ASSESSING THE STATUS OF CALIFORNIA’S PHYSICIAN WORKFORCE: SHORTAGE OR SURPLUS?

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Governor’s Council Room, State Capitol ♦ Sacramento, CA

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Focus of This Roundtable

This Roundtable will explore recent estimates of California’s present and future physician supply, the issues that affect the state’s physician workforce, and approaches for ensuring an adequate number and mix of primary care and specialty physicians, as well as a balanced geographic and demographic distribution. While the supply of other health care personnel, including nurses, has been a focus of attention nationally and in California, this Roundtable will focus exclusively on physician supply.

Questions to be Addressed at This Roundtable

♦ What is the profile of California’s physician workforce?
♦ Is there a surplus or shortage of physicians in California, and what is likely to happen in the future?
♦ What factors affect the supply of and demand for physicians in the state?
♦ Are certain populations and geographic areas disproportionately affected by physician supply problems?
♦ Does the California experience reflect what is occurring nationwide?
♦ What can policymakers do to influence the state’s physician supply?

A Profile of California’s Physician Workforce

According to American Medical Association (AMA) data presented on the Kaiser Family Foundation’s State Health Facts Online (www.statehealthfacts.kff.org), there were 92,985 nonfederal physicians in California in 1999 (including all physicians, whether or not they are actively involved in direct patient care). This translates to 280 physicians per 100,000 Californians (compared to 285 per 100,000 people in the U.S. overall, and to a low of 179 in Idaho and a high of 454 in Massachusetts). One-third are primary care physicians; the rest are in specialty care.

However, these statewide totals mask significant variation in the geographic and demographic distribution of physicians, as well as regional differences in the need for primary versus specialty care. The ratio of physicians to 100,000 people tends to be higher in urban areas and lower in rural regions, although there also are underserved populations in low-income and inner city areas. Moreover, there are marked discrepancies between the gender, racial, and ethnic composition of California’s physician population and the civilian population. The physician population is predominantly male (77 percent) and White (50 percent). And, while the White population is roughly proportional to the number of White physicians, there is a disproportionate number of Hispanics in the population compared to Hispanic physicians (31 percent versus 3 percent), and, to a lesser degree, more Blacks than Black physicians (6 percent versus 2 percent). These differences have potentially significant implications for Californians’ access to care and the cultural and linguistic competency of medical care.

The Roundtable Panel

Keith Richman, M.D.
Assemblyman
California State Assembly

Edward Salsberg, M.P.A.
Director
Center for Health Workforce Studies, SUNY-Albany

Jack Lewin, M.D.
CEO
California Medical Association

Edward O’Neil, Ph.D.
Director
Center for the Health Professions, UCSF

Sharon Levine, M.D.
Associate Executive Director
The Permanente Medical Group, Inc.

California’s Physician Supply: Shortage or Surplus?

Few analysts debate the existence of the nursing shortage or the uneven regional distribution of physicians, but the adequacy of the overall physician supply in California is a more contentious health workforce issue. In particular, two recent reports – one by the California Medical Association (CMA) and the other by the Center for the Health Professions at the University of California San Francisco (UCSF) – presented somewhat dif-
different perspective/predictions about the adequacy of California’s physician supply. Researchers at UCSF reported that California currently has an adequate number of physicians overall, while the CMA suggested that the state faces an impending physician shortage. The reports also presented slightly different views of physician satisfaction with their profession and the state’s current practice environment. These two reports have helped to spur debate about the status of the physician workforce in California and how to address any deficiencies that may exist.

The UCSF Analysis

In “The Practice of Medicine in California: A Profile of the Physician Workforce,” researchers from the California Workforce Initiative of the UCSF Center for the Health Professions analyzed data from the 2000 AMA Physician Masterfile, the nation’s largest database of primary source physician information, and a representative survey of nearly 2,000 physicians in California in 1998. The Center reported that the ratio of physicians actively providing patient care to the general population in California increased from 177 physicians per 100,000 people in 1994 to 190 per 100,000 in 2000, exceeding the standard of 145 to 185 physicians per 100,000 recommended by the Council on Graduate Medical Education (COGME) in 1995. These figures suggest that the overall supply of physicians in California is sufficient, though the analysis has been subject to criticism as overestimating the number of physicians actually practicing. Results from the UCSF survey of physicians further indicated that the majority of physicians were very or somewhat satisfied with being a physician in the state.

