There were days when Dr. David Goodman felt like he was making a real difference in the lives of his patients. It was the mid-1980s, and Goodman was serving as a National Health Service Corps physician in the rural town of Colebrook, N.H. “I was the only pediatrician in the county,” he recalls.

But other days, he wondered how much good he was actually doing. “The biggest needs in that community were not medical,” Goodman says. “They were mental and dental.” Another problem was that the focus of the local health-care system was always on treating the next patient in the waiting room. No one was thinking about how to improve the overall health of the community. For Goodman, the experience raised “these sorts of heretical questions about, well, how much influence do we have as primary-care doctors?”

He began trying to answer those “heretical questions” when he arrived at Dartmouth in 1988. Before long, he was working with Dr. John Wennberg, a pioneering health-outcomes researcher, and other DMS faculty interested in such topics. It was a momentous experience. “I left my first meeting with my eyes wide open,” Goodman says. In the 20 years since then, he has studied the association between physician supply and health outcomes as a researcher at the Dartmouth Institute for Health Policy and Clinical Practice (TDI). He’s now one of the nation’s leading voices calling for a reevaluation of physician workforce policy.

At the moment, U.S. medical schools are in a period of rapid expansion. Last fall, more than 18,000 students began working toward their M.D. degree—the largest first-year class in history. In coming years, class sizes are likely to grow still more as existing schools increase their enrollments further and several new schools open their doors. This expansion is part of an effort to avoid what some believe could be a health-care catastrophe. According to the Association of American Medical Colleges (AAMC), by 2025 the country could face a shortfall of more than 100,000 physicians. The organization points out that 30 million Americans live in areas that have been designated by the federal government as medically underserved, and that state agencies and academic researchers in more than 20 states have issued recent reports detailing local physician shortages. If nothing is done about the supply of physicians, the AAMC argues, the nation’s health will be at risk.

David Goodman doesn’t buy the AAMC’s reasoning. He agrees that there are widespread problems with health-care delivery, but he contends that increasing the number of doctors will actually make things worse. “While what doctors do is very important, the number of doctors does not determine the U.S. need? Many more, say some policy-makers, to address access problems and population trends. Not so, says a Dartmouth researcher, who argues that simply churning out more doctors won’t fix the problems and may make them worse. He and others call instead for a more rational payment system and better-organized workforce planning to rectify current imbalances in the physician supply.
The physician workforce debate has grown increasingly heated. “People have called it trench warfare,” says Jonathan Weiner of Johns Hopkins. He believes, like Goodman, that the methods used by the AAMC’s Center for Workforce Studies, explains that the AAMC’s conclusions rely on the assumption that beyond a certain point, the number of doctors that are doing it doesn’t make that much of a difference,” he says. Even he argues that the push to expand the physician workforce isn’t about improving health care—it’s largely about the money to expand the medical labor market into the future at a time when every one agrees that the last thing that we want is to simply perpetuate the health-care system.

As national organizations began warning of the potential physician shortage, Goodman accumulated evidence pointing to the opposite conclusion. It’s not a question of demographics, he says. The issue is “how populations are affected by physician supply and by growth in physician supply.” In other words, projections for the years 2015 and 2020 that make medical centers and found enormous variation in the amount of care provided to patients during the last six months of life. The amount of physician labor dedicated to each patient at the most-care-intensive hospital—New York University Medical Center in Manhattan—was more than three times higher than the amount at the least-care-intensive hospital—Medical College of Georgia. The study accounted for factors such as age, race, and gender and looked only at patients admitted for one of 12 chronic conditions. So, baby boomers will just be starting to turn 75.

As a result, the total number of practicing physicians has little to do with quality of care.

Edward Sulberg, M.P.A., the director of the AAMC’s Center for Workforce Studies, explains that the AAMC’s conclusions are based on several factors. “For 1980, it made sense to slow up what was then a very rapid increase in medical school enrollment,” he says. “But people are now questioning whether all the growth that occurred during the 1980s was necessary, “People have called it trench warfare,” says Jonathan Weiner of Johns Hopkins. He believes, like Goodman, that the methods used by the AAMC’s Center for Workforce Studies, explains that the AAMC’s conclusions rely on the assumption that beyond a certain point, the number of doctors that are doing it doesn’t make that much of a difference,” he says. Even he argues that the push to expand the physician workforce isn’t about improving health care—it’s largely about the money to expand the medical labor market into the future at a time when everyone agrees that the last thing that we want is to simply perpetuate the health-care system.

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goodman and Fisher are far from alone in making these arguments. “Many Ameri- can physicians are getting too much health care,” he says.

In talking about the physician workforce, Good- man always returns to the basic goal of health care: to improve the health of patients, not just to deliv- er care. He realizes it can be hard, especially for doc- tors, to accept the notion that increasing the physi- cian supply might not do much to meet that goal. “If the number of doctors isn’t all that important, I mean, that’s not welcome news,” he admits. He em- phasizes, however, that he offers his criticisms as a “way to help care.”

In the opinion of the New America Foundation’s Shannon Brownlee, increasing the number of specialists under the current payment system is “a recipe for disaster. It is a great way to drive costs up even higher and faster than they’re going up already.”

In response to Starfield’s findings, the AAMC’s Edward Slaibog argued that using over- treatment as a way to drive care would be counter- productive. “i don’t like to see health-care services being used as a way to drive costs up even higher and faster than they’re going up already.”

In a recent survey of 12,000 physicians, less than 30% of the respondents who practice primary care said they’d go into primary care again if they had the choice.

