The GMENAC report and the PA profession

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ABSTRACT

The 1980 report of the Graduate Medical Education National Advisory Committee (GMENAC) predicted a surplus of physicians by 1990 and 2000. The report appeared to have a depressing effect on the growth of the PA profession in the early 1980s; in the 9 years following its release, no new PA programs were started and a number of existing programs closed. The GMENAC forecast proved to be inaccurate and the PA profession saw significant program growth in the 1990s and beyond. A lesson of GMENAC is that accurately predicting health workforce supply and demand is difficult.

Keywords: Graduate Medical Education National Advisory Committee, GMENAC, physician assistant, 50th anniversary, physicians, shortage

Physician supply and PAs

PAs and similar types of healthcare providers were introduced in the mid 1960s and early 1970s concurrently with an expansion of the physician workforce. The number of annual medical school graduates increased from 6,135 in 1950 to 15,135 in 1979. Health workforce observers began to develop an ideology that a reciprocal relationship existed between the number of physicians in the workforce and the perception of the need or the marketplace need for PAs. One manpower expert noted that “the greater acceptance of the role of physician extenders and the greater recognition of the increase in system efficiency that can result from this new division of labor comes at the very moment when rapid supply increases of physicians are likely to reduce job opportunities for extenders.” Therefore, in 1980, when a prestigious panel of experts endorsed by the federal government predicted a future surplus of physicians, many PA observers believed that this would mark a sharp blow to the fledgling PA profession in US medicine.
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**GMENAC**

The GMENAC was convened in 1976 to provide advice to the secretary of what was then called the Department of Health, Education, and Welfare (now Health and Human Services) on issues related to the physician workforce. The committee comprised 24 persons: 18 physicians (nine from academic settings, five from private practice, and four from government), four nurses, and two laypersons, and was staffed by a technically proficient group of economists and forecasters. The objective was to forecast the supply of and need for physicians for 1990 to 2000. The committee’s projections encompassed the best available supply data of physician production and immigration along with sophisticated demand models—analyses that included assumptions on future epidemiologic and demographic trends in the population, projected demand levels for medical services, and physicians’ choice of specialty and geographic distribution. The committee took note of the trend of an increasing infl ow of US citizen international medical graduates (IMGs), stating that “a particular concern is with the continued infl ow to practice of US citizens who have studied medicine outside the United States. This concern is stimulated by the recent development of many new medical schools outside the United States. GMENAC strongly urges that special attention should be given by the federal government to adopting measures to reduce substantially this infl ow.”

GMENAC concluded that, if nothing changed, the United States would have a surplus of more than 70,000 physicians by 1990 and 145,000 physicians by 2000, or 23% of the projected number of 643,000 physicians needed to meet demand. The committee predicted shortages in four specialties, surpluses in 15, and a near balance with its predicted requirement in eight. The report recommended that the positions made available for graduate education in the various specialties be adjusted to correct imbalances and went further to recommended restricting both the number of places in physician training programs and the number of IMGs permitted to enter US graduate medical education. GMENAC stated that it appeared unnecessary to continue the expansion of domestic medical education capacity and flatly recommended that no new schools be established. The committee considered the effect and contributions of NPs and PAs; despite acknowledgment of their contributions to medical service delivery, accompanied by prescient recommendations to expand practice laws and regulations, award prescribing authority, assure reimbursement for services, and conduct extensive future research, the committee also recommended that “the number of PAs and NPs and CNMs [certified nurse-midwives] in training... should remain stable at their present levels.”

**EFFECT**

Reaction to the GMENAC report was largely widespread acceptance of the findings despite vigorous criticism from prominent health workforce experts who pointed out the unproven validity of its complex methodology, the ambition of its scope and sophisticated methods, and the boldness of its predictions. Nonetheless, in 1981, in response to the report, Congress discontinued general federal support provided to medical schools for the education of new physicians. This congressional action, however, addressed only one of two important determinants of the physician supply—the number of graduates of US physician training programs. The other important determinant is the number of graduates of foreign medical schools who are admitted to postgraduate training in the United States, in addition to graduates of US medical schools. After acting to limit the supply of graduates of US medical schools, Congress inadvertently gave teaching hospitals an incentive to increase the numbers of IMGs entering graduate medical education in the United States as well as providing an incentive for US students who could not qualify for entry into US medical schools to seek admission to offshore medical schools.

As part of Medicare hospital reimbursement reforms in 1983 that created the diagnosis-related group system, Congress provided extra payments to teaching hospitals to cover the special costs associated with medical education and other academic functions such as research. These new graduate medical education payments increased with the number of trainees, and hospitals responded by increasing the number of interns and residents. The result was that although the number of US medical school graduates increased only modestly over the next 20 years, the number of trainees in US hospitals grew substantially, expanded by an infl ow of IMGs.

The prediction of GMENAC prompted questions of whether PAs had much of a future in the face of an oversupply of physicians. From 1981 to 1990, no new PA programs were started (Figure 1) and several PA programs sponsored by major academic health centers closed (University of Indiana, Johns Hopkins University, Penn State University). The 9-year period of no PA program growth is made more stark with the knowledge that funding for PA education was available through Title VII Section 747 authorization.

Directly inferring some form of cause and effect relationship between the delivery of the GMENAC report and the following lull in interest among institutions of higher education to sponsor PA programs is risky but the temporal relationship is evident. The common belief was that if the nation was likely to have too many physicians, what would be the purpose of having the PA profession? This period in PA history was characterized, at least anecdotally, by a scarcity of available PA jobs, continuing challenges and uncertainty in legal status, and lack of any form...
of reimbursement to employing practices and hospitals. These circumstances led some to abandon the PA career or seek entry to medical schools. Also during the 80s, the country was in an economic downturn that could have contributed to the slowdown in PA program growth and career opportunities.

RECOVERY AND FINAL LESSONS
Following the delivery of the GMENAC report, during which the future for the profession was uncertain, the PA profession continued to evolve and ultimately move forward and flourish. In the mid-1980s, the profession seemed to rebound with two landmark events signaling significant incorporation of the occupation into the health workforce. The first was an important PA milestone—congressional passage in 1986 of an amendment to the Medicare law providing reimbursement policies for PA services under Medicare Part B. Recognition by Medicare, the largest health insurance program in the nation, indicated the legitimacy of PA services in medical care. The other event was a no less significant milestone—the attainment of commissioned officer status in US uniformed services in 1988. Given the rich history between the military and the PA profession, this event was of particular significance and satisfaction to the profession. Thus, although the GMENAC prediction could account for the observed depression in interest in new PA programs and sluggish use of PAs, the profession stayed the course. This was due in no small part to the efforts of the American Academy of PAs to educate the public and federal and state legislatures about PAs and their contributions to medical care delivery. In the early 1990s, the PA profession entered a period of substantial growth that is still booming, with 210 training programs in the US as of March 2016.

The final lesson of GMENAC was the now-obvious inaccuracy of its predictions. GMENAC demonstrated how difficult it was and still is to make accurate predictions of health workforce supply and demand. Subsequent health workforce forecasting attempts by federal agencies like the Council on Graduate Medical Education were tempered following the failure of GMENAC.

REFERENCES