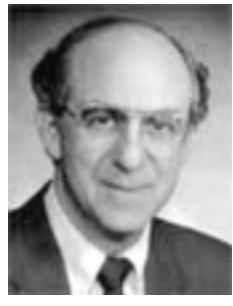
To Train More Doctors, Remove Residency Caps



Dr. Cooper is the former dean, executive vice president, and Health Policy Institute director of the Medical College of Wisconsin, and has been a professor of medicine and a senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania, in Philadelphia, since 2005. Patricia Salisbury interviewed Dr. Cooper on Dec. 12, 2006.

EIR: I understand from researching the shortage of physicians around the country that you were one of the few people who accurately forecast the fact that we would have a shortage of physicians, rather than sharing the institutional view that there is a glut of specialist doctors around the country. Would you fill us in on the dimensions of the shortage, and also how you came to the conclusions that you did?

Cooper: As to the dimensions, probably overall at the moment there is something between a 5 and 10% shortage, probably closer to 5%. It varies from area to area, and from specialty to specialty. Some areas have too many physicians, some too few, but if you were to average it across the country, it is probably a 5%, 6%, 7% shortage, which is a lot, because unlike lots of other professions, the number of physicians is kept pretty close to the absolute number needed. I mean, you always have more McDonald's than you could possibly need, and you have more lawyers than anybody would want; but for physicians it is always pretty close to the margin.

But we are looking at a progressive increase in that number, hitting probably 20% by the next 15 or 20 years. So 5% is already a problem, people are already waiting; but when it gets to 20%, they are going to really be waiting. It is going to be a big problem.

How did I come to this conclusion? It's not very difficult to come to; it is very simple. If you just think about it, the population is growing; technology is growing; the economy is growing; the population is aging; we have the economic capacity to purchase more health care because the economy is growing. That has been going on for 50 years or more; as the economy grows, the nation spends more on health care as a percentage of the Gross Domestic Product. So it doesn't

take a great deal of insight to recognize that these past trends are likely to continue.

A Myth, Like WMD in Iraq

Now why did people think the opposite of that? It was not based on any real analysis statistically; it was a belief that a shortage shouldn't happen, kind of like the weapons of mass destruction in Iraq—they sort of believed they were there. So, the belief was that health-care spending is bad for the economy, and that if you have a lot of doctors, you spend more on health care, and therefore we needed fewer doctors, and if health care was organized in a way that people used less health care, we wouldn't need as many. What they did was, they modelled a future in which fewer health-care services would be used. You can do that if you want, but that is not what people want; people don't want less, they want more. And it is like modelling a future with smaller houses: You say houses are too big, we'll model a future where all the houses are small. Well, that is okay if you want to do that; except people don't want small houses, they want big houses.

So, this was the wisdom that was out there, and these people felt that their view was in the public interest, and it turns out not even to have been in the public interest. Think about health care as the most rapidly growing sector of the economy: In big cities like the one I live in, Philadelphia, health care is a major industry. It is not uncommon to have small towns dependent on health care for economic survival. I was in California, with a legislator from California at a meeting talking about how if the hospital in this little town closed, the town would close, because it was the only real industry in the whole town.

There are two sides to this. One is health care as a public good, and the other is health care as a factor in our economy. Both are true. You begin to shrink health-care spending, and the question is, where are the jobs for people? How are people going to work; how are they going to buy groceries, and stimulate the retail industry, because that is where the jobs are?

EIR: Would you like to say more about who relied on this kind of modelling?

Cooper: Everybody, all of them, Everybody who is in a public position. In fact Theodore Marmor, who is a very well-known economist at Yale, referring not to this specifically, but to the whole notion of the poor leadership of the policy community, said that there should be a truce. That the policy experts should just abandon their policy, make a truce, stop arguing with each other, and all get together and think of something creative. We have been in this trap for decades: the policy people believing something that is contrary to what the public wants, and then some crazy policy gets developed that the public doesn't want, like managed care; it doesn't work, and the policy people lament the fact that they were right, but nobody would listen to them. Well, maybe they weren't right, maybe they were wrong. And maybe what you have to understand is what the public wants, because the public gets what it wants. This is a democracy.

EIR: I noticed references to the Council on Graduate Medical Education and other institutions, now changing their views. Why have they done that?

Cooper: Because they couldn't continue to argue, in the face of what we were publishing, ultimately. We were publishing something that was so logical, and people were all gravitating to it, that eventually they had to say okay. So they watered it down. Sort of like they do everything else: They either lie, or make it up, or water it down. So their estimate is about half of ours; their call for action is about half of ours. But at least it is in the right direction. They are philosophically driven. I've often said they make Enron look honest, It is such a travesty, but no one really cares. They care about Enron. They don't care about economy.

EIR: Many people probably didn't know of the role of the Council on Medical Education.

