Missing: A National Medical Manpower Policy

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GENERALISM IS IN RETREAT IN AMERICAN MEDICAL practice. Currently, approximately one-third of American physicians practice family medicine, general internal medicine, or general pediatrics. This figure represents a considerable downward trend from previous years and, in light of the growing reluctance of medical students to select primary care disciplines, promises to fall further in the future (Politzer et al. 1991; Colwell 1992). These circumstances appear at the end of a period characterized by the spectacular growth of medical technology, the absence of successful medical cost-containment strategies, and the lack of a national health manpower policy. In this environment it is not hard to see why physicians and medical students have migrated toward specialty practice. Money and hi-tech prestige are to be found, preferentially, in the specialty sector.

The logical conclusion of this trend would be a future much like the past, with few remedies for the specialty demographics of medicine. Is this a likely scenario?

There are important signs that elements in the health care environment are changing. Health care reform is an important item on the

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short list of policy issues for all 1992 presidential candidates. In most cases these politicians and their advisers envision a system built on a stronger generalist base. The managed care movement is a heavy user of primary care physicians and its expansion will increase the need for medical generalists (Weiner 1991). The business community, which is clearly concerned about health care costs, has expressed interest in primary care systems (Kenney 1992). The Health Care Financing Administration (HCFA) has recently implemented the Resource Based Relative Value Scale (RBRVS), designed to increase payments to generalist physicians and to lower fees for procedure-oriented practitioners. The Johnson, Kellogg, and Pew foundations all have major programs underway intended to promote primary care medical education (Sandy 1992; Kellogg Foundation 1991; Pew Health Professions Commission 1991). Finally, the Council on Graduate Medical Education (COGME) has recently endorsed a national goal of training 50 percent of our medical graduates as generalist physicians (Council on Graduate Medical Education 1992). The opinions of leaders in public policy, medical education, medical care, business, finance, and philanthropy are converging on the conclusion that a major redirection in medical manpower policy is required in the United States.

Changing Course

If one contends, then, that a consensus is emerging that favors augmenting the generalist component of medical education and practice, the tough question that arises is, How? Well-intentioned people on all sides of this issue claim powerlessness when faced with the dual problems of the current systems of undergraduate and graduate medical education and adverse practice incentives. Medical schools blame the power of specialty departments and the deans' inability to control residency training. Residency program directors cite student choices, hospital directors speak of clinical staffing needs, students complain of debts, and residents mention lifestyle requirements. Everyone thinks that someone else should fix the problem.

Acknowledging this crossfire of complaints, I offer my analysis of the problem and propose a strategy to solve it.

At the outset, we must agree that practice income is an important real *and* symbolic factor in career decision making for physicians, as for

all workers. The most thoughtful and even well financed redirecting of medical education toward primary care will be undone by a system of practice reimbursement that does not provide equitable compensation for the generalist practitioner. If the seed of reimbursement parity planted by the RBRVS reforms fails to engender broad public and private sector primary care pay equity, efforts to reform medical education in favor of generalism will have little impact.

The main factor within American medical education that undermines any major agenda for augmenting generalist training is its two-story nature. Medical schools resemble the many large apartments that make up the ground floor of an enormous building, with the residency programs occupying the small and numerous rooms constructed above them. From a manpower policy point of view, the problem is that multiple landlords control the various apartments, leading to an unpredictable and irregular pattern of building stewardship. In fact, there are 141 schools of allopathic and osteopathic medicine and more than 1,500 teaching hospitals that provide residency training. Although all medical schools sponsor programs of graduate medical education, the preponderance of residency positions is in teaching hospitals not immediately governed by medical schools.

The relatively straightforward process of medical school accreditation and quality control administered by the Liaison Committee on Medical Education (LCME) becomes far more complex on the graduate level. The Accreditation Council for Graduate Medical Education, the 24 residency review committees, the 23 specialty boards, the American Board of Medical Specialties, and the Educational Commission for Foreign Medical Graduates all play roles in policy making, accreditation, and certification in the various upstairs rooms of graduate medical education.

Although this system has evolved for good and documented reasons, its current complexity and lack of coordination render it virtually immune to coordinated redirection—regardless of the source or purpose. Deans and undergraduate medical educators can reasonably take credit (and bear a responsibility) for their graduating senior medical students' patterns of residency selection. However, they have little or no control over the ensuing years of graduate medical education that principally shape the eventual patterns of national medical practice. To borrow a concept from economics, the marketplace of medical education lacks discipline. Undergraduate and graduate medical education are *dys*-articulated so that no one is able to establish clear policy direction for any-

thing other than a limited element within the system. Producing complex, costly, important human products such as automobiles, military officers, or professional athletes from such a poorly coordinated system would be inconceivable. Until undergraduate and graduate medical education are bound together more effectively, course corrections of any planned nature will not be possible.

The Landlord Question

If dysarticulation is the problem, what is the solution?

The solution is to reduce the number of landlords in this two-story building to a workable number so they can serve both as executors of public policy and as leaders in medical education. In addition, regularized, vertical integration of the medical schools on the ground floor and the graduate teaching programs above must be initiated. This reorganization might take many forms. A simple and workable one would be to establish a series of medical education consortia, each consisting of a medical school and a series of affiliated teaching hospitals and programs within one geographical area. This reorganization would produce a tenfold reduction in the number of focal points in financing medical education, effectively reducing the "landlords" from 1,500-plus to less than 150.

With the house of medical education now vertically integrated into a manageable number of units, we turn to the question of manpower policy. If the national objective was for 50 percent of physicians entering practice to be in generalist disciplines, this goal could be set for each consortium. A phase-in period would allow time for each medical school to coordinate with its associated teaching hospitals, for university hospital medical educators to negotiate with their colleagues in community hospitals, for tertiary care programs to coordinate with ambulatory care sites, and for the entire organization to develop a coordinated plan to recalibrate its residency output.

The incentive for the consortia to undertake this educational retooling would come from the public financing provided to the institutions within each consortium. For medical schools and teaching hospitals to remain eligible for these funds, they would have to join a consortium. Once in a consortium, they would either meet the residency output goals established as a part of a national policy or would receive signifi-

cantly discounted federal funding. Direct and indirect medical education allowances for Medicare, totaling an estimated $5.1 billion in 1992, are the largest source of federal funds that could be targeted to support this strategy. Health Professions Educational Assistance Act (title VII) funds, National Institutes of Health indirect cost payments to grant recipients, and funds for eligible applicants to the Department of Veterans Affairs' graduate medical education and to research and demonstration funding are other federal funds that could be tapped. The principle underlying this approach would be macromanagement. The consortia would be required to meet only the performance standard as measured by the practices of physicians trained at their member institutions in "PGY-4" – the fourth year following medical school graduation. The medical schools and their collaborating hospitals would handle the administrative and educational modifications needed to achieve this goal. Selection of inter- or intrainstitutional initiatives (including admissions policy, undergraduate curricular change, faculty appointments, residency selection criteria, and staffing of residency slots) would be the responsibility of each consortium.

Although some might feel that this strategy trespasses inappropriately on the traditional domains of medical education and hospital administration, my reply would be that this sort of gentle, but firm, intrusiveness will be necessary to gain control of currently operating systems of medical education. Without focusing and aligning institutional interest and national policy, no major redirection of the system will be possible.

This concept, in fact, would lend plausibility to the development and implementation of a national medical manpower policy. Absent a reform of this nature, I cannot envision how even the most articulate discourses and the best intentions will lead us to succeed in charting a course for medical education and manpower in this country.

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