

**COUNCIL FOR EDUCATION POLICY, RESEARCH AND IMPROVEMENT****MEDICAL EDUCATION NEEDS ANALYSIS****STUDY OUTLINE****Purpose**

In a letter dated March 29, 2004 to the Council for Education Policy, Research and Improvement, Carolyn K. Roberts, Chair of the Board of Governors, requested that CEPRI “define the parameters of a model to be used to quantify the adequacy of the State’s physician workforce; project the extent to which a physician shortage exists and to develop cost/benefit estimates of various alternatives to produce the required number of additional physicians including but not limited to: expanding the capacity of existing medical schools, creating new medical schools, expanding or creating new residency programs and other incentive programs to attract physicians to Florida.”

The letter calls upon CEPRI to “define the parameters of the model in collaboration with an advisory committee including representatives of the Council of Florida Medical School Deans, the Graduate Medical Education Committee, and representatives from other interested public universities. Upon completion of the definition of the model’s parameters, the model shall be developed in collaboration with The Bureau of Economic and Business Research of the University of Florida, under contract with the Department of Education.”

**Background**

Currently, there are four allopathic and one osteopathic medical education programs serving Florida. The three public allopathic programs are located at the University of Florida in Gainesville, the University of South Florida in Tampa, and the Florida State University in Tallahassee. The independent University of Miami houses that state’s first medical school, receiving state funding through the First Accredited Medical School Act. The one osteopathic program is located in Ft. Lauderdale at Nova Southeastern University.

There currently is no centralized repository for statewide health workforce data. The Council of Florida Medical School Deans, the Graduate Medical Education Committee, and the Community Hospital Education Council have endorsed the creation of a state-level entity that could serve as the official state repository for health professions workforce supply and demand data. The repository would serve as the official statewide source of valid, objective and reliable data used to make policy decisions on such issues as: capacity; the mix of specialists; the geographic distribution of physicians; and the role of medical education in the production, retention, practice specialty area and practice location of physicians.

In addition to data concerns, determining a need for additional physicians has been a difficult task, depending heavily on the approach used to assess need. Two general approaches to assess the need for additional physician have been employed. The first method assesses past levels of the use of physicians’ services, tries to identify the forces that influenced these levels, and then predicts the future need by projecting these forces forward. This approach, exemplified by the work of Cooper et al., holds that the economy is the major factor affecting the demand for physicians, predicting that demand for physicians will grow with population and the Gross Domestic Product per capita.<sup>1</sup> The

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<sup>1</sup> Blumenthal, David. 2004. “New Steam from an Old Cauldron—The Physician-Supply Debate.” *The New England Journal of Medicine* 350(17):1783-1784.

second approach used to assess adequacy establishes an optimal number of physicians needed to take care of a population in a properly organized health care system. The prediction of demand using this approach is based on a physician-to-population benchmark.<sup>2</sup> Whether or not a shortage exists, using this approach, depends heavily on how and where the benchmark is set.

In its 1999 study, *An Assessment of the Adequacy and Capacity of Florida's Medical Education System*, MGT of America employed an approach to assessing need similar to the first method discussed above, assuming that as the state's per capita income rises, the demand for physician services will increase. To project future demand for physicians, the study argues, a model should take into account the need to replace physicians leaving practice due to retirement or other reasons; the growth in demand attributable to population growth, an aging population and income growth; and the number of new medical graduates entering the workforce each year. Instead of focusing on the overall physicians-to-population ratio for comparison, this analysis focused on an age-weighted population given that Florida has a much greater proportion of older citizens than the average state, and older citizens have a considerably greater incidence of physician visits than the average of the overall population. Their analysis concludes that increased demand for health care results from an increased ability of the people to purchase health care services and from the aging of the population.

