

HEALTH CARE REFORM AND ITS IMPACT ON THE MEDICAL PROFESSION

Presented to the
NATIONAL MEDICAL ASSOCIATION ANNUAL CONFERENCE
REGION III

by

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EDUCATING PHYSICIANS AT MEHARRY MEDICAL COLLEGE IN THE 1990'S

I BRING YOU GREETINGS FROM THE MEHARRY FAMILY AND ESPECIALLY FROM PRESIDENT SATCHER. WE ARE PLEASED THAT YOU HAVE INVITED OUR PARTICIPATION IN THIS CONFERENCE ON THIS EXTREMELY IMPORTANT TOPIC OF EDUCATING PRIMARILY MINORITY HEALTH CARE PROFESSIONALS. THE NATIONAL MEDICAL ASSOCIATION UNDER THE STALWART LEADERSHIP OF DR. BUTCHER AND THE PROGRAM CHAIRMAN, DR. SANDERS, ARE TO BE COMMENDED FOR CONVENING THIS MEETING ON THIS TOPIC. BEFORE I ADDRESS SPECIFICALLY THOSE ISSUES THAT DIRECTLY IMPACT MEDICAL EDUCATION AT MEHARRY AS THEY RELATE TO THE 1990'S, LET ME FIRST PROVIDE SOME HISTORICAL BACKDROP ON OUR INSTITUTION.

MEHARRY'S ORIGIN IS MOST INTERESTING. IT BEGAN IN 1826 WHEN 16 YEAR OLD SAM MEHARRY'S WAGON BECAME MIRED IN MUD WHILE HAULING SALT BETWEEN OHIO AND KENTUCKY. HE AND HIS THREE BROTHERS HAD IMMIGRATED TO THIS COUNTRY FROM SCOTLAND. MOST OFTEN OMITTED IN HISTORY TEXTS IN THIS COUNTRY IS, DURING THAT ERA OF THE 19TH CENTURY, THE IRONWORKERS, BLACKSMITHS AND ARTISANS WERE MOSTLY SLAVES. IT SO HAPPENED THAT IT WAS A BLACK FAMILY THAT CAME TO SAM MEHARRY'S AID; THEY FED HIM, PUT HIM UP FOR THE NIGHT AND FREED HIS WAGON AND MADE REPAIRS THE FOLLOWING MORNING. UPON HIS DEPARTURE, YOUNG SAM INFORMED THE BLACK FAMILY THAT, "IF MY BROTHERS AND I BECOME SUCCESSFUL, WE WILL DO SOMETHING TO HELP YOUR RACE." A HALF CENTURY LATER, THE MEHARRY BROTHERS HAD INDEED BECOME SUCCESSFUL INDUSTRIALISTS IN OHIO AND IN 1876 THEY MADE A GIFT OF \$38,000 TO CENTRAL TENNESSEE COLLEGE TO ESTABLISH A SCHOOL OF MEDICINE FOR NEWLY FREED MEN.

HENCE, THIS SINGLE ACT OF KINDNESS EVOKED A RECIPROCAL ACT THAT LED TO MEHARRY -- AN INSTITUTION THAT HAS CONTRIBUTED SO MUCH TO AMERICAN EDUCATION FOR WELL OVER A CENTURY.

ALLOW ME TO REVIEW WITH YOU SOME ADDITIONAL INFORMATION ABOUT MEHARRY. THE NAME MEHARRY MEDICAL COLLEGE BELIES OUR TRUE ACADEMIC CONSTRUCT. IN FACT, WE ARE A HEALTH SCIENCES CENTER COMPRISED OF FOUR SCHOOLS EACH WITH ITS OWN DEAN. THESE ARE THE SCHOOLS OF MEDICINE, DENTISTRY (THE ONLY ONE IN NASHVILLE), GRADUATE STUDIES AND RESEARCH AND ALLIED HEALTH PROFESSIONS. MEHARRY EMPLOYS APPROXIMATELY 1,600 PEOPLE, HAS AN ANNUAL BUDGET OF \$76 MILLION AND IS IN THE TOP 20 LARGEST EMPLOYERS IN THE CITY. AN ECONOMIST, DR. ROBERT VOWELS, HAS DETERMINED THAT MEHARRY'S ECONOMIC IMPACT ON THE COMMUNITY IS \$230 MILLION ANNUALLY.

NOW, AN UPDATE ON THE HOSPITAL MERGER IN NASHVILLE ABOUT WHICH YOU HAVE HEARD SO MUCH; THIS ISSUE IS MOST CENTRAL TO MEHARRY'S ROLE OF EDUCATING PHYSICIANS IN THE 1990'S. THE MERGER IS LOGICAL AND HOLDS MUTUAL BENEFITS FOR BOTH MEHARRY AND THE CITY OF NASHVILLE. THE FOLLOWING ADVANTAGES TO THE CITY OF NASHVILLE WILL OCCUR:

- 1) THE MERGER WILL SAVE THE CITY THE COST OF REBUILDING METROPOLITAN NASHVILLE GENERAL HOSPITAL OR THE COST OF COMPLETELY RENOVATING IT, EITHER OF WHICH COULD EXCEED \$100 MILLION IN TODAY'S MARKET.
- 2) EACH YEAR THE MERGER WILL SAVE THE CITY AS MUCH AS 10% OF THE OPERATING COST FOR THESE SERVICES.

- 3) THE MERGER WILL IMPROVE THE QUALITY OF SERVICES THE CITY OFFERS BY IMPROVING SPACE AND FACILITIES AVAILABLE, BY INCLUDING FAMILY AND PREVENTIVE MEDICINE FOR HEALTH PROMOTION AND DISEASE PREVENTION, AND BY PROVIDING MODERN EQUIPMENT.
- 4) NASHVILLE HAS AN OPPORTUNITY TO DEVELOP A NATIONAL MODEL OF HEALTH CARE FOR THE POOR AND UNDERSERVED.

ADVANTAGES TO MEHARRY MEDICAL COLLEGE WILL INCLUDE THE FOLLOWING:

- 1) THE MERGER IS CONSISTENT WITH MEHARRY'S HISTORIC MISSION OF ACCESS FOR THE UNDERSERVED AND EDUCATING THE UNDERREPRESENTED FOR HEALTH CARE CAREERS.
- 2) THE MERGER WILL END MEHARRY'S HISTORIC FINANCIAL DRAIN ASSOCIATED WITH CARING FOR NASHVILLE'S INDIGENT, AND WILL FULFILL THE PROMISE OF FINANCIAL SUPPORT MADE TO MEHARRY BY THE CITY IN 1948.
- 3) NORTH NASHVILLE WILL BENEFIT FROM THE ECONOMIC IMPACT OF THE MERGED SERVICES, AND THUS ENHANCE THE ENTIRE NASHVILLE COMMUNITY.
- 4) THERE WILL BE INCREASED CLINICAL EXPERIENCE FOR THE TEACHING PROGRAMS.

THE MERGER IS MOVING AHEAD ON SCHEDULE AND ITS SUCCESSFUL CULMINATION WILL BODE WELL FOR OUR EDUCATIONAL OBJECTIVES WHICH IS THE EDUCATION PRIMARILY OF AFRICAN AMERICAN HEALTH CARE PROFESSIONALS.

