Background Paper

The University of California's Compliance with the 1994 Memorandum of Understanding to Increase the Number of Primary Care Physicians Trained in California

May 2005

Prepared by: Marlene Garcia

Senate Office of Research
Donald Moulds, Director
1020 N Street, Room 200
Sacramento, CA 95814
(916) 651-1500
www.sen.ca.gov

Executive Summary

Over the past 15 years, California has suffered a severe shortage of primary care physicians. In the early 1990s there was a push throughout the nation to achieve a 50/50 balance between training primary care and non-primary care physicians. In 1994 the University of California (UC) and the state of California entered into a Memorandum of Understanding (MOU) to address this problem.

The primary goal of the MOU was to establish by 2001 at least a 50/50 primary care to non-primary care distribution of resident physicians, and to substantially increase the number of family practice positions "toward a goal of approximately 20 percent" of all UC residents. UC projected it would achieve by 2001 a ratio of 55/45 primary care to non-primary care physicians based on its internal calculation of proposed changes. The goal of the MOU was not to increase the overall number of residency positions, but rather to redistribute them. This required a reduction in the number of non-primary care residents and an increase in primary care residents. In other words, it was a zero-sum game. The prevailing wisdom in 1994 was that there was an over-supply of physicians and it was unnecessary to increase the overall number of physicians. (See attachment).

Along with the MOU, the Legislature also approved Supplemental Report Language as part of the 1994 budget, requiring UC to submit annual reports to the governor and the Legislature on the progress the university was making to increase the number and proportion of primary care and family practice physicians trained by UC through 2001.[1]

Throughout the period of the MOU, UC reported that it made steady progress in increasing the numbers of primary care and family practice residents. Overall, the university shifted the primary care to non-primary care resident ratio from 45/55 in 1992-93 to 52/48 in 2001. This exceeded the MOU goal of achieving at least a 50/50 ratio, but fell short of its projected goal of 55/45.

By 2000-01, UC reported that family practice residents at UC accounted for 17 percent of all residency positions, 3 percentage points below the MOU goal. This represented an increase of 43 percent from 1992-93 to 2000-01. Most of this growth, however, resulted from UC's affiliations with outside community-based hospitals and other health organizations and not from any major increases in state-funded, UC-based residents.[2]

Furthermore, the university fell short of its goal, by more than one-third, of reducing the number of non-primary care physicians. The university did not shift as many of these positions as expected, arguing that further reductions would have caused the university to artificially cap and limit the growth of

emerging new subspecialties, such as pain management and medical genetics and high demand specialties, such as child psychiatry.

Legislative Background

In 1992 legislation (AB 3593, Isenberg) was introduced that would have required the university to allocate at least 50 percent of its total residency positions to programs in primary care. Primary care was defined as family practice, internal medicine, pediatrics, obstetrics and gynecology. The bill also required that at least 20 percent of all UC residents be reserved for family practice. Failure to comply with these requirements would result in reducing the university's medical school budgets by up to $8 million annually. While the governor ultimately vetoed this bill, the university agreed to conduct a study reviewing issues related to the state's need for primary care physicians and the university's role in addressing this need.

A virtually identical bill (AB 1855, Isenberg) was introduced the following year. At the same time, the university was nearing completion of a systemwide planning process that required each medical school campus to develop specific plans for increasing the number of primary care physicians trained on their respective campuses. The governor again vetoed the legislation, but this time stating he took this action because the university had entered into an MOU with the state specifying how it would increase primary care physician training.[3]

As part of the Budget Act, the Legislature adopted Supplemental Report Language in 1994 calling for the university to provide an update on its primary care expansion efforts beginning February 1995 and annually thereafter through 2000-01.

The Provisions of the MOU

The basic framework of the MOU was derived from 1) legislative efforts, 2) a 1993 UC report entitled "Changing Directions in Medical Education: A Systemwide Plan for Increasing the Training of Generalists" and 3) a 1994 update to the 1993 UC report issued at the urging of the governor to accelerate timetables and increase the commitment to expanding family practice residency positions.