At the same time, there’s widespread agreement that access to excellent primary care is fundamen- tal to an effective health-care system. “There’s en- tirely different model of how we think about the provision of primary care important, in a measurable way, what happens to a population in an area,” Good- man says. A number of studies support that conclu- sion. In 2005, for example, Dr. Barbara Starfield of Johns Hopkins published an article in the journal Family Practice, arguing that the presence of a primary care physician can drive costs down.

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Instead of simply ramping up the production of physicians, Goodman would like to see better-organized workforce planning and changes in federal funding of medical education. “I don’t believe that training programs should be rewarded for producing ever more doctors just to practice in the most affluent communities in the country,” he says.

Salsberg and Cooper say that the high utilisation of specialists means Americans are demanding those services. But Goodman doesn’t believe there’s any evidence that the services provided by specialists are, in fact, what Americans value most. What’s of value, he says, are the services that actually improve health. “We are interested in having a health-care system that helps improve the health and well-being of populations,” he says.

And, Goodman adds, training more specialists will make it that much harder to enact the reform that everyone acknowledges the U.S. health-care system requires. “Health-care reform doesn’t need more opposition from the profession,” he says. “It doesn’t need more anesthesiologists and radiologists saying that, ‘Yes, we really should get paid twice as much as a primary-care doctor.’”

DMS’s Nierenberg points out that the discrepancy in pay between primary care and most other specialists is one important reason that U.S.-educated M.D.’s tend not to go into primary care. Under the nation’s current fee-for-service medical payment system, he explains, physicians get paid for performing procedures, not for spending time advising and counseling patients on their health-care options. According to a recent survey, family physicians and pediatricians earn an average of about $185,000, whereas the average for orthopaedic surgeons and radiologists tops $400,000. “We’re the only system in the world that has such a disparity,” says Johns Hopkins’s Weiner.

A further factor in the specialty-choice problem, Nierenberg says, is debt. The average educational debt for U.S. medical school graduates who take out loans is now almost $140,000, and three-quarters of graduates have at least $100,000 in loans to repay. This gives young doctors a strong financial incentive to enter high-paying specialties instead of primary care—as well as to practice in areas populated with patients who are well insured.

But despite his concerns about the future of primary care, Goodman stops short of endorsing an increase in the supply of primary-care providers. “Primary-care physicians’ effort can be as easily wasted as specialists,” he says. “So again, supply is not the answer to primary care.” Instead of simply ramping up the production of physicians, Goodman would like to see more-inclusive and better-organized workforce planning. Academic medical centers’ have dominated the discussion, he says, and that has resulted in a narrow focus on the role of physicians—excluding nurses, physicians’ assistants, insurance companies, employers, and patients from the conversation.

Goodman also supports changes in federal funding of academic medical centers. He proposes enacting a competitive process for Medicare funds, similar in principle to the competition for research funding from the National Institutes of Health. “I believe that a competitive process has served us incredibly well in terms of research,” he says. “And it could do the same in terms of promoting graduate medical education.” Criteria might include, for example, what fields graduates enter, where they practice, and how well schools develop innovative training techniques. “I don’t believe that training programs should be rewarded for producing ever more doctors just to practice in the most affluent communities in the country,” he says.

For now, the future of the effort to increase the number of physicians remains unclear. In a survey conducted by the AAMC, almost all of the nation’s medical school deans reported that their schools plan to expand; Salsberg thinks the goal of a 30% increase in M.D. graduates could be met by 2017. Osteopathic schools have also continued to grow, continued on page 58

This chart shows some of the data the AAMC uses in making its case that the U.S. does need more doctors. The blue lines show past and projected future increases in the overall population (dark blue) and in people over 65 (light blue), while the red line shows past and projected growth in the number of physicians. The blue lines show past and projected future increases in the overall population (dark blue) and in people over 65 (light blue), while the red line shows past and projected growth in the number of physicians. The blue lines show past and projected future increases in the overall population (dark blue) and in people over 65 (light blue), while the red line shows past and projected growth in the number of physicians.
The Supply Side of Medicine

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with first-year enrollment expected to surpass 5,000 next fall—a 40% increase over just the past five years.

Even Dartmouth Medical School has answered the call to grow. “Our senior class size a few years ago was about 68 to 70 a year, and in a year or two I think it will top out at about 83,” says Nierenberg. “Something like 83 is probably what Dartmouth can do to help the country and still have the resources to do a superb job of training students.”

Still, all that growth might not result in a significant increase in the actual number of doctors. Those medical-school graduates must go on to train as residents at teaching hospitals before entering practice, and most of the funding for residencies is provided by Medicare. But as part of the 1997 Balanced Budget Act, Medicare funding for this purpose remains capped at 1996 levels—about 80,000 residency slots—and it would take action by Congress to lift that cap. For now, at least, what seems likely to happen is that the growing number of U.S. medical graduates will displace some of the graduates of international medical schools, who currently fill about one-fourth of residency slots.

TDI researcher Elliott Fisher doubts that Congress will lift the cap anytime soon on spending for graduate medical education (GME). Russell Robertson, the chair of the Council on Graduate Medical Education, agrees. COGME has not officially revisited its stance on the physician workforce, but Robertson says at this point he doesn’t recommend an increase in GME funding. “I’m increasingly convinced that lifting the GME cap isn’t a good idea,” he says. “I’m more and more convinced that what we’re doing right now is probably going to produce a surplus of physicians.”

The AAMC, however, has urged Congress to increase Medicare funding for residencies. That call seems likely to grow louder as medical-school enrollment increases.

Clearly, the debate over the physician workforce is far from settled. Goodman, for one, has no plans to stop asking the questions raised by his experiences two decades ago in Colebrook. The difference is that now, they no longer seem quite so heretical.