Cooper: They have really had quite an influence. And the tragedy is that we have now wasted 15 years, from the mid-'90s, when I began writing about this, saying that we had to build medical education infrastructure. Nothing happened. And you can't really do it quickly. Nothing much is going to happen for another couple of years. There are some new medical schools forming, but for all intents and purposes you have got 15 years from—let's call it from 1995—during which there was no investment in medical education infrastructure. All those years more doctors were not trained, the infrastructure was not created to train more—and you can never catch up.

EIR: If you were in a position to dictate a kind of FDR-style emergency mobilization in this area, as Roosevelt was able to do during the last Depression, is there a way you could see, through mobilization methods, something that would permit this crisis to be averted?

Cooper: Yes, over time, but remember, it takes four years of medical school and four years of residency. So already you are locked into eight years, and it takes a while to make that happen. You are locked into 10 or 12 years just to make anything happen. But you can at least keep it in that time frame.

Absolutely, take the caps off. The other thing that the great policy wizards did, was they got the Federal government to put caps on the number of residency positions, because they thought that the training of residents was producing too many doctors. So, you've got to take the caps off residency training, so we can train more residents. If we don't have more residents, we won't have more doctors, and we have to build more medical schools. I don't think it is complicated.

The exact same thing happened in the 1960s and 1970s. There was a shortage after the Second World War. There was a huge national response, Federal and state response; more medical schools were built, more residency programs were created, and we worked our way out of it. We can do that again; but the national will isn't there. You still have too many policy people saying that what we really need to do is not train more doctors, but to change the system. I don't know any way to change the system that does not require more doctors. Make it more efficient, less administration, more money to pay for more medical services—you need more doctors. Provide health insurance for the uninsured. Well, if the uninsured have more health insurance, they need more doctors.

There are only two ways that you would need fewer doctors: if patients get less care or doctors work harder. The doctors I know are working as hard as they can. Of course the younger generation works less hard than the older generation, but they are working as hard as they want. So you are not going to get doctors to work harder and see more patients. And secondly, you are not going to convince patients that they shouldn't have what they can afford, or the nation can afford. If they want cancer therapy or a face-lift, either one. And the policymakers say we can't train people to do these consumer kinds of health care, such as face-lifts. Well, why not? If that gives people a better feeling about themselves, they accomplish more in life, so who am I to say that you or anybody else shouldn't have a face-lift, or who are you to say that I shouldn't? The fact is that if I am in charge of medical education, I have to serve you. And you say, when I get older, I want a face-lift, and I want there to be a doctor to do it. It is my obligation as a medical educator to ensure that that happens. Not to convince you not to have that. That is not my job. My job is to prepare a work force to give you the care that you need and can afford.

EIR: But the consequences of the deficit you are describing over a 10-15 year period are going to be a lot more dire than people simply not having face-lifts. What do you see occurring? Do you see an increase in mortality, a decrease in life expectancy?

Cooper: First of all, it will not be equal across society. Already, the rural areas can't get doctors, so you are going to see a declining standard of care in rural areas. And secondly, it will affect the poor, as it always does. You will have declining access or delayed access. You may say other professionals will rise to the occasion. Well, sometimes that works; I have a lot of confidence in nurse practitioners and midwives. They are really good, unless they get pushed beyond their level of competence. And when there are not enough doctors, they are going to get pushed. Just as happened in California during the managed-care boom. Primary care doctors were pushed to do things beyond their level of confidence, and there were bad consequences. If you begin with too few doctors, and take otherwise good people and push them beyond their level of confidence, I think it is going to be a bad situation.

EIR: We are also facing a shortage of nurses. Some sources say as many as a million by 2020.

Cooper: Yes, a similar situation. Linda Aiken, who is my colleague at the University of Pennsylvania, has been very "out front" on this. And the number we use is 800,000. It is a huge number. It is very clear. She has done elegant studies to show that, for hospitals at least, staffing relates very closely to outcomes. If you have too few physicians and too few nurses, you can always say, "We can have more orderlies or LPNs." Well, you can't hand health care over to LPNs and orderlies, even though they are very important. The real quality is determined by nurses and their level of education, and by doctors and their level of education, and that is why it is so obvious.

I would love to take a lot of credit for what I did, but I have to tell you that it was so obvious. All I did was stop and look at it, while everyone else was busy doing something else, so they believed all this policy stuff. But anybody who had any background in medicine, any kind of medical education, looking at this, would have arrived at the same conclusion. And lo and behold, they all have.

EIR: As I mentioned, we have been devoted for a long time to the question of Hill-Burton standards of hospital availability around the country. Are you of the same mind on that?

Cooper: Of course, but that is what is going to suffer. It is the distribution that is going to suffer first. It is a real problem, and it is happening already. A primary care physician goes to some small community, and he assumes that there will be a cardiologist and an orthopedic surgeon, and so forth. So the primary care physician has a little local referral network for the common things. Except the specialists aren't there, because there aren't enough, and the few that there are, are in the cities. Then the primary care doctor says, "I can't practice here." The primary care doctor goes to the city. Doctors have to have kind of a network to make it work. You can do it, I suppose, but mainly the way health care works, is as a kind of a web, and when you begin to be missing pieces of the system, then the rest of the system falls apart. And that is what is happening now, at our current level of shortage. In areas where the system is fragile, in the rural areas and the small towns, that is where it is falling apart. And the second is, doctors say, "Medicare is squeezing us, Medicaid is squeezing us. I can fill my practice with non-Medicare patients." And only two-thirds of doctors in America, on average today, are accepting new Medicare patients. And that is slowly trickling down, very, very slowly, but it is slowly trickling down.

