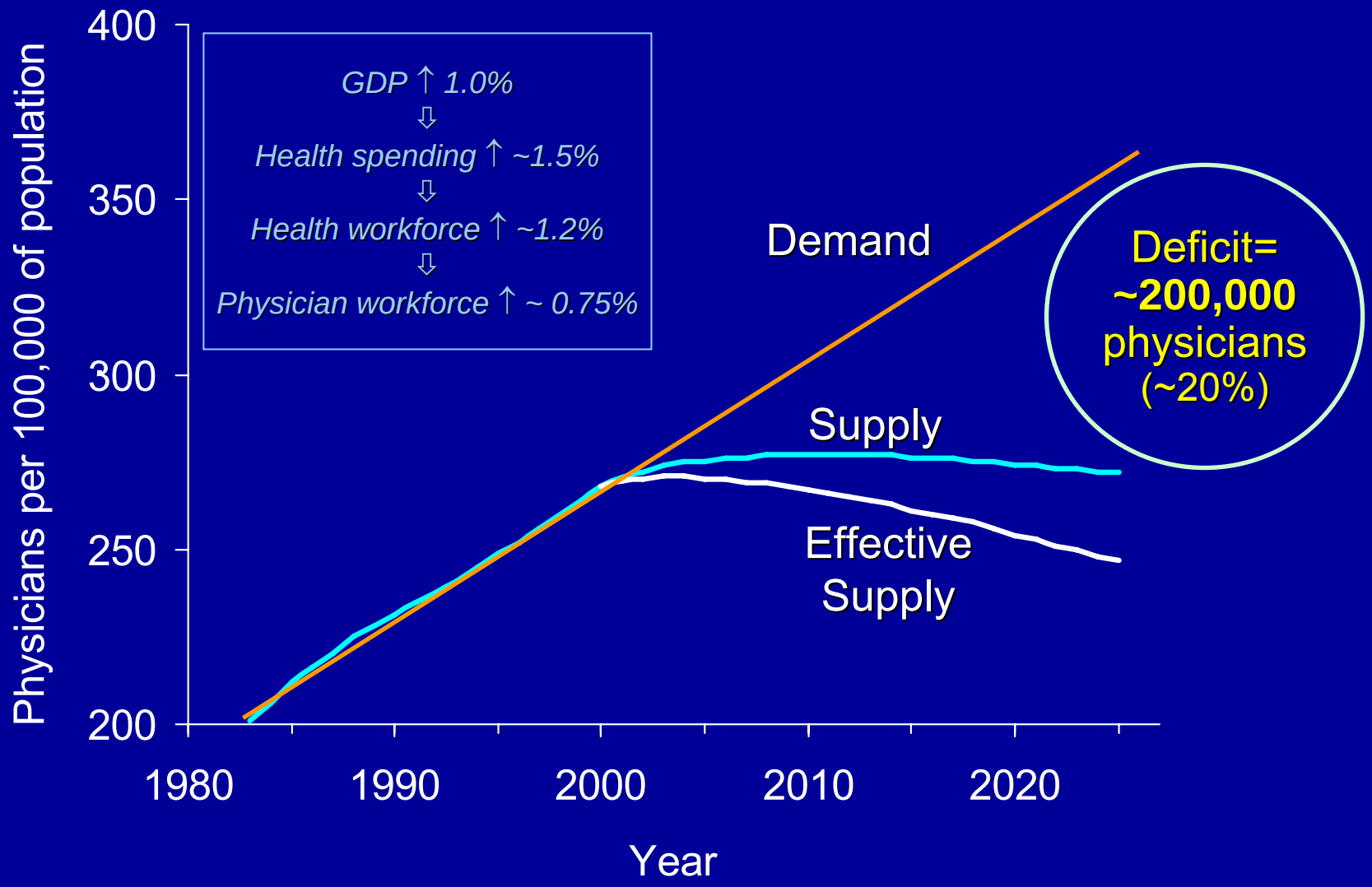
Variation in health care has been equated with inefficiency.

Variation is not a matter of efficiency. It's a matter of social inequality and social trust.

