

NHPF Forum Session Meeting Announcement



Too Few? Too Many? The Right Kind? Physician Supply in an Aging and Multicultural Society

A DISCUSSION FEATURING:

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Workforce Studies
and
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WITH COMMENTS FROM:

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**Tuesday,
September 10, 2002**

11:45 am–12:15 p.m. — *Lunch*
12:15–2:15 pm — *Discussion*

**Reserve Officers Association
of the United States**

One Constitution Avenue, N.E.
Congressional Hall of Honor
(Fifth Floor)
*(Across from the Dirksen Senate
Office Building)*

To register:

Please call Dagny Shiells at
202/872-1392 as soon as
possible. Space is limited.

**For additional information
on physician training:**

See
Issue Brief No. 764 — *Federal
and State Perspectives on GME
Reform* — available at [http://
www.nhpf.org](http://www.nhpf.org).



Too Few? Too Many? The Right Kind? Physician Supply in an Aging and Multicultural Society

How many doctors do we need in the United States? What is the right mix of generalists and specialists? Are physicians being appropriately trained to care for our aging and increasingly diverse population? How do we get more physicians into underserved areas? How can we increase diversity in our nation's physician workforce? What is the appropriate federal role for assuring an adequate physician supply? These questions have vexed policymakers for decades.

Rapidly shifting demographics mean that physicians and other health professionals will be serving a population with markedly different racial, cultural, and physical characteristics. Current projections are that racial and ethnic minorities will represent 32 percent of the U.S. population by 2010, and 40 percent by 2030.¹ Today, Latinos, African Americans, and Native Americans account for only about 6 percent of practicing physicians in the United States. Equally challenging is the growing number of older Americans. Between 2010 and 2030, nearly one in five Americans will be over the age of 65. Some estimate that the nation will need about 36,000 physicians with geriatric training to manage the complex health and social needs of this rapidly aging population. Today, there are about 9,000 certified geriatricians practicing in the United States.² Providing quality health care in the future will require physicians and other health professionals to acquire the requisite skills and knowledge to appropriately treat a diverse and aging population.

The appropriate federal government role in educating and training the nation's physicians has been the subject of serious debate for

SESSION OVERVIEW

This meeting will examine trends in the supply of physicians and the market, regulatory, and political forces that have influenced them. Discussants will focus on physician training and the extent to which medical doctors are prepared to care for an increasingly diverse and aging population. Participants will also consider the role of the federal government in educating physicians—especially as it relates to Medicare subsidies for graduate medical education and Title VII funding.

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several years. Some argue that policymakers should take a hands-on approach in shaping the number of medical residents and their distribution among specialties and geographic practice areas. They contend that regulation and planning are required to assure an appropriate physician supply to care for future populations. Since the federal government finances a great deal of health care, they argue, there is strong public interest in equipping future physicians with the competencies to provide high-quality care. Others maintain that the free market should determine physician supply, with the relative number and types of doctors driven by consumer demand. Physicians are among the highest-paid of all professions, and medical schools continue to have more qualified applicants than spaces. Therefore, the argument goes, the federal government should not be subsidizing the education of physicians.

In the midst of these arguments are debates not about *whether* but about *how* the federal government should finance medical education, particularly at the graduate level.³ Since Medicare's inception, the program has provided substantial financial support to graduate medical education (GME) through payments to hospitals based on the number of residents they train. Those payments now exceed \$7 billion a year, or more than \$70,000 per resident per year. Recently, some policymakers have questioned whether Medicare should continue to finance GME in this manner and have offered other approaches, such as a through the standard appropriations process or by establishing an "all payer" trust fund.⁴

In addition, the federal government finances physician and other health professional training through funds established under Title VII and Title VIII of the Public Health Service Act. Title VII and VIII authorize a variety of grants for students, programs, and institutions to improve the racial and ethnic diversity, geographic distribution, and quality of the health care workforce. In general, funding for these programs are appropriated annually as part of the Labor, Health and Human Services, and Education appropriations bill. On July 19, 2002, the Senate Appropriations Committee approved its version (S. Rpt. 107-216), which includes \$263 million total for the Title VII and VIII health professions and nursing education programs. This is \$153.5 million (140 percent) more than President Bush's fiscal year (FY) 2003 budget proposal, but \$125 million (32 percent) less than FY 2002 funding.⁵

In September 2002, *Health Affairs* will publish a thematic issue on health workforce issues. In collaboration with *Health Affairs*, this Forum session will highlight a paper featured in that issue written by Kevin Grumbach, M.D., entitled, "Fighting Hand to Hand over Physician Workforce Policy: The Invisible Hand of the Market Meets the Heavy Hand of Government Planning" (publicly available online at <http://www.healthaffairs.org> after September 7, 2002). At the meeting, Grumbach will examine market and public planning approaches to

Medicare's payments to hospitals for graduate medical education now exceed \$7 billion a year.

physician workforce policies. He will also discuss options for achieving long-term workforce objectives. His presentation will be followed by responses from five distinguished speakers, who will remark on the key issues of diversity, geriatric training, and federal financing of medical education.

