

The Looming Doctor Shortage

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November 2011

Key Findings

1. The aging of the baby boomer generation, plus the 32 million people newly insured under the new federal health care law, will further strain our existing provider network.
2. The government has imposed central planning on both the demand and the supply side of our health care system.
3. The government-planned, third-party payment system has created ingrained market distortion and has caused an excessive demand in health care.
4. For years the government has controlled the number of medical schools, the number of graduates from these schools and their licensure.
5. Supply and demand of health care can only be successfully determined by patients in an open market.

Introduction

It's the year 2020. A retired couple moves to Washington state and cannot find a doctor who has time to see new Medicare patients. A poor family enrolls in Medicaid health insurance, but cannot find a primary care physician who can fit new patients into her busy schedule. A worker in rural Washington state has excellent private health insurance, but must drive hundreds of miles to receive medical care.

Are these scenarios possible or even probable?

The United States in general and Washington state in particular are facing a severe doctor shortage in the next 10 to 15 years. Not only is the population growing, but the baby boomer generation is aging and will require more medical services in the near future.

Also, the new federal health care law, the Patient Protection and Affordable Care Act, will give health insurance to 30 million previously uninsured people over the next few years. These millions of newly insured patients will further burden our stretched provider network.

This paper explores the reasons we face an impending doctor shortage and offers recommendations for correcting the supply and demand imbalance in our health care system.

History of Physician Education in the United States

The American Medical Association (AMA) was formed in the mid-19th century to represent physician concerns in the United States. In 1904, the AMA created the Council on Medical Education (CME) to set standards for medical training. Up to that point, medical education in the U.S. had no uniform curriculum. School quality ranged from an excellent, formal education all the way to diploma mills that provided very little training in how to practice medicine.

The CME recruited the Carnegie Foundation to review existing medical schools and to make recommendations for improving quality. The results were published in 1910 and became known as the Flexner Report, named for the lead author.¹ The Flexner Report standardized medical education, but as quality improved, so did the cost of training doctors. The report recommended state oversight of medical schools. State legislatures were then placed in charge of

¹ "Medical Education in the United States and Canada A Report to the Carnegie Foundation for the Advancement of Teaching," by Abraham Flexner, The Carnegie Foundation for the Advancement of Teaching, 1910, online at www.ia600308.us.archive.org/22/items/medicaleducation00flexiala.pdf.

building new schools and the state also had the authority to regulate school class size.

Prior to 1905, there were 161 medical schools in the U.S. producing about 5,400 graduates a year. By 1922, the number had decreased to 81 schools turning out just 3,000 doctors annually. The number of schools dropped further to 66 in 1935, although class enrollment increased again to 5,400 students graduating as doctors.²

Controversy about the necessary number of medical graduates raged during the 1930s and early 1940s. The federal Committee on the Costs of Medical Education believed there were too few graduates, whereas the Commission on Medical Education felt there were too many new doctors coming out of school. The AMA opposed any new medical schools.³ From 1945 to 1956, the number of graduates expanded to 8,250 per year although only two new schools were built.

In 1959, the federal government issued a study, The Bane Report, which recommended increasing the number of medical schools and using federal taxpayer subsidies to assist the building and management of the schools. The federal government gradually increased funding for new and existing schools. The AMA continued to oppose the building of new institutions.

By 1965, however, with the passage of Medicare and Medicaid, medical educators, organized medicine and politicians struggled with a looming doctor shortage. Consequently, medical school output was doubled from 1965 to 1980 when 18,200 students graduated. A total of 44 new traditional, allopathic medical schools, plus 10 osteopathic schools were constructed from 1960 to 1980, the first major increase since 1920.⁴

In 1976, the federal government declared the doctor shortage was over and by 1979 there were reports of a “doctor glut.” Yearly medical school output has essentially been flat for the past thirty years, even though the U.S. population increased 37 percent over the same period.

The Number of Doctors Today

There are now 129 accredited allopathic, or traditional, medical schools in the U.S. The country also has 25 accredited osteopathic schools that combine traditional medical education with advanced study of the musculoskeletal system. Every student must pass the United States Medical License Examination after graduating and all states require separate licensing with variable reciprocity. According to the U.S. Bureau of Labor Statistics, 661,400 physicians were in practice in 2008, the latest year available; 32% were in primary care specialties (internal medicine, family practice and general practice) and 10% were in pediatrics.⁵

In 2010, there were 27.7 doctors per 10,000 people in the U.S. Washington’s numbers look about the same at 27.0 doctors per 10,000 people in the state.⁶ Medical schools graduated 16,838 students nationally in 2010 and the University of Washington, our state’s only allopathic medical school, graduated

² “Medical Schools and Their Applicants: An Analysis,” by Richard A. Cooper, *Health Affairs*, 22, no.4, (2003):71-84.