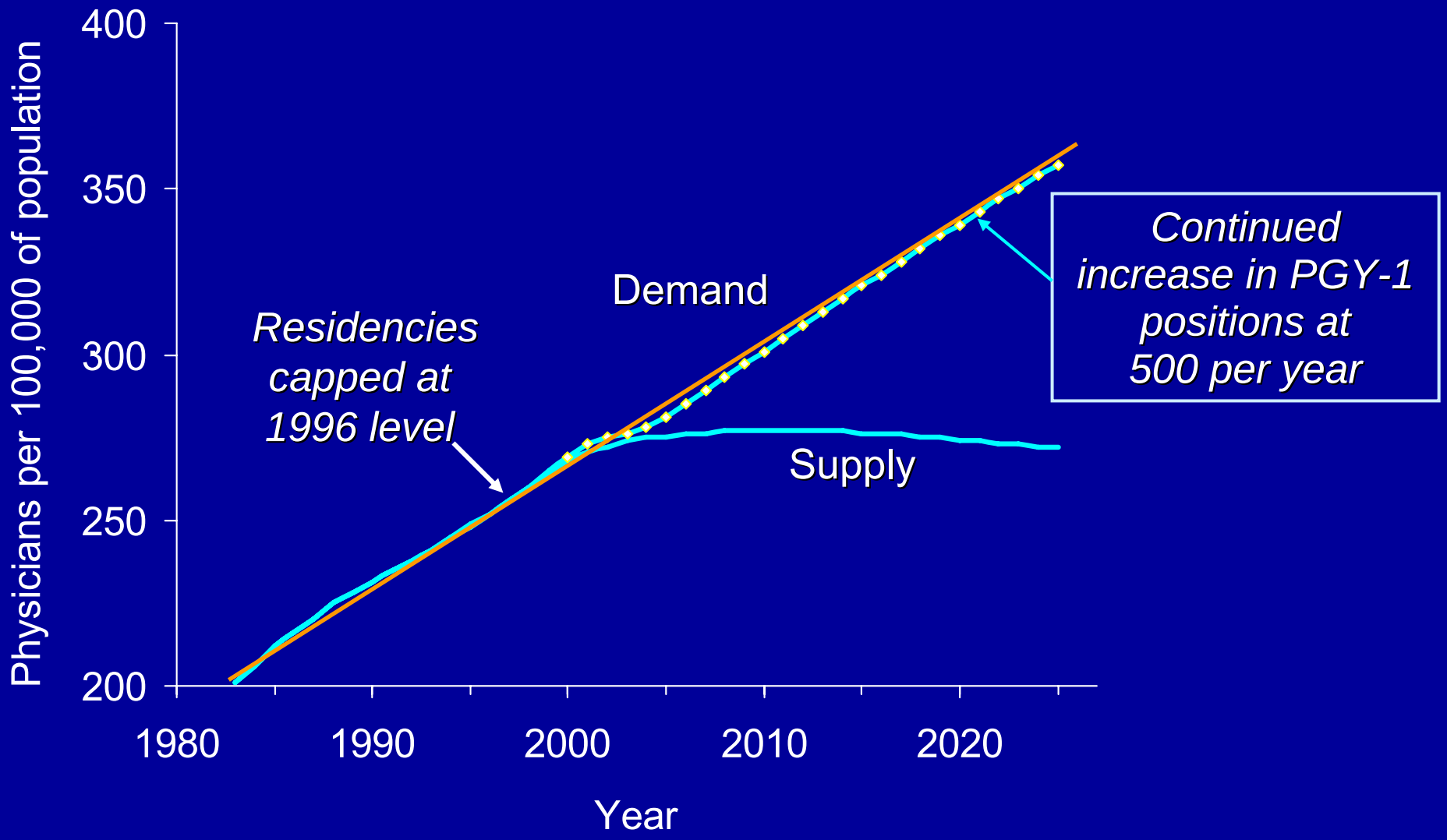
Physicians practice within the context of the economic and social realities that they encounter and the administrative and regulatory constraints that they must endure.

They now face the added problem that there will not be enough of them to provide the needed care.

