

Class Paper 2  
**Current Issues of Healthcare Delivery: Workforce, Staffing, Quality, and Cost**

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## **Introduction**

The 20<sup>th</sup> Century encompassed a period of unparalleled health progress. Technological advances and scientific discoveries have radically changed health care. They have also shaped the American healthcare workforce. New professions have emerged and traditional ones have significantly evolved. In this paper we analyze the recent evolution of healthcare professions in America in the context of recent trends in public expectations, career attractiveness, workforce composition, and delivery/financing systems.

### **American public expectations of health care**

Americans have new and expanded expectations of their health system and of the professions and institutions on which they rely to provide their care. Increased government involvement and spending in health affairs reflect the political significance of these new demands. The population is constantly exposed to the miracles of modern medicine. New studies, findings, and technology instill hope to millions. If they don't get this cutting edge care they feel short changed. No American wants to be denied our world-class medical care. At the extreme are those who want to enjoy the pleasures of unhealthy behavior and not pay the consequences. After making their bad choices, they expect medical science to bail them out. Some have a hard time accepting the effects of aging and the reality that life does come to an end at some point regardless of the advances of medical technology.

Consumer expectations have increased a lot over the last 25-30 years. These new expectations place great demands on health care systems and their human resources. Today's health care professionals are held to ever-increasing standards. Patients are now more suspicious and are highly influenced by the media. Experienced primary care providers tell us that many patients want each medical problem evaluated by an "expert." Patients demand dermatology for acne, orthopedics for funny wrist clicks, podiatry for foot odor, and OB/GYN for annual PAP smears or birth control pills. This has led to physicians becoming increasingly more specialized. By today's standards, graduate medical education (GME) is expected of any physician attempting to claim superior clinical competency, medical school alone is no longer enough. There is also a trend towards post-residency training. As an example, even family practitioners are sub-specializing in sports medicine, geriatrics, obstetrics, or specific body regions, organs, or functions.

Increased consumption of health care resources has triggered cost-containment schemes that have had tremendous impact in the health care professional sector. Managed care, professional standards, and consumer protection have increased clinical and administrative professional responsibilities. To ease the burden, many professional groups have delegated some of their traditional roles. Over time, support professionals have permanently taken over these roles. They have also taken responsibility for tasks that have been neglected or avoided by their original performers.

Public expectations have also forced many professions to redefine themselves. Some, particularly allied health professions, have done so in attempts to achieve greater professional autonomy. Others have done so due to economic pressures. Virtually all professions have faced

the demands of cost-effectiveness forcing them to look at their practices and refine, augment, and/or review their role in health care.

### **Attractiveness of medicine as a profession**

While practically all health care professions have experienced absolute growth in the last 30 years, a decline in interest in the medical and dental professional schools has been noticed as less people seek admission to these programs. For many, the investment of money, personal sacrifice, and time spent is no longer worth the pay off. Income and independence have substantially decreased. Managed care, costly equipment, and the astronomical cost of malpractice insurance make financial success more difficult. Increasing proportions of providers are not able to establish their own practices. Consequently, more and more physicians are being employed by HMOs. The net result is a gradual evolution from traditional solo medical practice to more restrictive hospital or HMO-based employment or group practice resulting in loss of professional autonomy.

Although it was not discussed in our readings, veterinarians have undergone similar professional changes. Education costs, return on investment, school debt, and high costs of starting practices have decreased professional school applications and increased group and corporate practices. Recent graduates are finding that starting out on their own is not worth it today. Furthermore, the situation has created a financial crisis for established practitioners wishing to retire but finding no one to buy their clinics. The parallels between veterinary medicine and human medicine are interesting given the fact that insurance for animals is in its infancy and has never gained popularity and Medicare or other government supports do not exist in veterinary medicine. However, the trends toward specialization and increased costs are similar to human medicine, with similar results as previously discussed. Wider acceptance of pet insurance would likely exacerbate the problem as seen in human medicine. This area is ripe for research and analysis as comparative medicine becomes increasingly important.