³ *Ibid.*

⁴ *Ibid.*

⁵ “Occupational Outlook Handbook, 2010-11 Edition,” Bureau of Labor Statistics, United States Department of Labor, 2010, at www.bls.gov/oco/.

⁶ “Professionally Active Physicians per 10,000 Civilian Population,” The Kaiser Family Foundation State HealthFacts.org, 2008, at www.statehealthfacts.org/comparemaptable.jsp?ind=934&cat=88.

169.⁷ Washington state has a new osteopathic school in Yakima that will graduate its first class of 75 students next year. Virtually all allopathic medical schools are affiliated with large research institutions.

According to the Association of American Medical Colleges (AAMC), there are currently 110,000 post-graduate residency positions in the U.S. Although Congress placed a limit on taxpayer funding in 1997, these residency hospitals rely heavily on federal taxpayer money. This money comes out of the Medicare program and last year totaled \$9.1 billion.⁸ Training programs that emphasize primary care are prioritized. The University of Washington realizes the importance of primary care, but does not require or encourage a prospective medical student to go into general or family practice.⁹

Many patients in the U.S. have access to care from doctor extenders, medical professionals in training who do not hold doctor licenses. Last year there were 75,000 physician assistants (PAs) in practice, with about 2,000 of them working in Washington state.¹⁰ Our country also had the services of 168,000 nurse practitioners (NPs), with 3,600 located in our state.¹¹

The supply of doctors is augmented by people from other countries coming to the U.S. to practice medicine. Last year almost 15% of all residency positions were filled by foreign medical graduates (FMGs).¹²

The Doctor Shortage

The Association of American Medical Colleges (AAMC) anticipates a shortage of 150,000 doctors in the next 15 years.¹³ Other sources predict a shortage of 200,000 doctors by 2025.¹⁴ The Bureau of Labor Statistics predicts a need for 145,000 new doctors by 2018.¹⁵ Washington state will potentially face a shortage of 3,000 to 4,000 doctors and 24,000 registered nurses over the next 10 to 15 years.¹⁶

In 2009, 18,000 students entered medical school in the United States. The AAMC is advocating for a 30% increase in medical school enrollment which would result in approximately 5,000 additional new physicians graduating each year.¹⁷

Population and policy trends show the U.S. is now facing a tsunami of health care demand. The baby boomer generation is reaching the age of high medical use. In addition, the new federal health care law will add millions of previously uninsured patients to our health care system. When increasing demand is not accompanied by increasing supply, access to health care will become a problem and waiting lists will become commonplace.

⁷ "Total Number of Medical School Graduates, 2010," The Kaiser Family Foundation, StateHealthFacts.org, at www.statehealthfacts.org/comparemaptable.jsp?ind=434&cat=8.

⁸ "Medical Schools Can't Keep Up," by Suzanne Sataline and Shirley S Wang, *The Wall Street Journal*, April 12, 2010.

⁹ "Understanding Admissions to UW Medical School," by Carol Teitz, MD, WSMA Reports, September, 2011.

¹⁰ "Projected Number of Physician Assistants in Clinical Practice, 2010," The Kaiser Family Foundation StateHealthFacts.org, at statehealthfacts.org/comparemaptable.jsp?ind=773&cat=8.

¹¹ "Total Nurse Practitioners, 2010," statehealthfacts.org, The Kaiser Family Foundation.

¹² Ibid No. 8.

¹³ Ibid No. 8.

¹⁴ Ibid No. 2.

¹⁵ Ibid No. 5.

¹⁶ "The Challenge," Health Work Force Institute, Washington State Hospital Association at www.hwfi.org/page.cfm?ID=challenge.

¹⁷ "Shortage of Doctors an Obstacle to Obama's Goals," by Robert Pear, *The New York Times*, April 26, 2009.

Surveys reveal that 86% of existing medical schools plan to increase enrollment.¹⁸ The AAMC found that 12 existing schools recently added 150 students and four new schools added a total of 190 students.¹⁹

The cost of a medical education is extremely high. Students at a public medical school pay, on average, \$49,000 per year for tuition, books, room and board. The average cost at a private medical school is now \$67,000. The median debt students have at graduation is \$150,000 at a public school and \$180,000 at a private institution.²⁰

The demographics of medical students are changing. In the past 30 years the number of women entering the medical field has increased dramatically. Many graduating classes now contain at least 50% women, a substantial increase from the 5 to 10% seen a generation ago. Women are more inclined to enter specialties with fixed hours and are more likely to take time off for child birth and care. The quality of students entering medical school is now as high as ever,²¹ but there are concerns that as the government encroaches more on health care through the Affordable Care Act, the best and brightest will seek other careers.