The State of Texas has completed various comprehensive needs assessments for professionals, including physicians. This assessment was last done for physicians in 2002. The Texas Higher Education Coordinating Board (THECB) builds a framework for analysis through two questions: (1) Is there an increasing need/demand for services? And (2) Is there increasing demand from people who want to be physicians? To answer these two questions, THECB employs a methodology similar to the second approach discussed earlier. Comparing current and a projected physician-to-population ratios to national averages, the top ten most populous states, and industry benchmarks (e.g., the American Medical Association), THECB is able to respond to the first question. Additionally, THECB examines the source of the physician pool – are they trained in-state, out-of-state, or internationally? The regional distribution of physicians and the reasons for the practice location of physicians are also considered to assess need. To assess the demand from people who want to be physicians, THECB examines the relationship between the number of baccalaureate degrees produced (i.e., the potential pool of medical students) and the availability of slots at Texas medical schools, as determined by the admissions rates.<sup>3</sup>

If a need exists, the available policy options include: expansion of the number of residencies, expansion of the number of slots in current medical schools, starting a new medical school, and recruitment and retention of physicians in Florida.

***Expansion of Residency Programs.*** The federal Medicare program is the largest explicit source of funding for residency training. As reported by the Graduate Medical Education Committee, the average cost per resident at Florida's three allopathic medical schools with residency programs (UF, USF, and UM) is \$190,000. The capacity and number of Florida residency programs has remained essentially frozen since 1998, due to budget reductions following the passage of the federal Balanced Budget Act of 1997. This has made expansion of residency programs difficult.

***Expansion of Slots at Current Medical Schools.*** Information presented to the Board of Governors on March 17, 2004 provided the expansion capabilities of Florida's three established

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<sup>2</sup> Ibid, p. 1784.

<sup>3</sup> Texas Higher Education Coordinating Board. 2002. *Projecting the Need for Medical Education in Texas*.

allopathic medical schools (UF, USF, and UM) and one osteopathic medical school (Nova Southeastern). Only Nova Southeastern reported they could increase capacity (by 30 first-year students in 2006-07) without renovation or new construction.

***Starting a New Medical School.*** According to Florida State University's *Plan for a Four-Year Allopathic School of Medicine*, the additional requirements for state support by year start at \$9.6 million in 2000-01 and increase to \$32.3 million in 2008-09.

***Recruitment and Retention of Physicians.*** There are various recruitment incentive programs currently in law in Florida. However, many of these programs have not been funded in recent years. The National Health Services Corps (NHSC) Scholarship program and Loan Repayment Program both provide physicians with incentives to serve in federally designated shortage areas. In 2003, Florida had more loan re-payers apply than any other state except New York. Another program designed to recruit physicians in shortage areas is the J-1 Visa Waiver (State 30) Program, which provides foreign physicians with a waiver of the two-year home country physicians presence requirement in return for working in an underserved area.

### **Policy Issues**

The basic issues to be addressed in this report are:

- Does a physician shortage exist?
  - What approach should be used to assess the need for additional physicians?
  - What factors need to be accounted for when assessing adequacy?
- If a shortage does exist, which alternative provides the state with the best cost-effective approach to address the need?
  - Additional capacity at existing medical schools?
  - Additional residency programs?
  - New medical schools?
  - Other approaches?

### **Methodology**

- Literature review of all pertinent information on the assessment of physician workforce needs, as well as methods used to address those needs, if shortages are believed to exist.
- The creation of an advisory committee including representatives of the Council of Florida Medical School Deans, the Graduate Medical Education Committee, and representatives from other interested public universities.
- Collection of available data regarding the current number of practicing physicians in Florida by region and specialty, capacity at existing medical schools and residency programs, population projections, and other relevant data used to assess the need for additional physicians.
- Consensus building among committee members to identify the parameters of a model to be used to quantify the adequacy of the State's physician workforce; project the extent to which a physician shortage exists, and to develop cost/benefit estimates of various alternatives to produce the required number of additional physicians.

### Timeline

June – July 2004

- Convene advisory committee to define the parameters of the model
- Reach consensus on parameters

August – September 2004

- Model developed in collaboration with the Bureau of Economic and Business Research of the University of Florida, under contract with the Department of Education

October 13, 2004, CEPRI Meeting

- Final Report