

Feast or famine



For more than a century various interested parties have been arguing over how many doctors we need, and whether we have too many or too few. Should there be a glut in desirable areas so there can be trickle down to less attractive ones? Should you regulate numbers or let market forces decide? Perceptions on these points have varied over the years, and so have official health policies, because in fact medical education in the United States is tightly regulated by professional licensing bodies and heavily subsidized by the government.

There seemed to be a shortage some 30 years ago. At the time even the rich often had to wait for weeks for a doctor's appointment. Whole counties without doctors would band together to recruit one. Private doctors shunned the poor areas of the inner city; and there was much talk about a crisis of access. Then the government encouraged the building of new medical schools and heavily subsidized medical education and training. Over the ensuing decades the number of US doctors increased, from 300 000 to 684 000, amounting to 214 doctors per 100 000 population, a higher ratio than in Canada (196) and Britain (164), but lower than in Italy (424), France (314), or Germany (256). At present some authorities estimate that by the year 2002 the US will have 20-30% more doctors than it needs.

Already signs of an abundance of doctors are apparent. Driving through Chicago you see many new medical facilities where once there were none. There are clinics run by health maintenance organizations and hospitals, emergency centers, day only surgicenters. There is no more talk about delays in getting to see a doctor, unless it is a well known specialist. Emergency rooms are fully staffed, hospitals have no trouble in recruiting doctors. Large rural towns have enough generalists and often boast a full complement of subspecialists. In most small towns the situation also seems to be under control.

Accordingly, young doctors no longer have it as easy as 20 years ago, when they could choose between competing practices and dictate their terms, some insisting on becoming full partners within one year. Now groups looking for new doctors are few, and many graduates hang around hospitals, work in emergency rooms, or join health maintenance organizations at comparatively low salaries. They go into full time positions or public health, a sure sign that the scales of supply and demand have tipped the other way.

As always, there remains a maldistribution between affluent and poor areas. But overall there is a perception of an impending glut of doctors and of a need to do something about it. Some officials have proposed cutting the influx of foreign doctors, a measure that would deprive less desirable and underserved urban and rural areas of needed services. Others want to close 10% of America's 125 medical schools, reduce student enrollment by 20-25%, or cut back on resident training positions in hospitals.

Earlier this year the Clinton administration proposed redirecting some of the government's \$6bn (£3.8bn) contribution to house staff training so that hospitals in New York could hire personnel other than residents. This was widely publicized as "paying hospitals not to train doctors" and

compared with subsidizing farmers not to grow crops. The debate is sure to continue, as will estimates of how many doctors are needed, underscoring the difficulties of central planning rather than relying on the dynamics of the market place, a pill that the medical establishment, health activists, liberal politicians, and government bureaucrats would find hard to swallow.