<u>The 1994 MOU specified that</u>:[4]

General goals:

- By 2000-01, achieve a ratio of at least 50/50 primary care to non-primary care resident physicians. UC projected it would achieve a

primary care to non-primary care resident ratio of 55/45 based on its internal calculations of proposed changes.

- By 2000-01, increase family practice residents "toward a goal of approximately 20 percent."

Numerical targets:

- Between 1992-93 and 2000-01, UC projected it would increase the total number of primary care residency positions by 445 for a total of 2,379 primary care residents (55 percent of all UC residents).

- Of the total increase of primary care positions, UC projected it would add 364 new family practice positions for a total of 885 family practice residents (20 percent of all UC residents).

- Between 1993 and 2001, UC projected it would reduce non-primary care residency positions by 452 for a total of 1,953 non-primary care residents (45 percent of all UC residents).

- UC was to report annually to the Governor, Legislature and the Office of Statewide Health Planning and Development (OSHPD) on the progress it was making to achieve the goals established in the MOU through 2000-01.

The university Office of the President and medical schools committed to allocating existing funds to support the increase in primary care positions and graduate medical educational opportunities established in the MOU. Each of the five medical schools were directed to develop plans for increasing the number of primary care physicians by reviewing and making changes to their organizational structures, admissions policies, undergraduate curricula, graduate medical school training, primary care faculty development and outreach programs.

The governor directed OSHPD to review and monitor the university's progress in meeting the goals and timetables for increasing primary care training, strengthening and expanding family practice programs and decreasing the number of subspecialists trained.

University of California Compliance with the Memo of Understanding[5]

Between 1994 and 2001 the university took steps to meet the terms of the MOU and reported the following:

General goals:

- UC exceeded the MOU goal of achieving at least a 50/50 primary care to non-primary care ratio. By 2000-01 UC achieved a primary care to non-primary care resident ratio of 52/48, but fell short of achieving its projected goal of a 55/45 ratio. The primary care to non-primary care resident ratio in 1992-93 was 45/55 percent.

- By 2000-01 UC increased the number of family practice residents it trains to 17 percent of all UC residents, 3 percentage points under the projected goal of 20 percent.

Numerical targets:

- Between 1992-93 and 2000-01, UC increased its total number of primary care residents by 357 positions, or an 18.5 percent increase. The total number of primary care physicians increased to 2,291.

- Of the total increase of primary care resident physicians, UC added 224 family practice positions. This increase fell short of the MOU's "approximate" goal by 140 positions. The total number of family practice residents was 745, an increase of 43 percent.

- The university reduced the overall number of non-primary care positions by 282, or 11.7 percent, since 1992-93. This reduction fell short of the 452 positions proposed in the MOU by 170 positions. By 2000-01 UC maintained 2,123 non-resident positions reflecting 45 percent of the total resident physician pool at UC.

- UC met the reporting requirements of the MOU and the Supplemental Report Language, although several of the reports were submitted late. The university submitted seven reports to the governor, Legislature and OSHPD, providing updates on the university's progress in meeting the goals of the MOU. They also provided useful definitions and summaries of campus-specific and university-wide activities undertaken to strengthen and expand primary care educational opportunities for medical students and resident physicians.

In September 2002, OSHPD confirmed that UC "complied with the terms and conditions of its MOU with OSHPD."[6] However, OSHPD never issued a final report specifically evaluating UC's compliance with the MOU.

Remaining Issues with the Memo of Understanding

1. Ongoing Commitment to Goals of the MOU

   The university issued its last report required by the MOU in July 2002. Since then, it is not clear what progress the university has made in increasing the number of primary care and family practice positions, or whether the university continues to reduce the number of non-primary care physicians as agreed to in the MOU. Is UC maintaining the MOU ratios reported in 2002 and is it continuing to make improvements in the areas where it fell short?