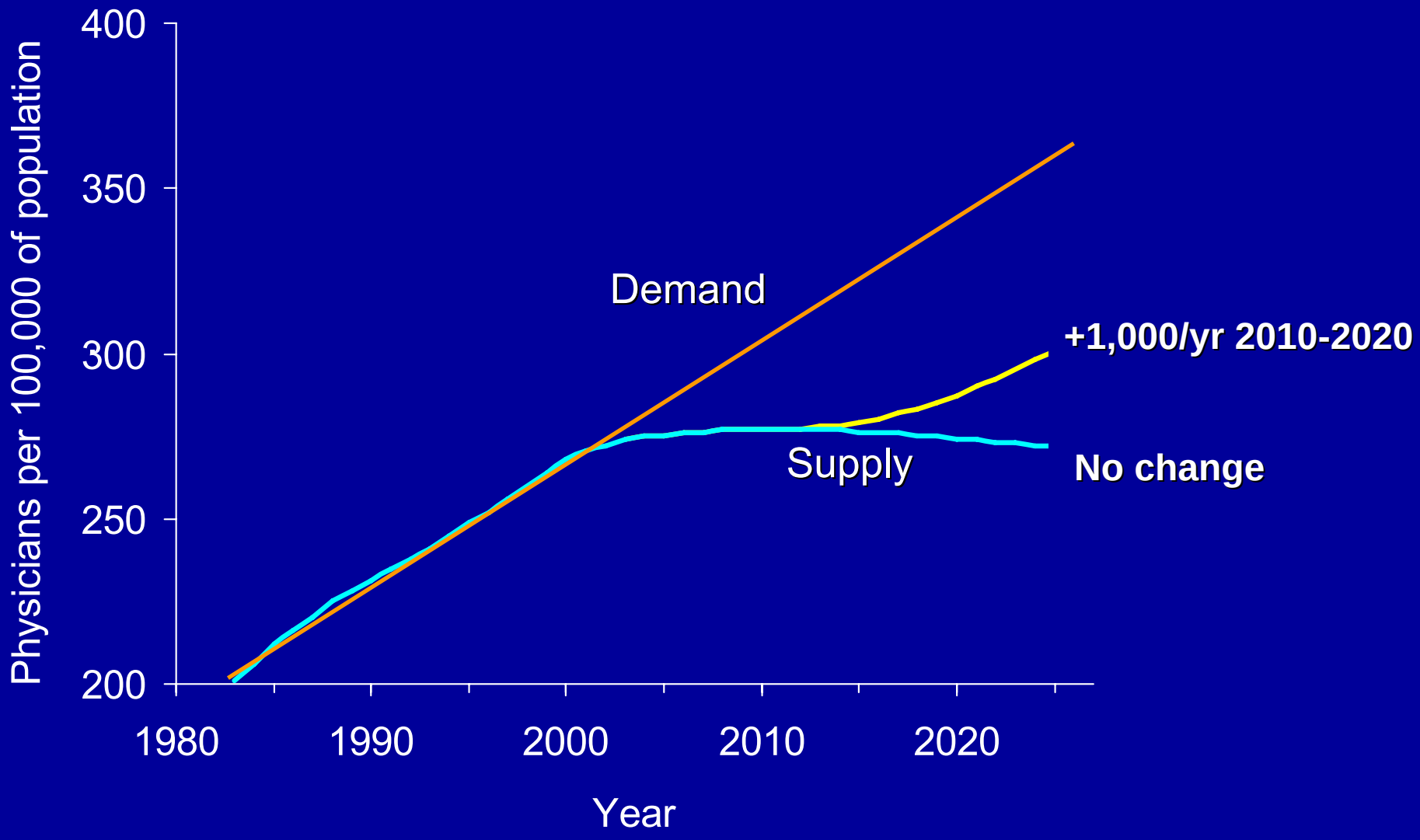
PHYSICIAN SUPPLY and DEMAND PROJECTIONS to 2025