OVER FOUR YEARS AGO A PROPOSAL WAS MADE TO THE CITY OF NASHVILLE TO CONSOLIDATE MEHARRY'S HUBBARD HOSPITAL AND THE STRUCTURALLY OUTDATED METROPOLITAN NASHVILLE GENERAL HOSPITAL

(MNGH). IN DOING SO, MEHARRY WOULD HOLD PRIME RESPONSIBILITY FOR THE PROVISION OF HEALTH SERVICES IN THAT FACILITY WITH VANDERBILT UNIVERSITY PROVIDING THOSE TERTIARY LEVEL SERVICES UNAVAILABLE AT THE CONSOLIDATED FACILITY AS THEY NOW DO AT THE MNGH. THE CITY GOVERNMENT WOULD CONTINUE TO BE RESPONSIBLE FOR THE ADMINISTRATION OF THE CONSOLIDATED FACILITY. AFTER NEARLY FOUR YEARS OF NEGOTIATIONS, ON AUGUST 18, 1992 THE METROPOLITAN NASHVILLE CITY COUNCIL VOTED 24 TO 13 TO PROCEED WITH THE MERGER. THE MERGER EFFORTS ARE STRONGLY SUPPORTED BY NASHVILLE MAYOR, PHILIP BREDESEN TO THE EXTENT THAT HE MADE THIS ISSUE A PART OF HIS ELECTION PLATFORM. CENTRAL TO THE MERGER PROCESS WAS MEHARRY'S NEED TO RECRUIT AMPLE ADDITIONAL FACULTY TO STAFF THE CONSOLIDATED FACILITY. THREE BENCHMARKS WERE SET.

THE FIRST BENCHMARK WAS JULY 1, 1992 WHEN 18 OF THESE 56 FULL-TIME EQUIVALENT (FTE) PHYSICIANS HAD TO BE IN PLACE. THE SECOND BENCHMARK WAS DECEMBER 1, 1992 WHEN ANOTHER 18 SUCH POSITIONS HAD TO BE FILLED AND THE LAST BENCHMARK WHICH IS JULY 1, 1993 WAS MET FOUR WEEKS AGO WHEN ALL 56 STAFF POSITIONS WERE FILLED.

THE PRESENTATION TODAY IS ABOUT EDUCATING PHYSICIANS AT MEHARRY MEDICAL COLLEGE IN A CHANGING HEALTH CARE ENVIRONMENT. THIS IS OUR LEGACY. FOR 117 YEARS, MEHARRY HAS FULFILLED QUITE A UNIQUE ROLE IN AMERICAN MEDICAL EDUCATION. WE HOLD A RICH HISTORY OF TRAINING HEALTH PROFESSIONALS WHO PRIMARILY PROVIDE SERVICES TO THE POOR AND UNDERSERVED -- THAT CATEGORY OF CITIZENS WHO ARE MOST VULNERABLE. SEVENTY-FIVE PERCENT (75%) OF MEHARRY'S GRADUATES ESTABLISH THEIR PRACTICES IN UNDERSERVED RURAL OR

INNER-CITY COMMUNITIES -- FOR MAJORITY GRADUATES THIS FIGURE IS 20%. IT HAS BEEN SHOWN BY THE ROBERT WOOD JOHNSON FOUNDATION THAT THOSE INDIVIDUALS WHO ARE MOST LIKELY TO PRACTICE IN UNDERSERVED AREAS ARE THOSE INDIVIDUALS WHO THEMSELVES ARE PRODUCTS OF SUCH AREAS. THESE STUDENTS, ALTHOUGH MANY OF THEM HAVE HAMPERED BACKGROUNDS, ARE BRIGHT AND EAGER TO LEARN. PASSAGE OF THE UNITED STATES MEDICAL LICENSING EXAMINATIONS (USMLE) STEPS I AND II [FORMERLY THE NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)] IS AN INSTITUTIONAL REQUIREMENT. NINETY-FOUR PERCENT (94%) OF OUR STUDENTS ULTIMATELY ARE SUCCESSFUL IN REACHING THIS MOST IMPORTANT MILESTONE WHICH IS CRUCIAL FOR THE EDUCATIONAL PROCESS FOR MEHARRY STUDENTS IN 1990'S.

THE CONSEQUENCES OF HEALTH CARE REFORM IN THIS NATION HAVE THE POTENTIAL TO NEGATIVELY IMPACT MEDICAL EDUCATION IN ALL AMERICAN MEDICAL SCHOOLS WITH A COMPOUNDED EFFECT ON SCHOOLS SUCH AS MEHARRY; BECAUSE OF OUR MISSION, WE ACCEPT STUDENTS WHO COME FROM MOSTLY POOR FAMILIES. NINETY-FIVE PERCENT (95%) OF MEHARRY'S STUDENTS RECEIVE SOME FORM OF FINANCIAL AID AND 75% COME FROM FAMILIES THAT EARN LESS THAN \$35,000 A YEAR. EVEN WITH MEHARRY HAVING THE LOWEST TUITION OF ANY PRIVATE MEDICAL SCHOOL IN THE NATION, AT \$14,000 ANNUALLY, THIS IS A FORMIDABLE COST FOR FAMILIES WHOSE EARNINGS ARE SO MEAGER. AS A CONSEQUENCE, OUR STUDENTS COMPLETE THEIR MEDICAL SCHOOL EDUCATION WITH HUGE DEBTS SOMETIMES EXCEEDING \$100,000. HENCE ANY ASPECTS OF HEALTH CARE REFORM AFFECTING MEDICAL EDUCATION THAT ARE NEGATIVE WILL MAGNIFY THE PROBLEMS FOR STUDENTS FROM LOW INCOME FAMILIES.

THE MANAGED CARE PACKAGE THAT THE STATE OF TENNESSEE WILL ATTEMPT TO IMPLEMENT JANUARY 1, 1994 DOES NOT BODE WELL FOR THE FINANCING OF MEDICAL EDUCATION -- ESPECIALLY POST GRADUATE MEDICAL EDUCATION. ALTHOUGH THE PLAN NAMED "TENNCARE" GIVES LIP SERVICE TO PRIMARY CARE PHYSICIANS' EDUCATION, THE FACT IS THE EXISTING SUPPORT FOR THIS PURPOSE IS LOST FROM THE CURRENT TENNESSEE MEDICAID FUNDING. A MAJOR SOURCE FOR POST GRADUATE MEDICAL EDUCATION THAT IS NOT BEING MAINTAINED IS THE DISPROPORTIONATE SHARE HOSPITAL (DSH) STRUCTURE; THE CURRENT PLAN PROVIDES NO OTHER MECHANISM THAT WILL ASSURE THE CONTINUATION OF THIS CRITICAL FUNDING SOURCE. THE TENNCARE PROPOSAL IS DESIGNED TO PROVIDE SERVICES FOR AN ADDITIONAL 400,000 CLIENTS WITHOUT INCREASING FUNDING FOR THESE NEW RECIPIENTS OF SERVICE. THE STATE WILL CAPITATE ALL 1.4 MILLION PARTICIPANTS AT \$153 PER MONTH PER ENROLLEE WHICH WILL COST \$2.5 BILLION ANNUALLY WHICH IS WHAT WAS SPENT LAST YEAR. HENCE, THE DOLLARS THAT HERETOFORE WENT TO THE DISPROPORTIONATE SHARE HOSPITAL FUND WILL NOW BE DIVERTED TO SUPPORT DIRECT PATIENT CAPITATION PAYMENTS.

WHAT ARE SOME INTERVENTIONS THAT WILL LESSEN THIS IMPACT ON INSTITUTIONS THAT EDUCATE PRIMARILY AFRICAN AMERICANS? EXPANSION OF THE NATIONAL HEALTH SERVICE CORPS (NHSC) SHOULD COMMAND INCREASING IMPORTANCE. IT HOLDS THE CAPACITY TO IMPROVE DELIVERY OF HEALTH SERVICES TO UNDERSERVED AREAS; MOREOVER THIS PROGRAM CAN FINANCE MEDICAL EDUCATION FOR QUALIFIED INDIVIDUALS WILLING TO PRACTICE IN UNDERSERVED AREAS AS A METHOD OF SATISFYING THEIR FINANCIAL EDUCATIONAL OBLIGATIONS. ALTHOUGH INSUFFICIENT,

APPROPRIATIONS FOR THE NHSC WERE INCREASED FROM \$49 MILLION IN FY 1992 TO \$101 MILLION IN FY 1993.