2. Growth in UC-Affiliates

   The university reported significant increases in the number of family practice residents it trained during the period covered in the MOU. Much of this growth is attributed to increases in the number of UC-affiliate residents.

   UC reported that the number of family practice residents it trained increased from 521 in 1992-93 to 745 in 2000-01, a 43 percent increase. Of the 745 residents trained in 2000-01, UC-affiliates trained 588 residents, while UC hospital-based programs trained only 157. In other words, three-fourths of the family practice growth came from UC-affiliates. It is unclear whether the expectation in1994 was that UC would add new state-funded, UC hospital-based family practice residents, or that it would substantially increase its UC-affiliate family practice positions. The state may want to clarify how it wants to calculate family practice residents in the future and whether UC-affiliate family practice residents should be disaggregated from the overall UC resident count in the future.

3. UC Role with Affiliates

   In the 1990s there was large growth in the number of UC-affiliations with outside health care providers. At the same time, these affiliates were developing new family practice residency programs and expanding the number of residency positions they offered. These UC-affiliates included entities such as counties, Veterans Administration, and private hospitals and community-based patient care facilities throughout the state. All agreements between UC and UC-affiliate programs must meet specified criteria, including a requirement that "the affiliated UC Medical School provides the affiliated program with educational resource support."

   Because of the large role UC-affiliates play in training the majority of family practice residents, it is important to assess the relationship between UC and its affiliates and whether this is where future growth should continue to

occur. If the future growth in family practice residents is within UC-affiliate programs, should the state understand more about this type of training versus training at UC-based hospitals? Does UC provide sufficient resource support to the affiliate programs? What type of support is provided and which efforts are most valuable? Does UC support contribute to the growth in the number of residency positions within UC-affiliate programs? These issues require further exploration.

4. How to Report Internal Medicine

When the MOU was developed, significant discussion centered on how to count and report primary care residents specializing in internal medicine. A large percentage of internal medicine residents pursue subspecialty training after completing their three years of primary care training. While estimates suggest that up to 50 percent or more of these residents do not end up practicing in primary care, UC reports all internal medicine residents as primary care physicians. Instead, it has been suggested that only 50 percent of these residents be counted as primary care physicians.

Internal medicine is one of the larger programs, so resolving this issue is important for gaining a more accurate count of the number of physicians going into primary care. The issue was never resolved in the MOU, and UC continues to report all its internal medicine residents in the primary care category. This question warrants clarification for determining future primary care physician needs.

5. Lack of Details to Evaluate Campus Efforts

Each of the MOU reports provided significant detail about the progress made in increasing the number and proportion of primary care and family practice residency training positions at the campus level and systemwide. However, the MOU reports did not provide any detail about funds allocated (including redirection of funds) to expand primary care programs.

In addition the reports provided general summaries of what each campus was doing to improve medical educational opportunities. While this was helpful, it lacked sufficient detail about the number of students served, effectiveness of various initiatives or funding allocated for these purposes. As a result, it was difficult to gain a sense of the overall scale and effectiveness of these efforts.

6. Balance Between Primary Care and Non-Primary Care Physicians
When developing the MOU, the prevailing wisdom at the time was that there was an overall surplus of physicians, but a severe shortage of primary care doctors. Thus, the MOU focused on shifting the number of non-primary care

resident positions to primary care slots, without increasing the overall number of residency positions.

In today's market there is growing evidence that California's population growth, coupled with virtually no growth in medical school enrollment or physician residency positions for the past twenty-five years, has created a serious shortage of many classifications of physicians, including primary care and some subspecialty areas. If the state were to fund increases in medical school capacity and physician resident positions, the challenge would be to increase this capacity strategically and with economic incentives to direct a portion of this growth to address shortage areas. This is a complex issue that requires further exploration.