EIR: We have editorially endorsed Congressman John Con-

yers' HR 676 universal health-care legislation, with the observation that it really begs the question of infrastructure. If you do insure everyone, where is the infrastructure, in terms of hospitals, physicians, etc., come from? What would you like to see come out of the new Democratic Party majority in the Congress?

Cooper: I don't exactly know the mechanism by which you would get everyone insured. People are looking to Massachusetts to see how that works.

EIR: Congressman Conyers' legislation has been described as "Medicare for all."

Cooper: There has to be something, whether it is Medicare for all, or something else. The problem with Medicare for all, is the Federal government runs Medicare. It will sink health care. They are too capricious; it is too politically driven, too bureaucratically onerous. Physicians hate Medicare. They like the reimbursement when it comes, but it carries so much regulation, so much inefficiency—caring for Medicare patients is a terribly inefficient process. So my own view is, if the Federal government does it, it is bad enough that they are doing Medicare. The view of the Federal government is that if they are paying the bills, they should make a whole bunch of rules. Well, that just doesn't work. They spend all their time looking for the rotten apple in the barrel. There are rotten doctors, everyone knows that. But good doctors are exposed to such scrutiny and such arbitrary action, that they are scared to death to take care of Medicare patients. So Medicare for all, in my view, is the death of health care in America. On the other hand, there are other ways to provide universal coverage. Massachusetts is looking at one way.

EIR: Well the Massachusetts plan has been criticized as more of a boondoggle for the insurance companies than anything that is actually going to deliver adequate health care.

Cooper: I'm not conversant enough with it, so I don't even know if it is any good or not. But there must be something. I have read, through the years, of many ways to assure universal coverage, without having Medicare for all. I just don't like the Federal government involvement, because they are central and not local; I think these decisions have to be local. And certainly working with the private health system as a provider, working through locally owned [operations]. We have the same problem on the private side, They get bought by these huge nationally owned companies, just as bad as Medicare. What you want is something that is a relatively local insurance that can deal with local reality. And maybe that is possible. The Clinton health plan was something like that. That would have had these local, or regional alliances. It has to be something like the Clinton health-care plan, but not Medicare as we know it.

EIR: What are some other aspects of the crisis and its solution?

Cooper: I think the emphasis is, if you want universal coverage, you have to have an infrastructure that can do it. And infrastructure is doctors, nurses, hospitals, and then lots of other people: psychologists and x-ray technicians, everybody. The country needs insurance attention. But it has to decide, either it wants more health care which it can afford, which CMS [Centers for Medicare and Medicaid Services] projects, and look at the projections and prepare for that future. Or say, okay, we agree we need to shrink the health-care system, and we'll have fewer doctors and nurses, and we'll get less health care. I can't imagine the public saying the latter. If it is the former, we are not doing it. We are not preparing the infrastructure for what the public expects it will get in the next decade, categorically not.

EIR: And that leaves aside also the issue of such things as pandemic flu, avian flu, and so forth.

Cooper: Oh yes, we have no margin. This is a point which Linda Aiken and I always make. There is no margin for emergency preparedness—nothing. You talk to doctors and nurses today, they are flat-out. God forbid there should be some huge crisis in some community. The hospitals are already turning the ambulances away because they are full. They have got this thing so stripped down. And the idea is, strip down the system, which is the barrier to patients getting care, and that will reduce health-care spending. That is the logic: You provide insurance as we do, with Medicare and employer-based insurance, but restrict access in this manner. That is the logic that has been followed in America for decades.

EIR: As I said, always our major thrust has been the emphasis on Hill-Burton standards in infrastructure, as the cornerstone of any health-care delivery system.

Cooper: And moreover, you cannot just build the infrastructure tomorrow. It's not like opening a coffee shop. You don't build this kind of infrastructure in a day. So you have to ask, what is the likelihood of need, and what is the time frame, and let's plan ahead. This country deals with everything in quarterly reports, and annual reports. We are talking now about 5- and 10- and 15- and 20-year plans. Nobody makes them for health care or anything else. So I'm glad you are out there talking about this.

This is not political: Whether you are the Christian right or the liberal left, it doesn't matter. If you are a person in America, this is what you have got to be thinking about.

EIR: Our intention is to get this package to the new Congress, through our youth movement, the minute the new Congress convenes.

Cooper: The message can be stated very succinctly: Build infrastructure—and in this case, infrastructure is residency programs, which means removing the caps that restrict the number at medical schools. It is not complicated.