Strengthening the Health Workforce Through Policy and Planning

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Invest in Health Workforce Policy That Has Works...

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What are the desirable outcomes of investing in the medical workforce?

- **Access:**
  to care when it is wanted and needed.
- **Quality:**
  Care that is technically excellent and personally compassionate.
- **Outcomes:**
  Care that improves the health and well being of patients and populations.
- **Costs:**
  Care that is affordable to the patient and to society.

If we agree on the desirable outcomes...

Then the question is:

What are the most effective and efficient ways to achieve these ends?

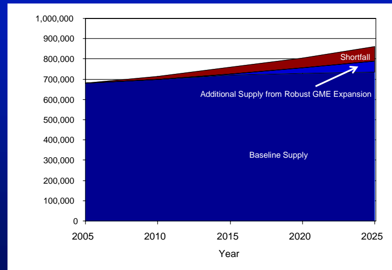
Health Workforce Investments that Work... Improve what doctors and nurses do:

- Reimburse fairly for primary care centered care.
- Reward effective and efficient care.
- Implement the U.S. Preventive Services Task Force recommendations: evidenced-based medicine.
- Increase implementation of Cochrane Collaboration recommendations: evidenced-based medicine.

Is there evidence that access, quality, and outcomes are sensitive to physician supply, per se?

If so, we should increase training rates.
If not, we should invest in what works.

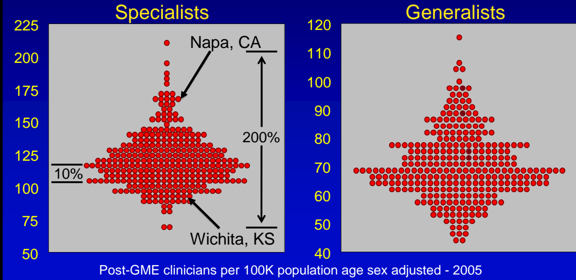
AAMC Projected National Supply & Shortfall of Physicians with GME Expansion



How large is the shortfall?

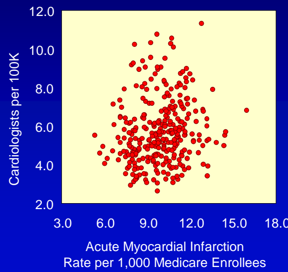
Source: Salsberg. International Medical Workforce Meeting. 2008.

The Per Capita Supply of Physicians Varies ~200% Across 306 Dartmouth Atlas Regions



Post-GME clinicians per 100K population age sex adjusted - 2005

Finding 1: Physicians do not settle where needs are greater.



There is virtually no relationship between regional physician supply and health needs.

Source: Wennberg, et al. *Dartmouth Cardiovascular Atlas*

So what?

Despite the idiosyncratic location of physicians...

maybe more physicians in an area leads to better health outcomes.

Finding 2: With Similar Outcomes, Many Health Care Systems Deliver Care with Far Fewer Physicians

		Last 6 months of life		
	Mean Age	Physician FTEs	Primary Care FTEs	Medical Specialists FTEs
NYU Medical Center	82	28.3	8.8	15.0
RWJ University Hospital (NJ)	80	19.8	4.3	12.2
Montefiore Med Center (NY)	83	16.5	6.5	7.1
MA General Hospital	80	15.3	6.3	5.5
Johns Hopkins Hospital	77	12.2	5.0	3.9
Yale-New Haven	82	10.6	3.4	4.4
UC, San Francisco	81	9.4	4.7	3.2
Mayo, Rochester MN	81	8.9	3.0	3.9
Strong Memor., Rochester,NY	81	8.1	3.8	2.4

Among Medicare Cohorts
(Full Time Equivalents per 1,000 beneficiaries)

Source: Goodman, Wennberg, Chang, Health Affairs,March/April 2006.

Finding 3: Technical Quality and Patient Satisfaction is Not Necessarily Better with More Physicians

	Physicians Per Capita		
	Lowest Quintile	Highest Quintile	Ratio highest to lowest
Total physicians per capita by Hospital Referral Regions (2005)	169.4	271.8	1.60
CMS Compare Composite Scores (2005)			
Acute myocardial infarction	91.0	93.1	1.02
Congestive heart failure	84.1	88.6	1.05
Pneumonia	79.5	79.2	1.00

Goodman DC, Fisher ES. New England J Med, 2008.

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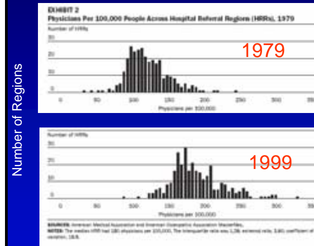
Medicare access and satisfaction (2005)			
Ever had a problem and didn't see a doctor? (% No)	91.7	93.2	1.02
Do you have a particular place for medical care? (% Yes)	95.0	95.5	1.01
Satisfied with ease of getting to the doctor? (% Yes)	94.9	94.7	1.00
Satisfied with doctor's concern for overall health? (% Yes)	95.5	95.7	1.00
Satisfied with quality of medical care? (% Yes)	96.7	97.0	1.00

Goodman DC, Fisher ES. New England J Med, 2008.

Finding 4: Physicians Continue to Settle Where Supply is Already High



Number of Atlas Regions by Physicians per 100,000 population

For every physician that settled in a low supply region, 4 physicians settled in a high supply region.

These are the regions associated with lower quality and higher costs.

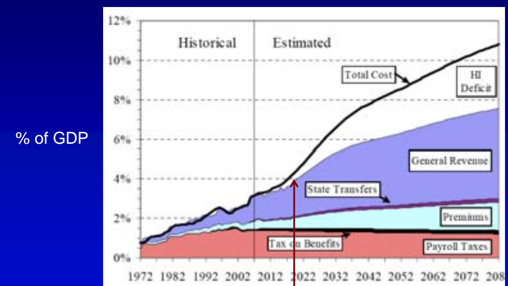
Source: Goodman. Health Affairs, 2004.

Don't COGME, AAMC, and others project substantial increases in "demand" for physician services?

What is meant by demand?
Is "demand" for health care like demand for autos or wheat or corn?

A National Nightmare of "Demand"

Medicare Costs and Non-Interest Income by Source as a Percent of GDP



2019 Part A trust fund goes broke
Part B and D premiums soar

What about the costs of expanding medical schools and removing the Medicare GME funding cap?

No published estimates...

probably an additional $5-10 billion per annum in training costs.
(NIH ~ $28 billion; CDC ~ $8 billion)

Health Workforce Policy that Works

- Workforce planning in the U.S. lacks coordination and depends on the individual decisions of hundreds of teaching hospitals.
  - *Public funds requires public accountability - establish a national workforce commission.*
- Health care systems are adaptable to varying levels of physician supply with comparable outcomes.
- Expansion of physician training will be costly, and could exacerbate many of our current health care ills.
  - *Physician training resources should be held constant, with incentive towards greater training of primary care physicians.*
- New health care investments should be based on the evidence that the funds will improve access, quality, outcomes, and efficiency.
  - *Invest to improve in what doctors and nurses do.*

Discussion

- Please identify yourself and your affiliation.
- Keep your question or comment brief.
- We’ll keep our comments focused and brief.