NEXT, SCHOLARSHIPS AND LOW INTEREST RATE LOANS MUST BECOME MORE AVAILABLE TO DESERVING AND ASPIRING HEALTH CARE PROVIDERS. AS STATED EARLIER, THOSE INDIVIDUALS THAT ARE MOST LIKELY TO PROVIDE HEALTH CARE TO UNDERSERVED AREAS ARE THOSE INDIVIDUALS WHO THEMSELVES ARE PRODUCTS OF SUCH AREAS. HENCE, INCREASED FUNDING FOR THE NHSC IS PRUDENT.

ESTABLISHING A PARTNERSHIP BETWEEN SOME VETERAN'S ADMINISTRATION HOSPITALS AND RURAL COMMUNITIES MUST BE REVISITED. THE EFFORT TO EFFECT THIS DURING THE PREVIOUS ADMINISTRATION WAS LAUDABLE; UNFORTUNATELY, POOR COMMUNICATION, POOR PLANNING AND GENERAL INEPTNESS IN ATTEMPTING TO IMPLEMENT THIS EXCELLENT IDEA DOOMED IT TO FAILURE. TUSKEGEE ALABAMA (MACON COUNTY) DEMONSTRATES SUCH A NEED; THE TWO HOSPITALS IN MACON COUNTY OTHER THAN THE VA HOSPITAL, HAVE HAD TO CLOSE. HENCE, THE COUNTY AND ITS CITIZENS ARE WITHOUT A MEDICAL FACILITY WHILE THE HOSPITAL BUILT AND SUSTAINED WITH PUBLIC FUNDS SITS WITH MANY EMPTY BEDS. IN ADDITION TO MEETING THE HEALTH CARE NEEDS OF MANY OF THESE ISOLATED CITIZENS, THE TUSKEGEE VA HOSPITAL IN ALABAMA AND THE YORK VA HOSPITAL IN TENNESSEE WOULD BE IN EVEN A BETTER POSITION TO HELP MEET THE MEDICAL EDUCATION NEEDS OF MOREHOUSE AND MEHARRY RESPECTIVELY.

ON OTHER FRONTS, THERE EXIST AT LEAST TWO LEGISLATIVE INITIATIVES STRUCTURED TO ASSIST HISTORICALLY BLACK COLLEGES AND UNIVERSITIES (HBCU'S). TITLE III OF THE HIGHER EDUCATION ACT, SECTION 326, STRENGTHENING HISTORICALLY BLACK GRADUATE

INSTITUTIONS IS ONE SUCH PIECE OF PENDING LEGISLATION. FOR SCHOOLS NOT ENROLLING UNDERGRADUATE STUDENTS SUCH AS MEHARRY, WE ARE INELIGIBLE TO RECEIVE PELL GRANTS AND, AS SUCH, CANNOT RECEIVE REGULAR TITLE III, PART B FUNDING. THE OTHER INITIATIVE IS PENDING LEGISLATION TO REAUTHORIZE THE NATIONAL INSTITUTES OF HEALTH (NIH S.1 AND H.R. 4) WHICH WILL ESTABLISH AN EXTRAMURAL GRANTS PROGRAM FOR BIOMEDICAL AND BEHAVIORAL RESEARCH FACILITIES CONSTRUCTION. THIS IS A PROGRAM LOCATED IN THE NATIONAL CENTER FOR RESEARCH RESOURCES (NCRR). LEGISLATION SUCH AS THIS IS PIVOTAL IF HBCU'S ARE TO EFFECTIVELY COMPETE FOR BIOMEDICAL RESEARCH FUNDING.

A WORKING GROUP ON MEDICAL EDUCATION AND HEALTH SYSTEM REFORM, OFFICE OF MEDICAL EDUCATION, AMERICAN MEDICAL ASSOCIATION, HAS JUST RELEASED A DOCUMENT ENTITLED, "THE POTENTIAL IMPACT OF HEALTH SYSTEM REFORM ON MEDICAL EDUCATION." IT IS INESCAPABLE, THERE WILL BE SOME GENERIC EFFECTS OF HEALTH CARE REFORM THAT UNDOUBTEDLY WILL NEGATIVELY IMPACT TO VARYING DEGREES ALL MEDICAL SCHOOLS. I WILL SHARE WITH YOU A PORTION OF THE SUMMARY FROM THAT MANUSCRIPT. "AS A RESULT OF HEALTH CARE REFORM, MANY ACADEMIC MEDICAL CENTERS WILL EXPERIENCE A SIGNIFICANT IN PATIENT REFERRALS AND, THEREFORE, A DECLINE IN THEIR HOSPITAL AND PRACTICE PLANS REVENUES. THE MAGNITUDE OF THE REVENUE LOSSES THAT WILL OCCUR WITH A SYSTEM BASED ON MANAGED COMPETITION SYSTEMS WILL BE GREATER THAN THOSE THAT MIGHT OCCUR WITH A SYSTEM OF GOVERNMENT IMPOSED PRICE CONTROLS, BECAUSE A TRULY COMPETITIVE ENVIRONMENT WILL ADVERSELY IMPACT BOTH

PATIENT VOLUME AND PAYMENT OF INDIVIDUAL SERVICES. HEALTH SYSTEM REFORMS THAT DRIVE ACADEMIC MEDICAL CENTER HOSPITALS INTO SEVERE FINANCIAL DISTRESS AND DO NOT PROVIDE FUNDING FOR MEDICAL STUDENT AND RESIDENT PHYSICIAN EDUCATION AT OTHER SITES IN THE COMMUNITY WILL IN THE LONG RUN UNDERMINE THE COUNTRY'S SYSTEM OF MEDICAL EDUCATION AND, ULTIMATELY, THE HEALTH OF THE PUBLIC."

IN CLOSING, IT IS APPARENT THAT MANY UNKNOWNNS EXIST WITH RESPECT TO HEALTH CARE REFORM AND ITS EFFECTS ON MEDICAL EDUCATION. HOWEVER, NOTWITHSTANDING THIS, THERE ARE SOME VERY APPARENT KNOWNNS. FIRST, EDUCATION OF THIS NATION'S HEALTH CARE PROVIDERS MUST CONTINUE; SECOND, EDUCATING HEALTH CARE PROVIDERS IS EXPENSIVE AND THIRD, THIS EDUCATION MUST BE PAID FOR. HENCE, WE ARE BEYOND WHAT WE MUST DO -- THE QUESTION NOW IS, HOW WILL WE DO IT. WHAT ARE OUR OPTIONS? AND PARTICULARLY WHAT DOES HEALTH CARE REFORM PORTEND FOR EDUCATING PHYSICIANS AT MEHARRY MEDICAL COLLEGE IN THE 1990'S. I DO NOT KNOW FOR CERTAIN BUT I CAN ASSURE YOU THAT WE WILL WORK ASSIDUOUSLY AT MEHARRY TO ENSURE THE INTEGRITY OF OUR EDUCATIONAL MISSION. MEHARRY HAS COME TOO FAR AND HAS WORKED TOO HARD TO DO OTHERWISE. THANK YOU VERY MUCH FOR AFFORDING ME THE OPPORTUNITY TO MAKE THIS STATEMENT TO THIS ORGANIZATION.

FREP/709

WHAT DOES HEALTH CARE REFORM PORTEND FOR UNDERGRADUATE
MEDICAL EDUCATION?

To answer this question, what is needed is a crystal ball but, alas, no such implement avails itself. The fate of undergraduate medical education including obstetrics and gynecology in this changing health care milieu is uncertain. We are all in a fog; I have spoken with no colleague who holds any better insight into this issue than I. If some of you out there hold this insight, please come forth. Currently, we are dealing with the unknown and it is the unknown that renders us mostly ineffectual in either acting or reacting thus creating a state of significant anxiety. Several scenarios are plausible.