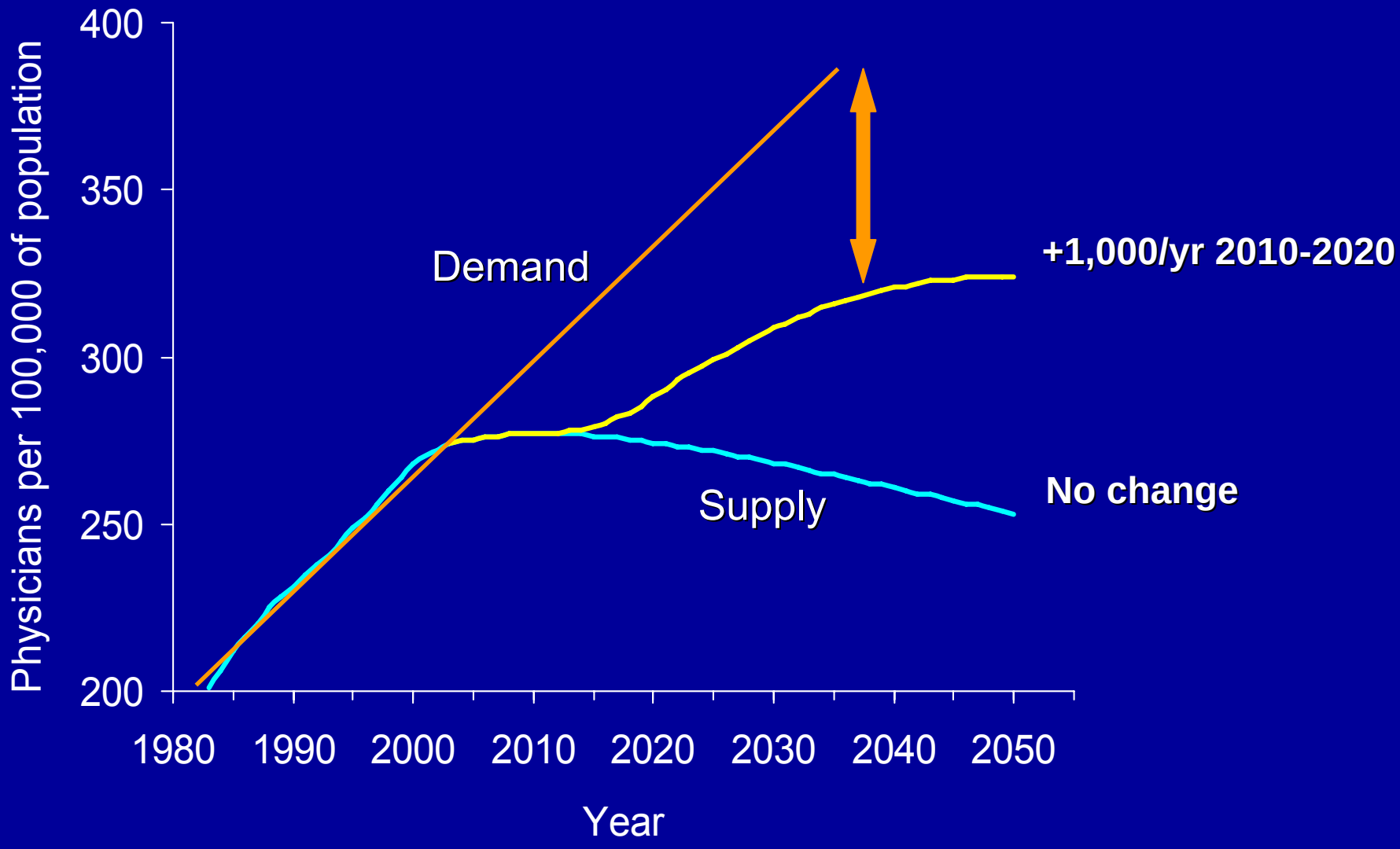
If residency programs had continued to expand after 1996, the US would not now be facing severe shortages.