SPEAKERS AND RESPONDENTS

Kevin Grumbach, M.D., is the director of the Center for California Health Workforce Studies and professor in the Department of Family and Community Medicine at the University of California, San Francisco. His research on topics such as primary care physician supply and access to care, racial and ethnic diversity in the medical profession, and the impact of managed care on physicians have been published in major medical journals, including the *New England Journal of Medicine* and *JAMA*, and cited widely in both health policy forums and the general media.

Brenda Armstrong, M.D., is associate dean and director of admissions at the Duke University School of Medicine. She was the second black female in the United States to become a board-certified pediatric cardiologist. She is known for recruiting the most diverse classes in the medical school's history.

Robert Dickler is senior vice president for health care affairs at the Association of American Medical Colleges. In this capacity, he oversees the association's activities that focus on the interface between the health care delivery system and academic medicine.

Julian Pettengill is a research director at the Medicare Payment Advisory Commission (MedPAC). He has written about a wide range of Medicare payment policy topics, including policies for GME and teaching hospitals, and case-mix and input-price payment adjustments.

Fitzhugh Mullan, M.D., is a contributing editor of *Health Affairs* and a clinical professor of pediatrics and public health at the George Washington University. He is a member of the medical staff at the Upper Cardozo Community Health Center in Washington, D.C. Previously, he served as the director of the National Health Services Corps and the Bureau of Health Professions in the Health Resources and Services Administration.

Gregg Warshaw, M.D., is the director of the Office of Geriatric Medicine at the University of Cincinnati College of Medicine. He is the past president of the American Geriatrics Society and the Association of Directors of Geriatric Academic Programs.

KEY QUESTIONS

The discussion will center on the following questions:

- What barriers exist in recruiting more racial and ethnic minorities to the medical profession? What are the implications of the

scarcity of minority physicians for health care quality? What federal initiatives have been most successful in increasing diversity among health professionals?

■ How well prepared are physicians to care for the aging population? Why is there a shortage of geriatricians? Should the federal government provide incentives to medical schools and teaching hospitals to incorporate geriatrics into training programs?

■ Should federal financing of GME be more explicitly tied to long-term objectives for the supply, training, and distribution of physicians? Would other federal initiatives (such as Title VII programs) be a more appropriate way to achieve these objectives? Would they be sufficient?

ENDNOTES

1. Philip Gonzalez and Betsy Stoll, "The Color of Medicine: Strategies for Increasing Diversity in the U.S. Physician Workforce," Community Catalyst, Boston, April 2002; accessed August 19, 2002, at http://www.communitycat.org/acrobat/The_Color_of_Medicine.pdf.
2. Janet Firshein, "Filling the Geriatric Gap: Is the Health System Prepared for an Aging Population?" National Health Policy Forum Issue Brief No. 729, January 25, 1999.
3. See Karen Matherlee, "Federal and State Perspectives on GME Reform," NHPF Issue Brief No. 764, June 22, 2001; Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, 20, no. 2 (March/April 2001); and Bureau of Health Professions, Health Resources and Services Administration, *Graduate Medical Education and Public Policy: A Primer*, U.S. Department of Health and Human Services, Washington, D.C., December 2000; accessed August 19, 2002, at <ftp://ftp.hrsa.gov/bhpr/nationalcenter/GMEprimer.pdf>.
4. See Bill Frist, M.D., Chairman, GME Study Group, "Protecting the Future of Graduate Medical Education: A Look at Financing within the Premium Support Model," National Bipartisan Commission on the Future of Medicare, Washington, D.C., February 12, 1999; and Medicare Payment Advisory Commission, *Report to the Congress: Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals*, August 1999; accessed August 13, 2002, at http://www.medpac.gov/publications/congressional_reports/august99.pdf; and Council on Graduate Medical Education Fifteenth Report, "Financing Graduate Medical Education in a Changing Health Care Environment," accessed August 13, 2002, at <http://cogme.gov/rpt15.htm>, for a discussion of a variety of financing proposals for GME.
5. Association of American Medical Colleges, "Health Professions Education, FY 2003 Funding," accessed August 19, 2002 at <http://www.aamc.org/advocacy/library/laborhhs/labor0002.htm>. At press time, the House Appropriations Subcommittee on Labor, Health and Human Services, and Education was scheduled to meet on September 4, 2002, to approve its version.