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Provider Supply Series: GMENAC: The Start of Supply Regulation

Government agencies and physicians have long attempted to understand and make predictions regarding the supply of, and demand for, the U.S. healthcare workforce. While the first workforce survey was conducted in 1819 by Dr. Samuel Bard, Dean of the Columbia School of Medicine, the *Flexner Report*, published in 1910, detailed the existing healthcare workforce as part of a recommendation to restructure the U.S. medical education system.[1] From the 1920s through the late 1930s, the existence of a physician shortage was understood among primarily solo practitioners.[2] In the post-war period, many physicians returning from military service utilized the G.I. Bill for financial support to pursue specialization via residency programs. In this period, the number of medical schools and their respective class sizes were increased in order to supplement the number of practicing physicians in the country.[3] Despite these measures, a physician shortage continued into the late 1960s, resulting in numerous health commissions which were limited in scope and purpose, and consequently unsuccessful in posing solutions to the problem.[4] In 1966, the Surgeon General lamented a lack of physicians stating, "*We shall never have all the physician manpower we need*."[5]

However, the trend of a perceived physician shortage was reversed in the decade from 1970 to 1980, as the ratio of actively practicing doctors to patients increased by 50 percent.[6] This increased physician-to-patient ratio led to concerns over quality of care and cost-effectiveness, which, in turn, caused the creation of a government committee to evaluate physician distribution. The Graduate Medical Education National Advisory Committee (GMENAC) first chartered in April 1976 and later extended through September 1980[7] was tasked with the mission to "*analyze the distribution among specialties of physicians and medical students and to evaluate alternative approaches to ensure an appropriate balance,*" as well as to "*encourage bodies controlling the number, types, and geographic location of graduate training positions to provide leadership in achieving the recommended balance*."[8]

The GMENAC's efforts produced seven volumes of recommendations regarding physician manpower requirements.[9] Through the development of several models the number of future physicians that would be needed by different subspecialties to achieve "*a better balance of physicians*" was determined.[10] Using these models, the GMENAC predicted that there would be a significant surplus of 70,000 physicians by 1990 and an oversupply of 150,000 doctors by 2000.[11] In order to counter this growth, the U.S. government halted its past expansionary policies towards the physician sector. Specifically, the *Summary Report of the GMENAC to the Secretary, Department of Health and Human Services* recommended that medical schools reduce the size of their entering classes by 17 percent and prevent the rise in the number of non-physician healthcare providers, such as nurse practitioners and physician assistants.[12]

The GMENAC report based its model on several key assumptions. The report assumed that a surplus of physicians is an undesirable situation and that physicians will have the same work load and procedures in the future as they have today.[13] Moreover, the accuracy of the report's projections was dependent on the assumption that it is possible to create an accurate computer model of physician manpower.[14] Critics of the GMENAC report noted this, stating that, the GMENAC modeling panel failed to predict the rise of cesarean sections, as well as, the increase in organ transplantations due to new technology.[15] In 1980, the existence of AIDS had also not been recognized and the significant additional costs of care the disease imposed on several medical specialties were therefore not included.[16] The combined effect of these relatively small, yet unanticipated, changes may have been large enough that the entire model should be discounted as an inaccurate prediction.

In response to the GMENAC model's recommendations, U.S. medical schools adjusted their enrollment of students, causing a significant shift in the supply of new physicians going into the 21st century. This series will examine the various effects of GMENAC, and related events, on the healthcare workforce and consider the current perceived physician, particularly in light of the growing demand for healthcare services.

1 "Great expectations: the 21st century health workforce" By G.F. Sheldon, The American Journal of Surgery, 2003, p. 36-37.
2 Ibid.
3 Ibid.
4 "Summary Report of the Graduate Medical Educational National

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Advisory Committee to the Secretary, Department of Health and Human Services" U.S Government Printing, Vol. 1, (1981). p. 54.
5 "How Many Doctors are Enough?" By J.E. Harris, Health Affairs, Vol. 5, no. 4 (1986). p.74.
6 Ibid.
7 "Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services." U.S Government Printing, Vol. VII, (1981). p. 5
8 Ibid., p. 73
9 Ibid., p. 5
10 "GMENAC: Its Manpower Forecasting Framework" By D.R. McNutt, American Journal of Public Health, Vol. 71, (1981) p. 1119
11 "Projecting Physician Requirements for Child Health Care-1990" By B.C. Morgan, American Academy of Pediatrics, Vol. 69, no. 2,(2001), p. 156
12 HHS "Summary Report of the Graduate Medical Educational National Advisory Committee to the Secretary, Department of Health and Human Services," p. 115.
13 "An Analysis of the Report of the Graduate Medical Education National Advisory Committee", California Post-Secondary Education Commission, (1982), p. 7.
14 Ibid.
15 J.E. Harris, Health Affairs, 1986, p. 77-78.
16 Ibid.

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