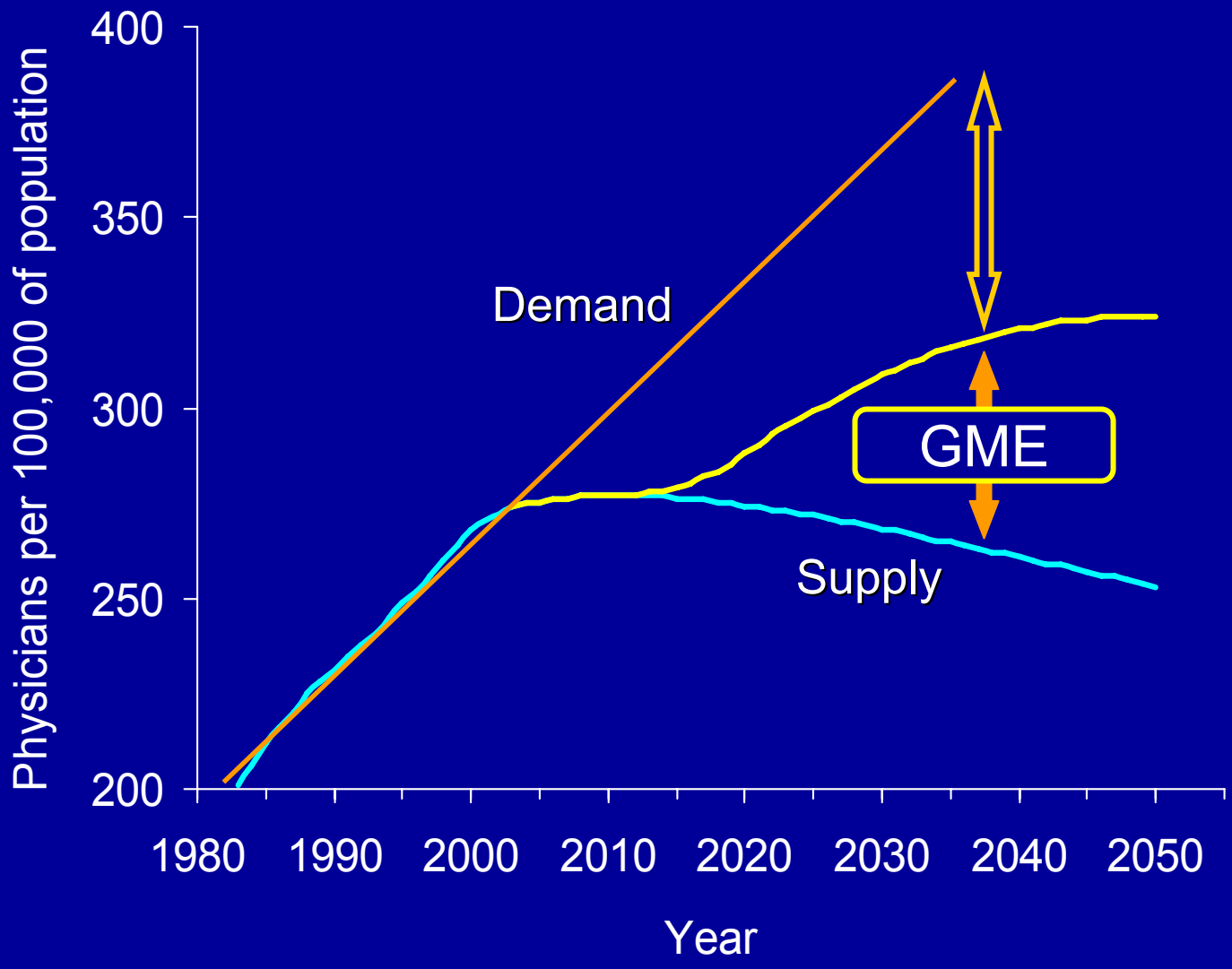


Increasing PGY-1 residency positions by 10,000 (40%) is essential, but even that will not close the gap…



…and the gap will continue for decades.




Physicians per 100,000 of population
400
350
300
250
200
1980
1990
2000
2010
2020
2030
2040
2050
Year
Demand
Supply
GME

IMPERATIVE

Medical educators have long accepted the responsibility for assuring an adequate supply of competent physicians.

Fulfilling that responsibility is an obligation they must now embrace.

Thank you