Perspectives:
A Policy Analyst

by Robert J. Blendon

The essay by Robert Ebert and Eli Ginzberg is likely to arouse quite exceptional interest, both as an analysis of recent trends in medical education policies and as a statement of the attitude that the nation’s “medical establishment” might be wise to adopt in view of signs of a growing doctor surplus and a fall-off in applicants to medical school. Ebert and Ginzberg’s policy recommendations are not new. The proposal to substantially shorten the length of medical education appeared in both the Millis and Carnegie Commission reports, and the recommendation to reduce the future supply of physicians was the centerpiece of the Graduate Medical Education National Advisory Committee (GMENAC) study. What is significant is that two senior statesmen of the nation’s health and medical establishment are making these recommendations during a period of great uncertainty in medical academe about the future of medicine in this country.

The authors recognize that the nation’s medical educational enterprise has been very responsive to improvements in knowledge from the basic sciences and the availability of new technology and clinical treatments. But it has resisted changes growing from the broader problems facing the nation in the provision of medical care. Historically, faculty attitudes to reforms emerging from these concerns could be summarized by a quip from Bert Lance, President Carter’s budget director, “If it ain’t broke, don’t fix it!” Thus, it is the timing of this article that is of such great importance. For the first time since World War II, medical education looks to its faculties as if it might be “broken.”

What evidence supports such concern? First, applications to medical schools are declining, and the numbers of young people aged twenty to twenty-four are shrinking. The specter of plummeting medical school admissions can be seen through the prism of today’s experiences of dentistry and nursing. Second, surveys show 72 percent of physicians see

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an impending future surplus of physicians in their community, and nearly half (46 percent) feel it exists today. The concern of practicing physicians is mirrored in the academic health center, which sees its recent physician graduates setting up practices adjoining smaller community hospitals and establishing highly sophisticated subspecialty units that duplicate those of teaching centers. In many parts of the country, recent graduates are now reducing significantly the patient referral normally going to teaching hospitals.

**Public Opinion Of Medical Education**

Because of the state of anxiety within medical academe, the recommendations of Ebert and Ginzberg will exert a strong formative influence in the years ahead on the leadership of academic medicine and on private foundations, with their historical interest in advancing medical education. But how will these proposals be received by the larger society?

Looking with some uncertainty into the future suggests that in the 1990s, it will not be easy to garner public or governmental support for resolving these problems. If the oversupply of physicians and the decrease in medical school applicants are to be addressed, it will have to be by the efforts of medical school faculties themselves with the aid of private foundations. Federal policy will be dominated by the problems of a huge federal deficit, the lack of international competitiveness of U.S. industry, and a slowly growing economy, all of which will generate powerful pressures to reduce support to today's highly expensive academic medical institutions. Currently undergraduate and premedical education involve only a small role by the federal government. Financial pressures will dictate even less involvement in these complex issues in the years ahead.

In addition, there is not likely to be much consensus among the public or governmental leaders to limit the future numbers of doctors. Those who, like the authors, feel that it is a problem will point to three concerns: (1) medicine is the most heavily subsidized advanced professional training, and in periods of fiscal stringency, underwriting the educational costs of unneeded physicians is wasteful; (2) new physicians eventually may drive up the nation's health care costs by generating more services; and (3) the quality of care provided in medicine may deteriorate as increased "competition" leads some physicians to provide unnecessary tests, hospital admissions, and surgery as a means of compensating for a shortfall in patients.

On the other hand, an equal number of politicians and policy analysts will oppose limiting the supply of doctors, arguing that: (1) it is “unfair” if
qualified young people desiring to become doctors are not given a chance to pursue their chosen career, just as “qualified” young people are still able to pursue law, social work, or history as a life’s vocation regardless of “surpluses” in these fields; (2) reducing the output of medical schools may be “unfair” to underrepresented minority groups who tend to be admitted more readily to majority medical schools when more opportunities are available; (3) there may always be some communities in America that remain underserved by physicians and that clearly would benefit by more doctors; and (4) having more doctors might lead to lower physician fees and more convenient service.

