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Provider Supply Series: The Aftermath of GMENAC

In the previous article of the HC Topics *Provider Supply Series*, the Graduate Medical Education National Advisory Committee (GMENAC) recommendations, published in 1980, to reduce the size of medical schools' entering classes in order to counter a projected *oversupply of physicians* in the healthcare market were discussed. These recommendations were supported by subsequent studies by the U.S. Bureau of Health Professions and the American Medical Association (AMA).[1] The second article in this series discusses the after effects of the GMENAC report, including the implications of decreased federal funding for medical education and the resulting reduction in medical student enrollments.[2]

Immediately after GMENAC's recommendations were released, many healthcare associations published negative reactions to the report, including the AMA and the American Academy of Pediatrics. The American College of Surgeons stated that *"The basic assumption behind GMENAC- that physician requirements can be predicted 10 years in advance- must be challenged. The many unquantifiable variables and the rapidly changing environment preclude making estimates with any degree of confidence."*[3] Despite these and other protestations, policy makers implemented many of the report's suggestions.

The physician "*oversupply"* was generally viewed by policy makers and the public as a state of unsustainable imbalance. Throughout the 1980s, policymakers were concerned that *"unchecked growth in the US physician-to-population ratio may undermine other efforts to bring healthcare costs under control."*[4] It was also thought that the growth of the physician supply would lead to unnecessary utilization of physicians by patients.[5] Analyses conducted of directors of residency admissions revealed that their perceptions regarding the potential future surplus of physicians significantly influenced their decisions to restrict the size of their programs.[6] Overall, the perception of a physician oversupply caught the public's attention and achieved broad acceptance in the 1980s leading to wide-ranging cuts in funding to medical education.

A number of policies were enacted in the mid-1980s by the Reagan Administration to stem the projected growth in the number of physicians. *The Budget Reconciliation Act of 1986* limited both direct and indirect payments to medical education and decreased reimbursement for subspecialty training.[7] The *Physician Payment Review Commission*, formed in 1986 to advise Congress on Medicare payments to physicians, also developed a policy to limit the size of residency programs and shift physician ratios to favor generalists.[8]

In contrast, policy makers also recognized the increasing demand for general practitioners that was attributed to the growing elderly population, as well as research and treatment demands for people afflicted with AIDS (a disease that first appeared in the early 1980s).[9] It also became apparent that the physician workforce was skewed to favor specialists. By the early 1990s, more than 70 percent of all physicians were specialists. In comparison, most European countries had a percentage of specialists in the physician workforce between 25 to 50 percent.[10] The smaller proportion of new and existing primary care physicians compared to specialists may have been caused by various factors, including dissatisfaction among practicing physicians caused by lower incomes and larger administrative burdens, as well as values and biases regarding specialties within the healthcare profession.[11] During the 1980s and early 1990s governmental policies attempted to address the growing deficit of primary care providers, while concurrently decreasing the number of physicians overall. These contradictory aims and the absence of a concrete governmental policy led to the unsuccessful re-alignment of the physician population.

By the early 1990s, physicians and policy makers were already beginning to call into question their previously confident predictions regarding a potential oversupply of the physician workforce. Although the previous decade did experience a large growth in physician supply, as predicted, physician distributions in certain specialties and geographic areas did not change accordingly. Further, the time physicians allocated to each patient care session rose faster than the supply of physicians, which caused a steep increase in demand without simultaneous increases in the number of graduating medical students.[12] Shortages continued to be reported in the fields of primary care, pediatrics and internal medicine throughout the 1980s and 1990s.[13]

By the mid-1990s it was apparent that reactions to GMENAC's predictions of a physician oversupply had led to a shortage. This realization was accompanied by a noticeable shift in public perceptions to concerns

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regarding an undersupply of primary care providers. Though the beginnings of a primary care shortage were becoming apparent in the 1980s and 1990s, it was overshadowed by the pervasive public perception of a physician oversupply. HC Topics *Provider Supply Series'* next segment will explore the modern realities concerning physician supply from the late 1990s to today and discuss drivers of the current perceived physician shortage.

1 "Foreign Medical graduates and U.S. physician supply: old issues and new questions" By Stephen S. Mick, Health Policy, Vol. 24, 1993. p. 213.
2 "National Study of Internal Medicine Manpower" By Lu Ann Aday et al., Archives of Internal Medicine, Vol. 148, 1988, p. 1509.
3 "Perspectives on The GMENAC Report" By Marjorie Bowman and William Walsh, Health Affairs, Vol. 1, no.4, 1982, p. 60.
4 "Reforming Graduate Medical Education: Summary Report of the Physician Payment Review Commission" By Anne Schwartz, Paul Ginsburg and Lauren LeRoy, JAMA, Vol. 27, no.9, 1993, p. 1079.
5 "Physician Manpower: GMENAC and Afterwards" By Itzhak Jacoby, Public Health Reports, Vol. 96, no. 4, 1981, p. 302.
6 Lu Ann Aday et,1988, p. 1510.
7 Ibid.
8 Anne Schwartz, 1993
9 "Foreign Medical Graduates and U.S. Physician Supply: Old Issues and New Questions" By Stephen S. Mick, Health Policy, Vol. 24, 1993, p. 221.
10 "Physician supply and the U.S. medical marketplace" By Steven Schroeder, Health Affairs, Vol. 11, no. 1, 1992, p. 235.
11 Ibid, p. 239.
13 Stephen S. Mick, 1993. p. 220.
14 Ibid, p. 222.

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