

OPINION

Physician supply: Evaluating the need for more doctors

The AMA is well-suited to facilitate consensus on a national work-force strategy.

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With its recent decision to revisit its long-time position that the United States has or soon will have too many physicians, the American Medical Association joined a chorus of voices calling for a fresh look at national work-force policies. Those policies were based on a prediction of physician surplus and called for limits on entry-level GME positions.

In November 2003, the Council on Graduate Medical Education cast aside its forecast of a surplus, held since the mid-1980s after commissioning a work-force expert to study the issue. The expert, Ed Salsberg, executive director of the Center for Health Workforce Studies at the State University of New York, anticipates a shortage of 85,000 physicians by 2020. Salsberg also has been tapped by the Assn. of American Medical Colleges to examine work-force issues. He has been named head of the association's new Center for Workforce Studies, aimed at determining the AAMC's agenda on the issue.

The AMA's policy was itself 15 years old and ripe for review when the Council on Medical Education began its examination in 2002. The move away from a physician surplus position is the result of recommendations the council presented to the Association's House of Delegates in December 2003.

The AMA stopped short, however, of declaring an outright shortage, recognizing instead a shortage in some areas of the country and in some specialties. Caution is indeed warranted, as history has shown that many of the factors that ultimately determine physician supply are difficult to forecast. It is nearly impossible to predict how long medical student debt and medical liability rates will continue rising and whether international medical graduates will continue to experience visa delays. Federal legislation could alleviate those pressures. A propensity among younger physicians to work fewer hours and the increase in elderly people who will require more care also needs to be figured into any new supply predictions.

But physician supply is about more than raw numbers. The longstanding geographic maldistribution of physicians -- a sticky wicket if ever there was one -- cannot be ignored. Despite the increase in the overall physician supply in recent years, the number of rural physicians has not risen proportionally, and a further decrease in rural physicians is expected with the declining interest in family medicine as a specialty.

The council encourages multiple strategies to address the problem, including developing mechanisms to encourage practice in underserved areas and maximizing the use of technology that supports access to care. Both are a good start, as is the Association's pledge to work with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and to improve recruitment for primary care specialties.

Delegates also directed the Association to collaborate with state and specialty societies and other interest groups to develop a national consensus on physician work-force policy. There is no organization better suited to take on this role. The AMA, a nationally recognized leader in setting medical policy, carries the clout to forge consensus from stakeholders as disparate as government, academia and private-sector practicing physicians -- all of whom will have much to say about the matter.

The goal of work-force planning should be to determine appropriate physician numbers, specialty mix and geographic distribution, all for a future that can be expected to make greater demands on medicine than ever before.