A Review Essay

Health Manpower and Government Planning

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LAST SEPTEMBER, the secretary of the Department of Health and Human Services received an imposing volume with an even more imposing name: the *Report of the Graduate Medical Education National Advisory Committee to the Secretary.* GMENAC had been created by HHS's predecessor department in 1976 to examine medical manpower issues, and its report projected the supply of and demand for medical manpower through the year 2000. But the issues raised by the study go beyond those of forecasting. In effect, the study poses the question of how far we should allow central government planning to replace individual choice in medical care.

There were two ways for the committee to approach its task. The more modest approach would have been simply to forecast future supply and demand conditions for medical manpower so as to permit policy makers to consider alternatives in a more informed manner. This would have recognized that final policy judgments necessarily depend on more than mere projections of the future. Unfortunately, the authors of the GMENAC report were more ambitious, and chose the other course. They decided not merely to project market conditions, but also to call for specific policies, concluding —at least implicitly—that policy decisions could proceed from such projections alone.

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An Exercise in Government Planning

The authors adopted a characteristic form of government planning. First, they projected future supplies of available resources—in this case, medical manpower—and future levels of demand, represented as "requirements." With those projections in hand, it was a simple matter to detect any impending imbalance between supply and demand, for medical manpower as a whole and for each specialty. They then proceeded to suggest various ways to expand the output of physicians in specialties where they expected shortages and restrict it where they expected surpluses. Since they considered the demand to be "required," they made all the adjustments on the supply side.

When medical resources are allocated according to government plans, prices and financial incentives have no equilibrating function. Prices serve merely to compensate those who provide medical services. Both supply and demand are deemed to be fully determined by technological and demographic factors. Any imbalance can therefore be rectified only by government action.

Even more characteristic of planning documents, the GMENAC report substitutes the preferences of planners for those of consumers. To be sure, it refers to the "required number" of physicians and the health needs of society—but as determined by collective rather than individual decisions. The committee assembled panels of experts for each specialty and subspecialty and asked them to set "desired" levels of medical services specifically "without regard to economic barriers to care." Each accident or illness, the report assumed, requires a specific amount of care that can be determined on a scientific or technical basis and that should be provided, no matter what the cost might be. Any additional care constitutes sheer waste, and should be actively discouraged. The report avoided any attempt to assess the added benefit from a small amount more of a particular service and compare it with the corresponding benefit of various alternatives—for example, professional care versus drugs or medical equip-

ment. In short, the authors ignored individual preferences for more, less, or different care. They took the view that it is the preferences of medical authorities that count.

Clearly the rationale is that individual patients do not know enough about medicine to decide how much care they require. That individual patients are less informed about the effectiveness of medical care is of course correct. But that is not to say that patients in consultation with their own physicians would not express their own preferences better than an elite group of medical authorities acting alone. Such differences are especially likely since factors beyond the purely technical inevitably intrude into consumer decision making. As Victor Fuchs emphasized in his book *Who Shall Live?* (1974), patients frequently purchase medical services as much for "caring" as for "curing"—and who is to say that the former considerations are not as important as the latter?

Whatever else might be said of planning, it is very difficult to carry out since, among other things, it is not easy to foresee the future. Fifteen years ago, for instance, many believed we faced a doctor shortage, but now the best projections available indicate just the opposite. And there is no indication that the GMENAC planners have mastered the techniques of prophecy any better than the rest of us.

The problem is compounded by the rapid technological change that now characterizes the medical field. To forecast the demand for medical specialties, the GMENAC study necessarily had to forecast the future effects of scientific discovery on medical practice. Some diseases may require more or fewer services as new diagnostic tools and therapies are developed, and new services may be more or less physician-intensive. For example, the discovery of potent tranquilizers substantially decreased the amount of hospital care required for certain patients, while the development of new surgical techniques increased the hospital care required for others.

Given the skepticism that must apply to all such forecasting, it is hardly surprising that the authors of the GMENAC report tempered their policy prescriptions with a moderation not founded on their projections. But in doing so they departed from the implications of their own analysis, and thus inevitably invited the charge that they had been subject to "political influence." What factors, one might ask, determined which of their policy judgments rested on their projections and which did not? Planning models rarely encompass all of the factors that policy makers wish to take into account. But to the extent that the omitted factors become important, the planning process loses its claim to objectivity and becomes ensnarled with the tug and pull of conflicting interests.