The ambivalence among experts about government’s role in reducing the numbers of medical school graduates is not likely to be informed by public opinion. In 1986 more Americans thought there was a physician shortage (24 percent) than a surplus (14 percent), with 56 percent saying the numbers were about right.

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**Third-Party Payers’ Influence On Medical Education**

In the future, third-party payers likely will be more aggressive in attempting to influence the content and nature of graduate medical education through their reimbursement mechanisms, but their efforts may not support the proposed changes in undergraduate medical education. Clearly, the artificial division between undergraduate education under the auspices of the university and residency training as the responsibility of the teaching hospital is an intellectual anomaly. However, the salient fact is that graduate medical education is now an integral part of our modern hospital system, involving more than a thousand hospitals across the country and accounting for 30 percent of the nation’s general hospital beds. More than 60,000 postgraduate physicians now provide substantial amounts of care to millions of patients annually in teaching hospitals.

Because this activity involves billions of dollars from third-party payers, the pressures such payers exert on medical education will reflect efforts to reduce costs, perhaps by decreasing funding for training of high-cost subspecialties and increasing the opportunity for less expensive generalist training—policies that support the proposals by Ebert and Ginzberg. However, because financial concerns will predominate, third-party payers may be reluctant to involve universities or medical schools in their decisions. Moreover, in setting priorities, both government and private payers will place patient care concerns over educational ones, and will attempt to avoid disrupting existing patterns of care. In particular, public opinion will reinforce attention to preventing cutbacks in support for nonuniversity-related hospitals providing care in politically sensitive
inner-city and rural communities. Such concerns may hamper remedying a historical accident by merging undergraduate and graduate medical education under university direction into a more rational and educational approach.

**Physician Training**

From the perspective of policymakers and practicing physicians, the authors’ two central recommendations—shortening the length of physician training and reducing the output of American medical schools—will be seen as competing or inconsistent. Significantly reducing the current requirements for eleven or more years of training after high school would be an effective way to increase the applicant pool and keep the output from medical school from declining. No other single educational policy change would have as dramatic an effect in bringing forth applicants who, because of costs, pending family responsibilities, or reluctance to be a student into their thirties, do not now apply to medical school.

However, such a change runs counter to the concerns about a physician surplus. In the face of more easily implementable educational alternatives, this proposal likely will prove distinctly unpopular among practicing doctors. For example, a more drastic reduction of medical school class size would be seen as more appropriately addressing this problem, particularly if this were accompanied by a further reduction in training opportunities for foreign medical graduates, both American and from overseas. Few countervailing forces will emerge to this alternative in the 1990s, which are likely to be an era of “trade barriers” against all forms of foreign competition.

Second-guessing which of these competing goals will predominate is hazardous. While a surplus of physicians would appear to be the major concern, previously uninterpreted events may alter that assessment dramatically. There is at least one such “wild card” that has gained recent salience. If the United States should adopt a universal health insurance program, the subsequent increased demand for care would eliminate our “physician surplus” and shift the direction of concern about medical education. The unmet health care needs of 35 million uninsured Americans, and another 15 to 20 million people who are underinsured, easily could absorb the time and professional energies of the nation’s future physician supply. Adopting a universal health insurance program, coupled with sharply reducing the inflow of foreign-trained physicians, would eliminate the perception of general physician surplus. This would occur without the need to either reduce the current output of the nation’s medical schools or shorten the length of training. Obviously, this would
not end the current imbalance between generalist physicians and subspecialists, but it might make it more attractive for young people once again to apply to medical school. In the future, if the leaders of academic medicine are not comfortable with the difficult choices being proposed by Ebert and Ginzberg, they might consider becoming major public advocates for the uninsured who need medical care. It would have both an altruistic and practical benefit for them.

In closing, it seems that cost pressures and perceived medical care needs will be the dominant forces shaping the nation’s ultimate response to the proposals for medical education reform included within this thoughtful article. However, within academic medicine, these significant recommendations could be an important guidepost for helping to shape the future of medical education through intelligent action.