Additional results from the UCSF analysis include:
- More than one-third of the state’s active patient-care physicians are in general primary care.
- The ratio of physician-to-population ranges from a high of 238 per 100,000 in the Bay Area to a low of 120 per 100,000 in the South Valley/Sierra region.
- Half of generalists report that the majority of their patients are enrolled in managed care.
- Median net physician incomes in California range from between $120,000-$140,000 for generalists and $201,000-$250,000 for specialists, which are comparable to physician incomes in other states.

The CMA Perspective

In its report, “And Then There Were None: The Coming Physician Supply Problem,” the CMA released results from a survey of California physicians distributed through county medical societies to practicing physicians in the state in early 2001. More than half of physicians who responded reported problems attracting new physicians to their practices or medical groups, and 43 percent of respondents said they plan to quit, retire, or move out of the state in the next three years. While the UCSF report discussed the maldistribution of specialists across different regions of the state, the CMA reports another dimension of this problem: the difficulty experienced by some medical groups recruiting new physicians, particularly in the Bay Area. The CMA suggests a variety of factors that could discourage physicians from locating in California or remaining in practice, including: a high cost of living; low reimbursement from private health plans and Medi-Cal relative to other states; and a practice environment dominated by managed care contracting arrangements, which is a source of dissatisfaction for over half of physicians who responded to the CMA survey. However, the CMA survey had a response rate of only 12 percent (2,300 responses of 19,000 surveys distributed), which has led to suggestions that the results may not be representative of physicians overall.

Other Findings about California’s Health Workforce

Complementing the recent studies from UCSF and the CMA is an analysis by the Center for Health Workforce Studies (CHWS) at the University of Albany, State University of New York, which conducted a survey of physicians completing a residency or fellowship training program in California in 2000. Almost 1,200 physicians responded to the survey, representing about 45 percent of the approximately 2,600 physicians completing training in California in 2000. Results from the survey suggest that the overall job market in California appears strong, with only one percent of respondents who had actively searched for a job failing to receive a job offer at the time of the survey in the Spring of 2000. Most graduates with confirmed practice plans (78 percent) were staying in California, suggesting that the environment in California may not be discouraging physicians from entering or remaining in the state to practice medicine. CHWS also analyzed California physician workforce data from 1996-1997 and concluded that:
- Although California had an adequate total physician supply because of high retention of physicians trained in the state and the in-migration of physicians trained elsewhere, the growth in the number of medical students in the state had not kept pace with the growth in the state’s population;
- While the overall number of patient care physicians increased by 23 percent between 1985 and 1996, after adjusting for population changes, California’s physician to population ratio increased only 2.6 percent;
- Hispanics, Blacks, and Native Americans were under-represented in medical school, residency training, and practice relative to their respective populations in the state.
A number of national public and private organizations also examine issues related to the health workforce. Within the federal government, the Bureau of Health Professions and the Bureau of Primary Health Care in the federal Health Resources and Services Administration (HRSA) administer programs that help to increase access to health care professionals in underserved geographic areas and subpopulations, with a special emphasis on increasing diversity in health professionals and primary care training. The federally chartered Council on Graduate Medical Education (COGME) provides advice and recommendations to the Department of Health and Human Services and Congress on the current and future supply and distribution of physicians and physician specialists in the U.S. COGME’s analysis of national physician supply data highlights the need for continued support of Federal and State programs that increase the number of physicians who choose generalist careers, and who practice in rural and inner-city areas and serve underserved populations. Other private organizations, such as the Pew Health Professions Commission, have been organized around this issue. The Commission was a high-profile group formed by the Pew Charitable Trusts in 1989 to inform policy makers and graduate medical educators on issues related to the education, supply, and regulation of the health professions. In 1999, the Commission ceased operating and many of its initiatives were passed on to the UCSF Center for the Health Professions.