There is a phenomenon already occurring in my state of Tennessee as well as in some others according to my colleagues. Specifically, as states have increased Medicaid reimbursement rates for obstetrical care for both physicians and hospitals, sizable numbers of these obstetric patients have now opted to utilize private physicians and hospitals. On some teaching services, the obstetric census has dropped by as much as 50% over the past three years. Further, unpublished reports suggest that health care outcome is now poorer for these former teaching hospital patients. Many of the social supports attendant to teaching hospital services, which are critical for high risk patients, are either absent or miniscule in many private settings. With health care reform, it is not known if this trend will continue, contract or expand.

In the state of Tennessee, our Governor has recently been to the White House and requested a waiver from Medicaid; in lieu of this, the state will use the federal matching funds to implement a competitive system of managed care called TennCare, to cover not only the existing 950,000 Medicaid recipients but also for an additional 500,000 uninsured or underinsured individuals. Moreover, it is to provide all of this care at the same dollar amount as in the previous year. Twelve geographic capitation regions have been established for the state of Tennessee with an average capitation rate per enrollee of \$153 per month or \$1,836 annually. This seems woefully inadequate to provide ambulatory care; surgical and non-surgical hospitalization; pharmaceuticals; and health promotion disease prevention interventions. Does this mean that the private sector will disengage from providing this care? This is but one of the unknowns that clearly can impact patient availability for medical education.

No doubt you may wonder, "How can Tennessee provide an acceptable level of care for an additional 500,000 patients without increasing funding?" Herein lies another ominous unknown for medical education. That portion of previous Medicaid funding designated as disproportionate hospital share will now be applied to funding the patient capitation rate. No replacement funds have been identified to supplement postgraduate education which is what disproportionate hospital share funds did. And all of us in medical education understand the interdependence of undergraduate and postgraduate education.

Now, in spite of the uncertainty attendant to health care reform, there exist three well-known factors - 1) education of health professionals must continue; 2) health care education is costly and 3) health care education must be funded by some source. It will behoove us, to the extent that we can, to be proactive rather than waiting until health care reform is fully upon us and then attempting to react. To help set the stage for a proactive forum, Dr. Hugh Gorwill, Professor and Head of the Department of OB/GYN at Queens University in Ontario, Canada, and a member of APOG will provide us insights as to how this issue is being addressed in Canada. He will make this presentation at our annual CREOG/APGO meeting being held in Nashville, Tennessee on March 3-5, 1994. We look forward to any and all words of wisdom Professor Gorwill can share with us.

Submitted by,

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FREP/735

IMPROVING ACCESS TO HEALTH CARE THROUGH PHYSICIAN WORK FORCE
REFORM: DIRECTIONS FOR THE 21ST CENTURY

Presented to the
GOVERNOR'S MEDICAID TASK FORCE

by

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IMPROVING ACCESS TO HEALTH CARE THROUGH PHYSICIAN WORK FORCE
REPORT: DIRECTIONS FOR THE 21ST CENTURY

To Governor McWherter, Dr. Frist and other members of the Governor's Medicaid Task Force, I am indeed pleased personally and on behalf of Meharry Medical College to participate in your timely program, "Primary Care Within A Managed Care Setting in Tennessee." It is laudable that you are working assiduously to address this vexing and very challenging issue that affects each of Tennessee's five million citizens.

As I view it, two very powerful imperatives cause us to be gathered here today -- lagging health care outcome in America and the excessive cost of financing that care. With respect to health care outcome, failure to adequately link health care needs and direct health services (access and utilization) have brought us to where we are today. With the exception of a single slide, I won't belabor you with all of the data that characterize our nation's substantially poorer health care outcome when compared with all other Western nations - be it life expectancy or infant mortality, we in the U.S. do poorly. And as you may know, what often is viewed as solely a medical problem has an equally as strong social genesis, for example teen pregnancy. The U.S. teen pregnancy rate of 96 per 1,000 is more than double that of the next Western nation which is the United Kingdom at 45 per 1,000

teenage females. For Japan, this figure is but 7 per 1,000. Clearly, we have much to do which have both a medical and social genesis.

If our current health financing methodology is not reformed, our nation will become bankrupt. In 1980 I wrote a chapter for a textbook on ambulatory gynecologic surgery; at that time we as a nation were spending about 6.8% of our gross national product (GNP) on health care or \$250 billion annually. At that time of my writing it was determined that with continued expansion at that rate, by the year 2000 we would be spending 20% of our gross national product (now gross domestic product [GDP]) on healthcare. That prediction regrettably has held; we are now spending 14% of our GDP on health care expenditures. This is more than \$2 billion daily or nearly \$800 billion for this year with a projected expenditure of \$1 trillion in 1995. In sum, our national health care expenditures are too costly and our product is substandard.

The Council on Graduate Medical Education (COGME) was authorized by Congress in 1986 to conduct an ongoing assessment of physician supply trends and to recommend appropriate federal private sector efforts to address identified needs. This study has now been concluded and has been published just recently in The Journal of the American Medical Association (JAMA) by Marc Revo and David Satcher. The Journal edition is September 1, 1993, vol. 270, no. 9.

The COGME findings are compelling and their recommended interventions, though complicated and challenging, are cogent. Foremost, the COGME study reveals that significant deficiencies in the physician work force, medical education system, and public health policy will hinder strategies to provide affordable health care to all of our citizens. These deficiencies are summarized in seven findings which I will share with you.

Finding No. 1: The nation has too few generalists and too many specialists.

In 1961, half of all U.S. physicians were generalists. Since then the percentage has dramatically declined. In 1990, 33.5% (183,349/547,310) of active allopathic physicians were generalists with 13.9% in general internal medicine, 12.9% in family practice and 6.7% in general pediatrics. In 1990, 55.4% (12,500/22,653) of active osteopathic physicians were in general practice.

Almost half of all allopoathic students chose internal medicine or pediatric residencies but 60% of internal medical residents and 40% of pediatric residents subspecialized.

The increasing generalist-specialist imbalance in the U.S. undermines the ability to provide universal access and limits the capability to meet the demands of managed care and the needs of

underserved rural and urban populations. Unless current trends are reversed, primary care services increasingly will be provided by specialists and subspecialists who have little or no primary care training or continuing education. As such, these services can be expected to be both costly and inefficient in as much as specialists tend to use technologies and procedures of their specialties more than do generalists.

Finding No. 2: Problems of access to medical care persist in rural and inner city areas despite substantial increases in the physician supply.

Physician geographic maldistribution remains an intractable problem despite a doubling in the physician supply during the past 25 years. Large metropolitan areas have three times the physician density of the smallest nonmetropolitan areas. The number of primary care shortage areas actually increased between 1980 and 1990 despite a net gain of 150,000 physicians. In 1990 almost 500,000 people lived in 129 counties with no practicing physician.

Finding No. 3: The racial/ethnic composition of the physician work force does not reflect the general population and contributes to access problem for minorities.

Although African Americans, Hispanics and Native Americans constitute 22% of the total U.S. population and will constitute almost 1/4 of all Americans by the year 2000, they represent only 10% of entering allopathic and osteopathic medical students, 7% of practicing physicians and 3% of medical faculty.

Increasing percentage of underrepresented minorities in the medical profession is vital as a means of improving access to health and health status of the nation's more vulnerable populations. The Association of American Medical Colleges (AAMC) has established a program entitled 3000 by 2000 whose implication is that entering minority medical students in the year 2000 will number 3000 thus reflecting their percentage of the population of this nation.

Finding No. 4: Shortages exist in general surgery, adult and child psychiatry, preventive medicine and among generalists physicians with additional geriatrics training.

The future growth in general surgical services is projected to exceed growth in the supply of general surgeons. Aging of the U.S. population will increase demands for surgical services. Because of the increasing trend toward other surgical subspecialties, the number of residents training in general surgery has declined.

Increases in the use of mental health services are projected to exceed growth in the supply of adult and child psychiatrists. In the late 1960's, 10% of medical students chose careers in psychiatry. After a generally upward trend in most of the 1980's, student interest in psychiatry is now declining with only 5.5% choosing that discipline.