It is extremely expensive to build a new medical school. Texas did a recent study and found that a new school with a modest class size of 60 students (240 in four years) and a faculty of 170 would cost \$92.6 million over six years with a one-time capital cost of \$65 million.²²

Receiving the proper accreditation is also a problem. The Liaison Committee on Medical Education, sanctioned by the U.S. Department of Education and Congress, must approve any new medical school. The accrediting process takes, on average, eight years.²³

Policy Analysis

The advantage of a free market is that resources are constantly adjusted and balanced so that supply consistently equals demand. As demand fluctuates, supply will increase or contract to meet the market's needs. In health care, demand is set by the patients and supply is a function of the number of doctors and their availability. The government has imposed central planning on both the demand and the supply side of our health care system.

Starting in 1943, the federal government allowed employers to take a business income tax deduction for the costs of employee health benefits. Individuals, however, were not allowed to take this same tax deduction. This was the beginning of the U.S. employer-financed health insurance model. In 1965, Congress passed Medicare and Medicaid entitlements into law, which placed millions of people into government-financed health insurance. The U.S. now has a health care system in which 90% of the costs are paid by a disinterested third-party; either the employer or the government. It has become very rare for patients to take responsibility for the total cost of their own medical care.

¹⁸ "Medical School Enrollment Plans: Analysis of the 2007 AAMC Survey," aamc.org.

¹⁹ Ibid No. 13.

²⁰ "How Much Does Medical School Cost?," by Tara Kuther, Ph.D., About.com Guide, 2010.

²¹ Ibid. no. 9.

²² "Basic Steps to Establish a New Medical School," Texas Higher Education Coordinating Board, September, 2008 at www.theccb.state.tx.us/reports/PDF/1515.PDF?CFID=22430987&CFTOKEN=51275481.

²³ "Overview: Accreditation and the LCME," Liaison Committee on Medical Education at www.lcme.org/overview.htm.

This government-planned, third-party payment system has created ingrained market distortion and has caused an excessive demand in health care. After all, when someone else pays, there is no incentive for patients to question the price or quantity of services that are consumed in their care. Economic law says that in this situation, prices will soar and goods and services will be heavily overutilized.

For years the government has also controlled the number of medical schools, the number of graduates from these schools and their licensure. This has created a further distortion in the supply of health care. Government central planners are now even attempting to legislate not only the total number of doctors, but also the number of primary care physicians and the number of specialists in the country. This is as futile and absurd as the government telling people how many laptop versus desktop computers we need. No amount of information or analysis will enable central planners to know how many doctors, and of what type, the country needs.

Only through balanced market forces, ones that allow patients to control their own health care dollars, can the demand be correctly determined. The necessary and sufficient number of doctors each community needs can only be known through millions of routine, voluntary actions made in the free market.

Recommendations

The following recommendations can guide policymakers in making sure the nation produces a sufficient number of doctors to serve the needs of patients in the years ahead.

1. Allow the health care market, not central planners, to determine the number of doctors needed.
2. Remove employers and government (except for safety-net programs for the most needy) from health care financing and allow patients to control their own health care dollars:
 - Change the tax code
 - Encourage the use of high-deductible health insurance
 - Encourage the use of health savings accounts
 - Allow the interstate purchase of health insurance to increase competition
 - Means test Medicare
 - Allow seniors to opt out of Medicare without penalty and encourage a private insurance market for seniors
 - Use Medicaid for the truly poor
 - Implement voucher programs for Medicare and Medicaid enrollees so these patients can direct their own health care dollars and benefits
 - Allow state block grants for Medicaid
3. Allow independent medical schools without the mandatory high overhead of accompanying medical research.
4. Allow medical schools to determine their own enrollment and graduation numbers.
5. Encourage the use of long-term, low interest rate loans for medical students.

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6. Encourage the use of physician extenders — physician assistants and nurse practitioners — to make the delivery of quality health care more efficient.
7. Increase the use of well-trained foreign medical graduates and reduce their visa/immigration requirements.
8. Encourage the use of community scholarships for medical students with guaranteed commitments to service in the community after graduation.
9. Foster innovative health care delivery methods such as convenient walk-in clinics and personalized concierge practices.
10. Remove government from the licensing process and use private rating agencies or professional specialty organizations for competency determinations and to maintain physician quality.