The Physician Workforce Shortage

California continues to face a severe physician workforce shortage, especially in specific regions of the state. This shortage is brought on by a number of factors, including continued population growth, increasing racial and ethnic diversity, an aging population with growing health needs and an aging physician workforce.

A Distribution Issue

This problem is compounded by the uneven geographic distribution of physicians, causing inadequate access to medical care in many of the state's rural areas, inner cities and poor communities. While California's overall physician to population ratio currently is 265 per 100,000 people, close to the national average, the ratio drops significantly in many regions. [7] For example, the central valley ratio is 131 per 100,000 people. In addition, more than 48 California counties have at least one area that qualifies as a federally designated Health Professions Shortage Area (HPSA).[8]

The average ratio of primary care physicians to the population in California is currently 77 per 100,000 residents, as compared to the average ratio of non-primary care or subspecialists to population in California, at about 114 per 100,000.[9]

Although the number and proportion of primary care physicians in the state has grown significantly in the past ten to twelve years, the shortage remains particularly acute in certain regions of the state. For example, the supply of primary care physicians dips to 54 physicians per 100,000 people in the Inland Empire and 59 physicians per 100,000 people in the southern end of the central valley.[10] However, in some regions of the state the ratio of subspecialty physicians to a population of 100,000 can also be quite low, such as in places like Tulare County.

The proper balance between primary care and non-primary care physicians serving an area is complicated. Some argue that there are growing shortages of non-primary care specialists, such as cardiologists, psychiatrists and anesthesiologists, most notably in poor and rural communities. Others argue that while there is a shortage of subspecialty doctors in some rural communities, the shortage is not as acute as the shortage of primary care physicians. The current challenge may not be to simply shift the ratio of primary care to non-primary care physicians trained in the state, but rather to assess the total number and proper balance of primary care to non-primary care physicians needed on a regional basis.

The Training Capacity Problem

The overriding problem is the university's limited capacity to train an increasing number of physicians to keep pace with the state's health care needs. The state has not increased UC state-funded medical school enrollment or residency positions for the past twenty-five years. While the California population grew 14 percent between 1992 and 2002, the number of students enrolled at the five UC medical schools remained virtually unchanged. As a result, UC medical schools have not been able to accommodate the growing number of qualified California students who wish to attend medical school. With applications far exceeding the available entering class enrollment, California now leads the nation in sending more medical students out-of-state than it trains in state.[11]

California medical school enrollment lags behind most of the country. In 2002 there were only 15.6 enrolled medical students for each 100,000 people living in the state compared to 27.1 per 100,000 in the United States as a whole. New York has the highest medical student enrollment with 42.5 per 100,000 people, while Texas has a ratio of 24 medical students to 100,000 people.[12]

Future Physician Workforce Needs

It is critical for the state to monitor future trends in access to primary care and subspecialty care areas, along with reviewing the various factors that may exacerbate the balance between the supply of physicians and the demand for health care.

The Center for Health Workforce Studies, in a December 2004 report, forecasts that between 2002 and 2015 the growth in physician demand in California will outpace the production of physicians by between 5 percent and 16 percent.[13] Many of the regions with the most severe shortages today are the areas of the state projected to have the most dramatic population growth between 2000 and 2015.[14] This trend is likely to further strain the health care system in the most underserved regions.

There is also a critical need to attract medical students and residents from diverse backgrounds who are culturally and linguistically competent and more inclined to practice in primary care specialties and in medically underserved communities. The state's physician workforce currently does not reflect the racial and ethnic diversity of the population it serves. The majority of California physicians are white (66 percent), followed by Asian/Pacific Islander (22 percent), Hispanic/Latino (4.4 percent) and African American (3 percent).[15]

Where Do We Go From Here?

As California faces ever-increasing health care needs and increased shortages in many areas of medical practice, there are essential issues that must be addressed.

What is the proper role for state government? State government does not generally attempt to directly influence the private sector labor market supply and demand. Precedent exists, however, for intervention in areas that affect the public good, such as the shortage of teachers and nurses.