Continued shortages remain in the field of preventive medicine which includes the specialty areas of public health, general preventive medicine, occupational medicine and aerospace medicine. In American medical schools students receive little information about preventive medicine training and career opportunities. We are fortunate at Meharry to have residency programs in both preventive medicine and occupational medicine.

Given the rate of population aging, geriatrics warrants additional emphasis. Family physicians and general internists are trained to provide comprehensive, quality care to the elderly -- a further justification of the need for more primary care physicians.

Finding No. 5: The nation's current physician-to-population ratio is adequate; further increases in the ratio will do little to enhance the public health or to address access to care problems and will hinder efforts to control cost.

The sustained growth in physician supply largely resulted from national policies initiated in the 1960's in response to a perceived physician shortage. Medical schools doubled class size and large numbers of foreign trained physicians joined the work force. Between 1960 and 1988, the total number of physicians doubled and the physician to population ratio increased by more than 70%. Despite concerns about a pending surplus expressed as early as a decade ago, the physician work force is projected to grow from 600,000 to 900,000 during the next three decades increasing the physician-to-population ratio an additional 25-30%.

The projected increase in physician-to-population ratio is unlikely to improve access to care for the underserved or to enhance the health of the public. Wide ranges in physician supply exist in the U.S. with little evidence of differences in health care outcomes. Likewise, HMOs provide care with physician-to-population ratios 25% lower than those of other sectors of the health care system with no apparent difference in health care outcome.

Further increases in the physician-to-population ratio are expected to have adverse effects on health care costs control strategies. Although 20% of health care expenditures are paid directly to physicians, an estimated 70-90% of all such

expenditures are physician initiated through ordering tests, seeking consultations, performing procedures, prescribing medications and hospitalizing patients. Consequently, measures to provide universal health care access and control costs should contain strategies to maintain the physician-to-population ratios at current levels.

Finding No. 6: The nation's medical education system can be more responsive to public needs for more generalists and minority physicians, fewer specialists and more physicians for medically underserved inner-city and rural areas.

In the past, the nation's undergraduate and graduate medical education system responded effectively to national needs to increase the number of physicians, advance biomedical research and develop new medical technology. As a result during the past 25 years, the physician supply has doubled and the U.S. has become a world leader in biomedical research and technology development. Today the medical education system must respond to the nation's need for more minority and generalist physicians, more primary care and health services research and increased access to primary care, particularly in underserved rural and inner-city communities.

Finding No. 7: The absence of a national physician work force plan, combined with financial and other disincentives are barriers to health care reform.

The nation has neither a physician work force plan nor a medical education financing strategy to meet the current and projected health care needs of U.S. citizens. Physician reimbursement policies and administrative burdens provide significant disincentives for selecting a career as a generalist physician and for practicing in underserved areas.

As a consequence of these seven findings, the COGME developed recommendations for a national work force plan and recommendations that are specific for medical educators. Based on the findings, the COGME recommends the establishment of a national physician work force plan and finance a strategy to address the nation's future physician needs. Five goals are established for this purpose.

- 1) The nation should move toward a system in which 50% of all physicians in practice in the disciplines of family medicine, general internal medicine and general pediatrics.

- 2) All primary medical care shortage areas should be eliminated and disparities between the metropolitan and nonmetropolitan distribution of physicians should be reduced.
- 3) The racial/ethnic composition of the physician population should reflect the population's overall diversity.
- 4) The percentage of physicians trained in general surgery, adult and child psychiatry and preventive medicine and the percentage of family physicians and general internists with additional geriatrics training should be increased.
- 5) The aggregate of allopathic and osteopathic physician-to-population ratio should be maintained at current levels.

In addition to strategies that redirect medical education financing and health care reimbursement, commitment and leadership from the nation's medical educators are needed. Specific recommendations for medical educators as follows:

- 1) mission statement and strategic plans that contain specific outcome measures for the number of graduating

With these thoughts in mind, it is my strong conviction that basic role of medical schools should be increased from three functions to four; the three current functions are teaching, patient care and research. The time has now come that we add a fourth which is community outreach.

In closing, it should be evident to most that the increased need for a more favorable ratio of primary care physicians to specialists, better access and utilization of health services and cost containment are all interdependent. The issue confronts us squarely, there can be no turning back, reform of the American health delivery system is imminent and immersed in the center of the flux is physician work force reform. This need for this change is well overdue and any further delay is too costly. Let us all go forward putting forth our best energies to assure the best possible health care system in the world.

Thank you very much for allowing me to share these thoughts with you today.

Henry W. Foster, Jr., M.D.
Dean, School of Medicine
& Vice President for Health Services

09/23/93

FREP/928

THE CHRONOLOGY OF SUCCESSFUL GRANTSMANSHIP

presented

by

**Henry W. Foster, Jr., M.D.
Acting President
 Meharry Medical College
Nashville, TN**

CHRONOLOGY OF SUCCESSFUL GRANTSMANSHIP

Grant procurement is now a necessity for academic health care faculty members. And as revenue from the provision of direct health services decreases, obtaining more grant support becomes imperative. The purpose of this presentation, therefore, is to provide basic information as to the sequential steps to apply in grant preparation that most likely will lead to success.

Presented will be fourteen (14) sequential steps which are as follows:

- o Pre-Grant Measures - There is a set of measures that should be investigated before one attempts to write a grant.
- o The choice of request for grants or contracts - Distinction must be made between which grants or contracts that should be sought or rejected.
- o Orientation to requests for grants (RFA - Request for Applications) and for contracts (RFP - Request for Proposals) - Follow the rules carefully.
- o The research environment - The clinical and/or basic environment must be sufficient to support the research that is being proposed.
- o Detailing what will be done - This should be explicit and done well.
- o Detailing how the grant works is one of the most frequent weaknesses in grant preparation. How a grant works should be such that the reviewer of the grant has an excellent sense of how the activities move from point A to point B.
- o Recognition of "soft" areas - All grant areas have weaknesses. This has to be recognized and made a part of the grant by the potential grantee.
- o The budget must be logical. Cost/effort clarification and alignment are critical.
- o Evaluation of the grant effort both process and outcome must be realistic.
- o Why you, for grant funding? It is imperative that you convince the granting agency why their money should be placed with you.
- o Tidiness and timeliness - These are essential parts of grant submission.

- o The mock site visit and role reversal is the key to maximizing the grant process.
- o The actual site visit - A time to promote and convince.
- o After the grant award - Maximizing the application of these steps best assures success in the grantsmanship process. Further, writing grants is like most other skills - one improves over time.

:gjt

11/16/93

FREP/995

MINORITY ACADEMIC HEALTH CENTERS OF THE FUTURE

Presented at the

**Annual Meeting of the
Association of Minority Health
Professions Schools**

at

**The Charles R. Drew University
of Medicine and Science
Los Angeles, California**

February 10-12, 1994

by

**Henry W. Foster, Jr., M.D.
Acting President**

**Meharry Medical College
Nashville, Tennessee**

MINORITY ACADEMIC HEALTH CENTERS OF THE FUTURE

To President Lewis, The Charles R. Drew University of Medicine and Science, colleagues and friends: I am indeed pleased to be able to join you today. The topic for discussion: "Minority Academic Health Centers of the Future" is of prime importance. We must analyze just how tenuous is our fate and determine those interventions that will best secure our position. In my view, this topic presents both severe challenges and great opportunities. There is bad news that is generic for all academic health centers. And, beyond this, there are further compounding nuances for historically black academic health centers.

The need for health care reform in this country is long overdue and is inevitable. At our current rate of spending for health care in this nation, our cost will exceed one trillion dollars annually by 1998 — this represents a quadrupling of expenditures since 1980. The time frame in which health care reform will occur is an unknown, but it will occur. For those who listened carefully to President Clinton in his recent State of the Union message, while asserting in unequivocal terms that universal access must and will be a part of any health security act, very adroitly, he also avoided the issue of the time frame in which this is to occur. However, irrespective, health care reform overall promises to benefit most those of lesser resources — patients cared for in disproportionate numbers by minority academic health centers.

