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Physician needs are more than a matter of ratios

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According to the Graduate Medical Education National Advisory Committee, an ad hoc council of healthcare experts, a population of 100,000 people requires the services of exactly 3.2 cardiologists. Nationally, however, the ratio of cardiologists per population is 5.81 per 100,000. If the GMENAC numbers are right, the country has far more cardiologists than it needs (but just try recruiting one).

Are the ratios compiled by GMENAC really reliable? For that matter, are any of the half-dozen or so suggested physician-to-population ratios commonly referenced by medical staff planners on target? More importantly, does it matter?

Let's look at the last question first. For a variety of reasons, hospitals, health networks and other organizations must be concerned about the number of physicians per population in their service areas. For one thing, hospitals seeking to recruit physicians must demonstrate to the federal government that their service areas have a true need for additional doctors. Hospitals that cannot demonstrate such a need may be subject to penalties for violating IRS and HHS physician recruiting laws.

But compliance is just one issue. Strategically-minded facilities want a medical staffing blueprint they can follow to know how many and what types of physicians they need now and in the future. They also want to avoid alienating existing staff by demonstrating that they are bringing in additional physicians for valid reasons.

Hence the importance of physician-to-population ratios. A lot is riding on these numbers, particularly if hospitals and health systems are relying on them as a guide to future staffing plans. If the ratios are wrong, hospitals can end up seriously over- or understaffed. They also may incur the wrath of established physicians who may view newly recruited doctors as unneeded and unwanted competition.

So, are the ratios reliable? Should they be used as an index to community need for physicians? In a word, no.

The GMENAC ratios serve as a case in point. GMENAC, which met only once, promulgated its ratios in 1980. Though its numbers are more than two decades old, they are still commonly referenced in medical staff plans. The fact that GMENAC ratios pre-date the proliferation of managed care and that the population has aged considerably since 1980 only partly explains why these and other ratios are faulty. The real reason they cannot be trusted is that they suggest standardization is achievable in the patchwork of healthcare markets that make up a vast heterogeneous whole.

Consider: Can the same ratio of cardiologists-per-population really apply in young, largely immigrant South Texas and in old, largely geriatric sections of South Florida? These disparate populations will no more utilize medical services at the same rate than they will purchase pizza, hair coloring, or shoe polish at the same rate.

Physician-to-population ratios, then, are only a signpost or general indicator of physician need, rather than a definitive benchmark. A reliable projection of community need for physicians requires a thorough analysis of local conditions, including:

> Physician demographics. Exactly how many physicians are practicing in the service area already? No projection of current and future physician need can be accurate without this core data. Deriving an accurate physician count can be difficult, however. Some physicians may split time in different service areas, and so cannot be considered full-time-equivalents. Family physicians or internal medicine practitioners may be providing OB or cardiology services, and therefore are neither FTEs in primary care nor in a particular specialty.

How old are established physicians and when are they likely to retire? And where do residents fit in the mix? Addressing theses issues can take considerable legwork, but a reliable physician needs analysis stands or falls on an accurate physician count.

Medical staff survey. Physicians know if there are long wait times to schedule their patients with specialists. They also know which specialty services their patients need that currently are not available in the community. A survey of established physicians can reveal how busy local physicians are relative to national averages, whether their practices are open to certain populations such as Medicare patients, and what recruitment needs they see in the community. A survey also allows physicians to participate in the medical staffing process, building a consensus that can be essential to during the physician recruiting process.

Patient demographics. Is the local population growing? What segments are growing the fastest? Medicare patients utilize some medical services at three times the rate of younger populations, so patient aging is a key factor. Which are the geographic areas of fastest growth? What level of insurance and access to healthcare services does the population have? Is language a barrier to care? These and other questions pertaining to patient demographics must be answered to accurately gauge physician need.

Disease incidence. Healthcare challenges differ from region to region. Cardiovascular disease is rampant in some areas of the Midwest, while skin cancer rates often are high in sunny, coastal areas. Hospital admissions data and other statistics can reveal how local disease incidence varies from national averages.

From this combined data, a portrait will emerge of the local service area, showing the number, age and practice patterns of established physicians, current patient demographic trends, disease incidence and areas of immediate and long-term physician need. Physician-to-population ratios can add depth or perspective to this picture, but by themselves they do not answer the critical question: "How many physicians are enough?"

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