Government needs accurate information for targeted and appropriate intervention. State government, therefore, must have the ability to obtain precise data on physician supply and demand. The capability to forecast needs in order to keep pace with changing demographics and health care advances is also essential.

There are policy choices, should state government choose to influence the supply and distribution of physicians. Incentives, such as increased funding, can be given to the university and its affiliates to expand physician training capacity to meet high demand priorities. Fiscal incentives can be provided to individuals who enter into medical practice in high demand fields of practice or underserved communities.

Oversight is necessary to review new investments and outcomes. Continuous assessment of goals within the changing marketplace also is critical.

Ultimately, the university must be a strategic partner with the state in addressing the overall supply of physicians, the appropriate mix between primary care and subspecialties and the geographic distribution of physicians in order to meet California's long-term health care needs.

ENDNOTES

[1] Primary care programs are defined as family practice, internal medicine, pediatrics, and obstetrics and gynecology programs. "Changing Directions in Medical Education," Update on Systemwide Efforts to Increase the Training of Generalists, Seventh Report, University of California, Office of the President, July 2002.

[2] The University defines UC-affiliate resident training programs as an Accreditation Council for Graduate Medical Education-accredited residency training program that fulfills all the following criteria:
(1) the purpose, terms and conditions of the affiliation arrangement are specified in an approved UC-affiliation agreement;
(2) the program director and core physicians responsible for supervising residents in the affiliate program hold UC faculty appointments;
(3) all graduating residents in the program receive a UC certificate;
(4) the affiliated UC medical school provides the affiliated program with educational resource support that:
a) appropriately supports the academic goals of the residency program;
b) reflects consideration of each program's size, needs, goals and resources in comparison to those of other UC-based programs and other state-supported affiliated programs; and
c) is discussed and/or negotiated on an annual basis. "Changing Directions in Medical Education," Update on Systemwide Efforts to Increase the Training of Generalists, Second Report, University of California, Office of the President, June 1994, 8.

[3] The Governor's Veto Message, September 3, 1994, stated in pertinent part: *The University recently signed a memorandum of understanding with the state to increase the number of primary care physicians trained in California. The memorandum establishes a goal of 20 percent of all residency positions in family practice throughout the University system by 2001. In addition, the agreement will increase the number of primary care physicians trained in UC colleges to 56 percent by 1998 and 70 percent in 2001*. The 56 percent and 70 percent figures reflect growth rather than the percent of overall UC residency population. The percentages in the MOU reflect the percentage of all UC residents. The percentages in this veto message are consistent with the goals of the MOU and are just reported differently.

[4] "Changing Directions in Medical Education," Update on Systemwide Efforts to Increase the Training of Generalists, Second Report, University of California, Office of the President, June 1994, 2-3.

[5] "Changing Directions in Medical Education," Update on Systemwide Efforts to Increase the Training of Generalists, Seventh Report, University of California, Office of the President, June 1994, 9.

[6] Memorandum of Understanding, Office of Statewide Health Planning and Development, Bud Lee, Chief Deputy Director to Keith Berger, Senior Negotiator, California Medical Assistance Commission, September 26, 2002.

[7] "Medical Education and the University of California," Final Report of the Health Sciences Committee, University of California, December 2004, 2.

[8] Ibid. 6.

[9] Ibid. 5.

[10] Ibid. 5.

[11] "California Physician Workforce, Supply and Demand through 2015," Center for Health Workforce Studies, University at Albany, State University of New York, December 2004, ES 4.

[12] Ibid. ES 4.

[13] "California Physician Workforce Supply and Demand through 2015," Center for Health Workforce Studies, University at Albany, State University of New York, December 2004, ES 2.

[14] "Physician Supply and Distribution in California, 2002," Center for Health Workforce Studies, University at Albany, State University of New York, 16.

[15] "Medical Education and the University of California," Final Report of the Health Sciences Committee, University of California, December 2004, 2.