You have all heard of the 35 million Americans so often referred to that are uninsured. These are mostly working individuals whose earnings disqualify them from Medicaid eligibility, but the level of their income is too meager for them to purchase health insurance on the open market. However, in truth of fact, this 35 million figure is deceptive. It is a cross-sectional figure looked at in a given time. However, if the uninsured are looked at in real-time over the period of one year, the figure then rises to near 55 million individuals. These are people going in and out of employment, thus gaining and losing their health insurance.

As academic health centers, be we minority or otherwise, our job is that of graduate medical education and undergraduate medical education, and currently in the Health Security Act, these programs are under-funded. Last fall, I had the opportunity to join 29 other U.S. medical school deans and provide input to Ira Magaziner, who has been appointed by the Clinton administration to staff the development of the Health Security Act. At the closure of a long and particularly difficulty session, in attempting to summarize our activities, there was despair expressed because there were so many uncertainties. People were having trouble reaching a conclusion. Mr. Magaziner recognized me from the floor during this discussion, and I admitted that I was in concurrence with most of the tenets of our discussion; however, I took that opportunity to point out to him and my fellow deans that, in spite of all of the uncertainties, of which there are many, there were nonetheless three clear and distinct unambiguous needs:

1. Education of health professions must continue in this country.
2. Health care education is costly.

3. Health care education must be funded by some source.

As currently proposed in the Health Security Act, by the year 1999, the educational cost per resident will be \$93,062 annually, but the payment per resident will be \$68,327. This total cost for resident education will be \$8.1 billion, but payment will be \$5.9 billion leaving a \$2.1 billion shortfall.

Further, in the Health Security Act, there is no provision to address the potential shortfall of funding for undergraduate medical education, transition to generalist and ambulatory care training, and the overall medical school infrastructure. Reducing IME from 7.7% to 3% is a cut that cannot be justified. A Saturday morning working group composed of about 20 academic health care individuals including your own Reed Tuckson here, Con Harper from the California State School System, and myself has recommended that a pool of dollars be dedicated to undergraduate medical education and medical school infrastructure. Currently, in the Health Security Act, this pool is set at \$1.5 billion annually. However, be assured that this funding will only augment the cost of medical education which now is \$68,000 per student per year which, for 62,000 medical students, equals \$4.21 billion or a shortfall of \$2.71 billion annually.

Why is this funding being sought through the Health Security Act? One method previously utilized by medical schools to help fund medical education will be materially altered with the full advent of health care reform. Heretofore, much of that educational cost has been acquired via university medical practice plan income. It is logical to expect that the general principles of managed competition, except perhaps in some remotely rural areas, will strongly influence health care reform resulting in decreased income from medical practice at academic health

centers. A second influencing factor will be the limitations placed on the number of funded graduate medical education positions in an effort to bring the specialty mix near a 50-50 ratio between primary care and non-primary care specialists (35 new subspecialties created just since 1978). In 1961, the number of primary care physicians and specialists was equal; there are today two specialists for every primary care physician. To help re-establish the 50-50 ratio, some design similar to the RBRVS (resource based relative value scale) "Harvard Plan" is likely to be invoked. Under this scheme, hospitals would be paid based on the number and specialty training disciplines of their house officers. A factor of 1.1 would be paid for primary care trainees, a factor of 0.7 for non-primary care trainees, and after three years, that factor would drop to 0.5 for non-primary care positions.

Now, in spite of these ominous signs, there is a significant potential opportunity for AMHPS schools and those institutions that have, as a part of their medical education ethos, sought to increase access to health care for the underserved. Increasing the number of primary care physicians is an idea whose time has come. This is an opportunity for AMHPS schools, and we must be opportunistic.

It has been interesting to watch the dynamics of the Saturday morning working group to which I referred earlier; I am sure Reed Tuckson and Con Harper have also noted a type of schizophrenia among some of the members. The more established schools that got in on the ground floor in the mid-1930's when NIH basic research funding program were being established are showing much ambivalence.

On the one hand, they are keenly aware that more federal dollars will be going to support more primary care training to help effect the 50-50 ratio between

primary care physicians and specialists as referenced. Yet, they know their real strength lies in the realm of basic research. Let there be no mistake, basic research is essential and must be maintained. If I have a quarrel, it relates only to the distribution of these limited dollars. There must occur increased funding for behavioral and epidemiological research. To have 40% of our children under the age of two years inadequately immunized is unconscionable. It's irrational to spend billions of dollars to develop miracle vaccines and then have no system of delivery of the product to the consumer. How long could a business enterprise last spending vast sums on research and development and having no mechanism for product distribution. It simply wouldn't occur. It must be emphasized that research is not a goal but rather a process.

I would refer each of you, particularly the panelists, to a letter that appeared in Science, Volume 262, 3 December 1993, written by Richard D. Lamm, former Governor of Colorado. In this letter, Lamm challenges Dr. Michael E. Debakey's policy in which Debakey attributes the increase in life expectancy and reduction of premature mortality to medical research, who Lamm says is self-serving and mostly wrong. Lamm acknowledges that medical research has done some truly wonderful things. He recognizes the increased life expectancy, but mainly through the public health system, and he cites Victor Fuchs as someone who also holds this position. It is observed further that, when the state of medical science and other health determinant variables are constant, the marginal contribution of medical care to health is very small in modern nations. "The great enemies of death and disease in the modern world have been sanitation, pasteurization, chlorination, refrigeration, soap, diet, and the high standard of living." I won't become totally immersed in the polemics of this issue, but I only cite them to reemphasize our

neglected area of behavioral and epidemiological research which is now beginning to be appreciated.

As an obstetrician-gynecologist, I well know that one of the best ways to increase life expectancy is to decrease infant mortality. Many forget that life expectancy is set at the time of birth; hence, it is apparent that the life expectancy is materially shorter for a population that has a high infant mortality rate. What is needed to lower the infant mortality rate is education and access and utilization of preconceptional, prenatal, intrapartum, and postpartum care. These are not high-tech interventions. They have to do with access and the distribution of systems and providers. The access issue is made quite clear from the findings of the Council on Graduate Medical Education (COGME), in their congressionally authorized study to assess physician supply trends and to recommend interventions. This study has now been concluded and has been published rather recently in the Journal of the American Medical Association by Marc Rivo and David Satcher. The Journal edition is September 1, 1993, Volume 270, Number 9. Time does not allow more than a listing of these findings and interventions; however, a more detailed paper has been prepared on the subject by me which was presented to the Governor's Medicaid Task Force in the State of Tennessee. The seven findings from the COGME study are as follows:

1. The nation has too few generalists and too many specialists.
2. Problems of access to medical care persist in rural and inner city areas despite substantial increases in the physician supply.

3. The racial/ethnic composition of the physician workforce does not reflect the general population and contributes to access problems for minorities.
4. Shortages exist in general surgery, adult and child psychiatry, preventive medicine, and among generalist physicians with additional geriatrics training.
5. The nation's current physician-to-population ratio is adequate; further increases in the ratio will do little to enhance the public health or to address access to care problems and will hinder efforts to control cost.
6. The nation's medical education system can be more responsive to public needs for more generalists and minority physicians, fewer specialists, and more physicians for medically underserved inner city and rural areas.
7. The absence of a national physician workforce plan, combined with financial and other disincentives, are barriers to health care reform.

As a consequence of these seven findings, COGME developed recommendations for a national workforce plan and recommendations that are specific for medical educators. They are summarized as follows:

1. The nation should move toward a system in which 50% of all physicians practice in the disciplines of Family Medicine, General Internal Medicine, and General Pediatrics.

2. All primary medical care shortage areas should be eliminated and disparities between the metropolitan and non-metropolitan distribution of physicians should be reduced.
3. The racial/ethnic composition of the physician population should reflect the population's overall diversity.
4. The percentage of physicians trained in General Surgery, Adult and Child Psychiatry, and Preventive Medicine, and the percentage of family physicians and general internists with additional geriatrics training should be increased.
5. The aggregate of allopathic and osteopathic physician-to-population ratio should be maintained at current levels.