One of the most controversial issues stemming from changes in medical education revolves around GME. During the mid 1980's, the growth of GME positions outpaced that of domestic undergraduate medical education. Consequently, residency positions (up to 5%) went unfilled. According to economists (Newhouse and Wilensky), federal subsidies for GME tended to increase the profit of hiring residents. Without enough U.S. medical graduates to sustain their growth, teaching hospitals turned to international medical graduates (IMGs) to fill the gap. This practice increased the total number of residents beyond the nation's demand for trained physicians. Medicare has footed a significant portion of GME's growth. Many of us were shocked when we learned Medicare subsidizes GME. We believe that neither Medicare nor Medicaid funds should be used to directly finance GME. As a matter of fact, Medicare should not be paying for the education or training of any health care professional; that should be the student's responsibility. GME funding has also been biased toward physicians and thus not fair for other health professionals. Funding through Medicare and Medicaid in teaching hospitals should be limited to financing medical care for its beneficiaries at standard regional rates. The practice of using the Social Security Trust Fund to directly benefit physicians by financing their residencies should stop. Hospitals should accurately and objectively extract GME costs from their billing. Education should be funded with education dollars, research with research dollars,

and charity work through charity. The total fiscal outlay required to keep teaching hospitals operational might end up being the same but breaking it out allows for tangible, honest, fair, and objective cost comparisons and thus rational decision/policy making. While the use of Medicare funds for GME was unanimously disapproved, our group did not object to using appropriations to fund state-sponsored medical schools. We all agreed that if public funds were made available for medical education, a public-service payback system, similar to that in the military, should be created.

While supportive of limited public funding in medical education, our group expressed concerns about the government's current approach to the regulation of health care professionals. Opinions were expressed that our government should not regulate health care any different than any other professional sector and that the number of professionals in any occupation should be a function of market supply and demand and not of governmental intervention. For example, the "physician surplus", if it really exists, should be worked out by supply and demand, not legislation. Some think the best way to reduce the number of physicians is by reducing federal funding of GME or at least link all federal funding to compulsory public service. However, realistically speaking, with the proportion of public outlays in health care financing reaching 50 percent of all national health care expenditures, the role of the government is unlikely to diminish.

One of the spin-offs of the convoluted Medicare financing of GME and the poor distribution of physicians (both by region and specialty) is the recent influx of IMGs in our health care industry. As previously discussed, teaching hospitals expanded their enrollment by hiring increasing numbers of foreign-trained doctors. Given that we have the appropriate level of domestic medical resources, it might not be necessary to import so many IMGs. By numbers, our domestic resources are more than sufficient to provide the primary and specialty care needs of our nation. Are IMGs the best solution to the externalities of our market-driven health care sector? It is hard to decide. IMGs have certainly addressed the problem of physician specialization and unequal distribution. The American health care establishment must decide if luring foreign-trained physicians with GME is in America's best interest.

Admitted was the fact American physicians do not go where they are most needed. This is clearly demonstrated by the continued poor distribution of physicians and shortage of primary care providers. However, this is not always the result of individual physician choices. Many physicians who originally wanted to practice in underserved areas are not able to because they find it difficult to pay off school loans when practicing in rural or inner-city areas or dedicating their careers to primary care. To address the issue of rural/urban physician distribution, several suggestions were proposed in our group. These included linking federal funding to a mandatory service obligation, requiring service in underserved areas, helping providers get established in these areas, offering tax breaks to physicians relocating to rural/inner city areas, and creating public corps similar to the Indian Health Service. A fact brought up in our discussion was that some of the programs developed to encourage primary care practice in underserved areas proved problematic as too many physicians reneged on their payoff obligations.

## **The new composition of the American health care force**

Today's American health care workforce is much more representative of our population with more women and more minorities. This new composition of our health care workforce probably has had a very positive impact in the delivery of services. It was argued in our group that the change in the composition of health care professionals is a direct result of the civil rights movement and its impact on the educational establishment and not a function of health economics. Similar trends are seen in the military. At any rate, training programs continue to open doors for many who were once sub-optimally represented. Still, gender and racial/ethnic trends in nursing do not mirror the experience in other health professions as it is still predominantly female and has been unable to attract minorities to the same degree as the other health care professions.