The Recommendations

The report projected an "aggregate oversupply" of medical personnel as well as "imbalances" among various medical specialties. It accordingly proposed "to decrease the number of medical graduates, to restrict the entry of foreign medical graduates in the United States, and to change the mix in residency positions." Inconveniently enough, the specialty with the largest projected shortage, general psychiatry, has been heavily dependent on foreign medical graduates in the past. On the other hand, the specialties of general surgery and cardiology have such large projected surpluses that supply and demand cannot be balanced even if all production of these specialists stops for several years.

In fact, the GMENAC panel admitted that to achieve a balance in each specialty as well as overall, the apparent solution "would be to close several U.S. medical schools and expand

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immigration of FMGs [foreign medical graduates]." But that would be "irresponsible" and "frivolous." So they recommended instead that no specialty increase or decrease its number of trainees by more than 20 percent by 1986. Moreover, they recommended that the number of foreign medical graduates be reduced, shortage or no shortage. These recommendations cast doubt on the overall validity of the model, for if the model is sound, how can its logical implications be irresponsible and frivolous?

The authors make other recommendations that do not follow from their analysis. Although they project a small surplus in the three pri-

mary-care fields of general pediatrics, general internal medicine, and family medicine, the report calls for increased manpower in these fields. Primary care is apparently popular in planning circles, and the report duly called for more. Even the American College of Surgeons complained that this recommendation stemmed from "preconceived political considerations."

A major premise of the GMENAC study was that surpluses of medical personnel, unlike surpluses of other goods and services, actually drive costs up. The extra doctors press their superfluous services on their patients, who pass the bills along to third-party reimbursers. And there is no countervailing drop in the salaries or fees of individual doctors, since these salaries and fees do not respond to such marketplace considerations as competition for patients.

Whatever support there may be for this line of analysis, it surely is not enough to justify the anticompetitive prescriptions found in the report. An example of such a prescription is the authors' treatment of nonphysician health providers. In recent years the supply of these providers has been expanded, largely as a means of limiting medical costs. Increasing the use of nurse practitioners, physician assistants, and nurse midwives instead of physicians for certain tasks might well reduce the cost of health care with no loss in quality. But the authors of the report are alarmed at this trend, fearing that it might exacerbate the impending medical surplus. They found that "the numbers of nurse practitioners, physician assistants and midwives will more than double by 1990" and suggested that "the growth rates of these professions be closely monitored in the future. . . ." Although they state this recommendation cautiously, there is a clear implication that something may need to be done—such as limiting the numbers of auxiliary professionals who are trained. Nowhere is there mention of any prospective gains to patients from permitting these professionals to compete with physicians and offer a choice of both services and prices.

What if Not Planning?

The primary issue is not the GMENAC report itself, but rather our commitment to market processes in medical care. Rejecting the report's recommendations does not imply that the current patterns of medical care result directly from the preferences of producers or consumers. Past health policies have affected incentives for all concerned. Favorable tax treatment of health insurance has stimulated the demand for medical care, and thus increased private returns on investment in medical education. At the same time, subsidies have also considerably reduced the cost of medical education, subsidizing those fortunate enough to study medicine in the United States. On both counts, existing policies towards medical education are hardly neutral.

Here, as elsewhere, we cannot achieve policy neutrality merely by standing pat. Because of the government regulations already in place, new measures would be needed simply to achieve neutrality. And some of the policy recommendations contained in the report would indeed move towards neutrality. For example, the report recommends that the Health Professions Educational Assistance Act of 1976 be amended so that a medical school is no longer required to maintain or increase enrollments as a condition of receiving certain funds.

Adopting the goal of neutrality would lead to maximum reliance on individual choice. A fundamental element of free choice is the right of all persons to enter the occupation of their choice so long as they are willing to bear the costs. (These costs involve not only training, but also the reduced earnings that might result from choosing one occupation rather than another.) Several of the report's conclusions would limit this right. They include not only the recommendation that the number of foreign medical graduates permitted to practice in the United States be severely restricted, regardless of their skills and specialties and regardless of whether they are U.S. citizens, but also the recommendation that first-year U.S. medical classes be limited to current levels and that no new medical schools be established here, regardless of the demand for medical education. Again and again the report chooses the course of greater reliance on collective than on individual decision making.

There is a final recommendation worth noting—that the activities of the Graduate Medical Education National Advisory Committee be continued for another year. In view of the committee's efforts to date, that recommendation is one I could not support. ■