In addition to strategies that redirect medical education, financing, and health care reimbursement, also needed is commitment and leadership from the nation's medical educators. Specific recommendations for medical educators are as follows:

1. Mission statement and strategic plans that contain specific outcome measures for the number of graduating generalists and minorities and the number of graduates who choose to practice in underserved areas.
2. Recruitment, school admission, and retention policies that reflect the need to increase the number of entering minorities and students who are inclined towards general practice.

3. Faculty composition and reward system that increases the number of minority generalist physician role models, primary care researchers, and community-based practitioners through strategies that reward excellence in primary care teaching and research in the same manner it recognizes excellence in biomedical research.
4. Medical education objectives and curricula that integrate the biopsychosocial aspects of health and health care, emphasize self-directed learning and problem-solving, and prepare medical students, residents, and practicing physicians with the competencies needed for primary care practice.
5. Medical education teaching environment that shifts a greater proportion of medical training from hospitals to physicians' offices, community health centers, health departments, and other community-based outpatient sites that provide most medical care.

In conclusion, let me end with two cautions. First, if we, the members of AMHPS, fail to infiltrate and influence public policy makers, all of the sensible funding and intervention solutions will go wanting.

The second caution is that, in spite of our needs and efforts to expand primary care, we must concomitantly provide tertiary level training sites in the areas of Nephrology, Otolaryngology, Neurosurgery, Orthopedics, and Ophthalmology. These particular areas of postgraduate training have been and remain difficult for minority physicians to secure — especially African Americans.

I thank you for inviting my participation in this annual meeting.

Will Health Care Reform Affect Undergraduate Medical Education?

Presented at the

**Fifth Annual W.F. Bernell James
Obstetrics and Gynecology Symposium**

February 11-13, 1994

**Henry W. Foster, Jr., M.D.
Acting President**

**Meharry Medical College
Nashville, Tennessee**

Will Health Care Reform Affect Undergraduate Medical Education?

To Dr. Grimes, faculty, staff, friends, and most importantly to you, Dr. McGruder, my teacher, colleague, and friend: I was indeed honored when asked by Dr. Grimes to make this presentation as a part of this symposium recognizing the myriad contributions of Dr. McGruder to medical education and Obstetrics and Gynecology at Meharry for such a long span of time. I, along with many, many students and residents, owe a deep debt of gratitude to Dr. McGruder. I well remember first meeting him when I came from Boston to conduct a residency in Obstetrics and Gynecology here at Meharry. He was a bedrock of educational inspiration. He was scholarly and a consummate surgeon. In fact, he carried the greater share of teaching non-abdominal pelvic surgery to residents. Further, the character of this man came through so strongly to me when I watched in the early 1960's as he packed up, left his family to further secure his education. For those of you who may not be aware, for many years, residences existed separately in Obstetrics from Gynecology when Gynecology was still often a part of surgical training programs. However, Dr. McGruder was accepted and went to the Chicago Lying In Hospital where he spent a

year and a half qualifying to take his certifying board examinations in Obstetrics and Gynecology and, it goes without saying, he was successful in becoming a Diplomate of the American Board of Obstetrics and Gynecology.

Before I move to the substance of my presentation, I must reflect on the many times I have gone into the solarium on the OB Floor and have seen Dr. McGruder surrounded by a half dozen students where he was pontificating, I am sure, much in the same manner as Socrates did in ancient Athens. Today, one can travel across the width and breadth of this nation and virtually every Meharry medical graduate, irrespective of his or her chosen discipline, will recall with fond affection such sessions with Dr. McGruder.

"QUESTION: Will health care reform affect undergraduate medical education?"

It already has — the broader question is how and to what extent. Last fall, I had the opportunity to join 29 other U.S. medical school deans and provide input to Ira Magaziner, who has been appointed by the Clinton Administration to staff the development of the Health Security Act. At the closure of a long and difficult session, in attempting to summarize our activities, there

was despair expressed because there were so many uncertainties. People were having trouble reaching a conclusion. Mr. Magaziner recognized me during this discussion, and I admitted that I was in concurrence with most of the tenets of our discussion; however, I took that opportunity to point out to him and my fellow deans that, in spite of all of the uncertainties, of which there are many, there were, nonetheless, three clear and distinct unambiguous needs:

1. Education of health professionals must continue in this country;
2. Health care education is costly; and
3. Health care education must be funded by some source.

And, I suggest that it behooves us all, to the extent that we can, to become proactive rather than waiting until health care reform is fully upon us and being forced only to react. Hence, we should get about the business of developing possible scenarios to meet these obvious and inevitable challenges.

Though fledgling, steps are now being taken in the draft of the Health Security Act. Initially, in the Health Security Act, there was not a single reference to funding undergraduate medical education. Only after numerous

meetings by deans of a group known as the Saturday Working Session, of which Meharry is a member, has the need for funding undergraduate medical education been considered in the Health Security Act. Our Saturday working group has recommended that a pool of dollars be dedicated to undergraduate medical education and medical school infrastructure. Currently, in the Health Security Act, this pool is set at \$1.5 billion annually. However, be assured that this funding will only augment the cost of medical education which now is \$68,000 per student per year which, for 62,000 medical students equals \$4.21 billion.

Why is this funding being sought through the Health Security Act?

One method previously utilized by medical schools to help fund medical education will be materially altered with the full advent of health care reform. Heretofore, much of that educational cost has been acquired via university medical practice plan income. It is logical to expect that the general principles of managed competition, except perhaps in some remotely rural areas, will strongly influence health care reform resulting in decreased income from medical practice. A second influencing factor will be the limitations placed on the number of funded graduate medical education positions

in the effort to bring the specialty mix near a 50-50 ratio between primary care and non-primary care specialties (35 new subspecialties created just since 1978). In 1961, the number of primary care physicians and specialists was equal; today, there are two specialists for every primary care physician. To help establish the 50-50 ratio, some design similar to the RBRVS (resource based relative value scale) "Harvard Plan" is likely to be invoked. Under this scheme, hospitals would be paid based on the number and specialty training disciplines of their house officers. A factor of 1.1 would be paid for primary care trainees, a factor of 0.7 for non-primary care trainees, and after three years, that factor drops to 0.5 for non-primary care positions.

The Clinton bill originally was to have cut \$5.5 billion from Medicare spending for graduate medical education. And, be ever mindful that undergraduate medical education and postgraduate medical education are interdependent. Medical residents provide substantial supervision and teaching of medical students.

The introduction of managed competition as mentioned earlier will result in decreased hospital and practice plan revenues for Academic Health Centers due to reduced demand for specialized, high-tech

services provided so extensively in such centers. But, this is just a part of what lies ahead — there is a ripple effect. This shift to a high number of primary care physicians and a decrease in subspecialty practitioners, as just stated, will cause a decrease in revenues generated by specialist faculty members leading to lower income, lower salaries, and the potential for faculty attrition. Academic health centers must form community health alliances to preserve their referral base, but in doing so, will have to allow for primary care faculty to be involved in the community setting.

In sum, health care reform will lead to decreased hospital and practice plan revenues, increased pressures for the primary care physician to generate practice income coupled with their diffusion into the community. Also, for those volunteer faculty members with little or no compensation from the academic health center, and the revised physician payment structure threatening their income, they probably will be less likely to teach without financial compensation.

The ripple effect extends even further. The reduced departmental discretionary funds generated by a clinical faculty will cause greater difficulty for medical schools to implement the newer curriculum changes which are more labor intensive. They call for small group

interaction, increased inter-digitation with basic science and clinical science faculties; courses such as Clinical Correlation and Problem Based Learning are all examples. Hence, a paradoxical situation has developed; market forces are drawing faculty and dollars away from the academic health center concomitantly with an increased need for faculty to develop new curricula paradigms.