## **Effects of system changes in the health care professions**

Economic, legal, political, and market pressures have changed the roles of traditional health professions. Managed care has limited professional growth and earning potential. However, growth and new technology have increased the number of health care career fields. The end result is a constant battle for the health care dollar, turf, and legitimacy. Fortunately this is not a battle fiercely fought in the halls of health care institutions but rather through congressional lobbying.

Healthcare has been affected by an explosive expansion of technology, new therapies, and medications. As a result of this proliferation, hundreds of health care fields have emerged adding thousands to the workforce. In addition, medicine has redefined services and interventions and increased physician sub-specialization. Insurance companies, which must make a profit, are finding it increasingly difficult to absorb the growth of health expenditures at current premium costs. The healthcare industry has responded by organizing individual providers, clinics, and hospitals into "cooperatives" such as HMO's. These larger groups are more efficient in containing costs and can offer a wider package of medical capability to the patient. However, organizational efficiency has been maximized and costs continue to rise.

Cost-control strategies have affected a shift towards technical professions and away from physicians. When properly utilized, support personnel can provide services at reduced costs and allow for more efficient organizational functioning. Also, a few professionals have emerged and flourished in response to uneven physician distribution and the drive for cost-effectiveness and primary care. Physician assistants (PAs) and nurse practitioners (NPs) provide a cost-effective alternative to the primary care physician shortage. These professionals have proven extremely capable and are considered by many a welcomed addition to the health care team. They accurately diagnose both simple and complicated maladies. Many patients prefer seeing these professionals for routine care such as Pap smears because they tend to be much more focused on education and spend more time explaining physical exam findings and answering questions.

In general, allied health care professionals are typically regarded as key contributors to the cost-effectiveness of health care systems. These non-physician professionals get an excellent return on their educational investment. This probably accounts for a rise in their numbers and

professional diversity. Allied health professionals are well trained for their positions in specific areas like ER nursing, dental hygiene, diagnostic imaging, and laboratory technology. They complement and enhance traditional clinical decision makers in the provision of accurate and comprehensive care. For example, today dental hygienists free dentists from performing dental prophylaxis allowing more time for complex procedures such as oral surgery. Besides being cost-effective, they have a very positive influence on health care consumers. Based on group member experience, some patients are more accepting of medical advice when received from allied health care providers than from physicians. Health care systems are increasingly relying on physician-allied health professional synergies to optimally manage their capacity. These synergies must be based on mutual cooperation, professional acceptance, and clearly defined responsibilities to in order to deliver quality services.

The military is a perfect example of how technical professionals, our enlisted force, and allied health professionals provide a variety of medical skills at reasonable cost without compromising quality or effectiveness. They are given opportunities to build advanced skills. Once qualified, they provide great assistance in critical decision-making. A significant number of enlisted members take advantage of our military physician assistant program and become efficient physician extenders. They do such a great job.

## **Conclusion**

The last several decades encompassed a period of profound change in American health care and its workforce. The new American health professional is more representative of our national population than that of 30 years ago. Overall, they are much more specialized, varied, and numerous. This evolution will certainly continue in the years to come. Future actions to reduce costs, improve quality, expand access, or ration resources will affect the health care workforce in one way or the other. Reliable, effective, and efficient professionals are our most important health resource. Without doubt, our nation's health is significantly dependent on them. In our success-driven society, lesser earnings and unattractive settings could prove challenges to attracting the most academically capable people to careers in health, particularly medicine. Paradoxically, these same forces could result in attracting more of the right people to the right vocation for the right reasons. Based on the complexity of American health, the training and distribution of health care professionals needs a higher level of integration if we hope to achieve national health goals. Qualifying and quantifying the personnel demand to achieve these goals will help us plan, prepare, and employ the optimal size, composition, distribution, and skill-mix of professionals required to meet our objectives.