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Public Policy and Health Manpower

Health, Education, and Welfare Secretary Joseph Califano recently acknowledged before the annual meeting of the Association of American Medical Colleges that the nation may face an oversupply of physicians. He indicated that HEW will seek ways to encourage medical schools to reduce enrollments.

This dramatic policy shift was made less than 2 months after the beginning of an academic year in which there was a federally mandated (one-time) enrollment increase. Even now, a number of medical schools across the country, old and new, are expecting state budgetary support for the 1979-1980 academic year to meet enrollment increases. In many instances, the federal government is obligated to assist in meeting construction or operations costs. The paradox of continued expansion in the face of a threatening surplus, with the associated costs to society, is poignant in a time of public fiscal constraint.

How did we get into this position? The first health manpower legislation (1963) was passed on the background of the Bane report, which contained concrete goals in terms of aggregate physician numbers and a plan for how to achieve them. Federal funds were provided for operational support, construction, and student aid. The possibilities were not lost on aggressive institutions, chambers of commerce, professional and academic entrepreneurs, political aspirants, and state legislatures. Community developers could envision the economic benefits of a publicly supported academic medical center. State legislatures had the statutory authority and the tax base to launch expensive new educational and service enterprises. In status and dollars, a medical school represents an especially attractive political spoil.

By 1968, the legislative goal had shifted from a reasonably concrete number to "meeting the demand," and a serious shortage of physicians was still envisioned. Barely noted in the congressional hearings was evidence of a decline in the rate of population growth. Although it was originally estimated that about 20 new medical schools would be needed by the middle 1970's, twice that number have been started. And programs in other health professions have been expanding at similar rates.

It is clear that decision-making in national health manpower legislation has been characterized by vacillating goals and increasing frustration. There is some evidence that aggregate numbers will not solve the problems of access to medical services, but may enhance the problem of increasing medical costs.

Although the answers are not yet in, even the questions point to a serious dilemma in health policy and in public policy. There has been no clear plan for the expansion of medical education, no continuity in setting and revising goals, and insufficient collaboration between state and federal agencies. A manpower shortage was perceived, and we raced pell-mell to correct it, incorporating a variety of agendas (other than the care of patients).

As we approach an era of probable retrenchment in health professional education, it is profoundly to be hoped that more rational, collaborative long-term planning and implementation can obtain. Administrative agencies, Congress, and the academic and professional communities should work together to achieve these ends. Prospects for such an approach have been compromised by the proposal of the Administration, made within months of the undertaking of new obligations by the schools, to reduce institutional funding as of 1 October 1979.

It is time for the establishment of a national commission, made up of leaders from the public and private sectors, to undertake the development of intermediate and long-range plans for health manpower and assist policymakers in serving the public interest.—CHRISTOPHER C. FORDHAM, III, *Dean, School of Medicine, University of North Carolina, Chapel Hill 27514*