Many of these organizations have examined the physician workforce from a national perspective, and such analysis has yielded results that are similar to what has been observed in California: the mix of primary and specialty care is unbalanced in many areas; rural and inner-city areas are often underserved; gender and racial disparities exist between the general and physician population; and many physicians express dissatisfaction with the practice of medicine in the current U.S. health care system. The question of whether there is an overall shortage of physicians nationally has not been analyzed in any detail recently, but regional shortages have been recognized, and federal programs such as HRSA’s National Health Service Corps attempt to address them.

What Can Be Done to Influence Physician Supply?

Some health workforce experts suggest that the only way to correct imbalances in physician supply, including geographic, gender, and racial disparities, is simply to train more physicians by increasing the number of medical students graduating from American medical schools. Roughly 16,000 physicians each year are admitted to and graduate from medical school, but schools deny entry to many qualified applicants. Since the number of open residency slots is approximately 22,000 per year, several thousand graduates of foreign medical schools are typically hired to fill the remaining vacancies.

However, while adding to the total pool of available physicians might address supply issues over the long-term, it would not resolve other more immediate issues that could influence physicians’ decisions where to practice or whether or not to remain in practice altogether. These include physician reimbursement levels in the public and private sector that are lower than in other states, and the predominance of managed care contracting in California. Two bills have been introduced in the California Legislature that would partially address these issues:

♦ AB 1043, authored by Keith Richman, would require Medi-Cal reimbursement rates for licensed physicians to be at least 80 percent of the comparable Medicare rates.

♦ AB 1600, as amended by its authors Fred Keeley and Keith Richman, would guarantee physicians and patients the right to challenge in court any current or threatened violation of the Knox-Keene Act (which regulates Health Maintenance Organizations in California). It would also provide a mediation process where the parties could settle their differences out of court. (The original bill would have allowed physicians collective bargaining rights in negotiating and enforcing contracts with health plans.)

Governor Davis recently signed into law a bill (AB 1586, authored by Gloria Negrete McLeod) that addresses the issue of physician supply from an analytic perspective, by requiring data collection that could generate a more complete and accurate picture of California’s physician workforce. The law requires physicians to report to the Medical Board of California their practice status and, if applicable, specialty board certification when they renew their licenses. The Medical Board is also required to collect information about physicians’ cultural backgrounds and language proficiency. This information will be posted on the Medical Board’s Internet web site.

Each of these policy responses attempts to address some aspect of the physician workforce issue, whether to influence payment levels or the practice environment, or to improve the ability to measure and evaluate the physician population. However, there remains uncertainty and disagreement over the extent to which physician supply is inadequate or distributed inappropriately, and over how best to address any problems that may exist. Moreover, changing economic circumstances – including a slowdown in the economy, disappearing state and federal budget surpluses, and more rapid increases in health care costs – could result in substantial changes in the practice environment for physicians in California and nationally and further challenges for policymakers.
For Further Reference:

♦ American Medical Association:  http://www.ama-assn.org/
♦ American Association of Medical College:  http://www.aamc.org/
♦ Bureau of Health Professions, HRSA:  http://www.bhpr.hrsa.gov/
♦ California Medical Association:  http://www.cmanet.org/
♦ Center for the Health Professions, UCSF:  http://futurehealth.ucsf.edu/
♦ Center for Health Workforce Studies, SUNY-Albany:  http://chws.albany.edu/
♦ Council on Graduate Medical Education:  http://www.cogme.gov/
♦ Kaiser Family Foundation State Health Facts Online:  http://www.statehealthfacts.kff.org/
♦ Medical Board of California:  http://www.medbd.ca.gov/
♦ National Center for Health Workforce Information and Analysis, HRSA  
  http://www.bhpr.hrsa.gov/healthworkforce/  
♦ Office of Statewide Health Planning and Development:  http://www.oshpd.ca.gov/
♦ Official California Legislative Information:  http://www.leginfo.ca.gov/

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