Although not directly a consequence of impending health care reform, there exists a specific threat to the academic integrity of undergraduate medical education in Obstetrics and Gynecology. Of particularly concern, I have to pause when the Association of American Medical Colleges (AAMC) recommends abolishing Obstetrics and Gynecology as a required clerkship for American medical students. It is known the U.S. ranks 17th, 19th, or 21st, in infant mortality in industrialized nations, depending on whose counting. I am unaware that any recommendation for eliminating Pediatrics as a required clerkship has been made. The biological inter-relatedness of Obstetrics and Pediatrics, in fact, makes the two disciplines a continuum not only functioning in tandem, but also in parallel during gestation. The pedagogical separation of Pediatrics from Obstetrics and Gynecology is, in fact, an artificial uncoupling done primarily to facilitate teaching. Students' ability to best

learn Pediatrics will be compromised significantly if they are not taught the biodynamics of intrauterine human development — an integral part of the course in Obstetrics and Gynecology for medical students.

Health care reform is an idea whose time has come. Change is not the enemy; it is simply a fact. Change has always been inevitable; it is when we fail to anticipate and to function proactively that the effects of change become threatening.

There is another whole agenda relating to underrepresented minorities as regards the future of medical education that time does not allow for a full discussion. But, as a generic statement, any problem for the whole of undergraduate medical education is compounded when addressed in the context of underrepresented minorities and historically black colleges and universities.

At Meharry, because of our mission, we accept many students who come from mostly poor families. Ninety-five percent of Meharry's students receive some form of student financial aid and seventy-five percent come from families that earn less than \$35,000 a year. Even with Meharry having the lowest tuition of any private medical school in the nation, at \$14,000 annually,

this remains a formidable cost for families whose earnings are so meager. As a consequence, very often our students complete their medical education with huge debts, sometimes exceeding \$100,000; hence, any aspect of health care reform affecting medical education that is negative will be magnified for students from low-income families.

In closing, Dr. McGruder, because of your philosophy, strong work ethic, and ability to accommodate to change, this renders you an indispensable member of Meharry's faculty and a mighty resource to undergraduate medical education in Obstetrics and Gynecology which you have fulfilled on both the local and national levels. Mac, I am grateful for having fallen in the light of your tutelage as a resident and as a co-faculty member. Continue your good works, and I thank you on behalf of all of your former students and residents of which I am one. My best wishes to you for this tribute in your honor which you have earned and so richly deserve. I wish for you long life and happiness.

RURAL AMERICA: HEALTH CARE ACCESS

Presented at the
102nd Annual Farmer's Conference

**Tuskegee University
Kellogg Conference Center**

February 24-25, 1994

by

**Henry W. Foster, Jr., M.D.
Acting President**

**Meharry Medical College
Nashville, Tennessee**

Rural America: Health Care Access

To President Payton, members of the dais, students, faculty and friends: you cannot imagine how pleased I was to have received Dr. Payton's letter of invitation to serve as your banquet speaker tonight. The buoyancy that his request caused emanates from two main sources.

First, I spent nine years of my life here in this most unique community, and as a consequence, I established many, many lasting friendships and, to all of you who are present and those who are absent, I extend a generous hello.

Second, and most germane for this keynote address, is the fact that Thomas Monroe Campbell, in whose honor this activity is held, was the father of Dr. Thomas Campbell who was both my trusted professional colleague and friend. I never met the senior Mr. Campbell, but it is most obvious from what I have read about this remarkable man, that he was indeed a man of vision. His concept of the mobile school is a quintessential example of his value of education, which he published in 1936 in the chronicle entitled, *The Moveable School Goes To the Negro Farmer*. He knew clearly the value of education. Let me share with you one of my favorite passages from *The Spectator* written in 1711 by Joseph Addison.

"Education is a companion which no misfortune can depress, no crime can destroy, no enemy can alienate, no despotism can enslave. At home a friend, abroad an introduction, in solitude a solace, and in society an ornament. It chastens vice, it guides virtue, it gives, at once, grace and government to genius. Without it, what is man? A splendid slave, a reasoning savage."

Before I get into the body of my presentation for this evening, let me share with you briefly some of the characteristics of Dr. Thomas Campbell which I am sure were a part of the make-up of his outstanding father.

Tom Campbell was a professional giant. He loved his discipline of pediatrics. He possessed the fundamental requisites required of the consummate physician:

ability, availability, and affability. Tom knew his science; he was readily accessible and he loved the children he cared for and their families. And, I should add parenthetically that they reciprocated that love. There are so many other admirable qualities this special human being possessed that I could go on and on, but in the essence of time, I cannot. I will, however, make just one additional observation about this colleague and friend — in all of my association with Dr. Campbell, I often saw him frustrated, but never, not once, did I see him lose his temper, and the Lord knows he often had cause to do so. Tom was always in control. Hence, with this background, no doubt you can understand my elation in having been asked to join you in this capacity tonight.

Now, as for the substance of my text, in the remaining time allocated, I will speak to the following:

1. The health status in rural America.
2. Some causes of the adverse outcomes that occur.
3. Interventions for redress including the potential effect of health care reform.

Rural health care is a serious problem in dire need of a solution. Quality of life and health status are inter-dependent. To help set the stage, let me begin with a question. "What everyday item typically eludes rural children?" It is clean water.

"Clean water is available to every urban child, but in rural communities, efforts to obtain drinking water are often snared by a nightmare of political hurdles and red tape from county, state, and federal agencies. As a result, parents of rural children must often travel as many as ten miles from home to haul water for drinking, cooking, or bathing. There are rural children who have never had a shower and whose nature calls are answered in porcelain coated pails. Ironically, families in communities without water or sewers often reside within a few yards of clear, sparkling water flowing to catfish ponds or pouring onto fields of row crops. This is a clear statement of relative worth."

This poignant observation was made by L. C. Dorsey, Executive Director of the Delta Health Center, Mound Bayou, Mississippi, and it appears in Meharry's Factbook published by its Institute on Health Care for the Poor and Underserved, the only such institute in the nation. This institute serves three basic functions:

1. A clearinghouse on all issues that relate to health care and poverty.
2. Conducts a conference on health care and poverty each year in conjunction with our Fall Convocation.
3. We publish a quarterly journal which is now listed in *Index Medicus*.

Many misconceptions are held regarding the magnitude of rurality in America. One-fourth of all Americans live in communities with fewer than 2,500 inhabitants. This is 62,000,000 people. This is 12,000,000 more than all of the inhabitants of Great Britain, or 4,000,000 more than Italy. And, as your conference theme infers, there is a disparity in economic well-being between rural and urban America. This inference is correct; the poverty level in rural America in 1987 was 16.9% and, for urban America, it was 12.5%.

Geographically, life expectancy is lowest in the South at 72 years, the national average is 74 years, and it is highest in Hawaii at 77 years. As an obstetrician-gynecologist, I must point out that many are not mindful that one of the best ways to increase life expectancy, which is set at the time of birth, is to lower infant mortality. The U.S. ranks 19th worldwide in infant mortality. An African American child born in the U.S. is less likely to survive its first year of life than a baby born in Cuba, Jamaica, Trinidad, or Tobago. For the wealthiest nation in the history of humankind, these kinds of outcomes are unconscionable. Only the United States and the Union of South Africa fail to provide universal access to health care for its mothers and their babies. It was this type of adverse outcome that I, along with my maternal and child health colleagues, was trying to improve when I directed the Title V Children's Bureau Maternity and Infant Grant at John Andrew Hospital. We were ahead of our times, but a national model for regionalized perinatal health care was a byproduct of that effort.

What are the underlying antecedents that cause for adverse health care outcome? Actually, the concept is not complex. Medical sociologists speak of barriers to care and distinguish "attitudinal" barriers from "organizational" barriers. Attitudinal prevent individuals from becoming motivated to seek needed health services where, on the other hand, organizational barriers prevent motivated individuals from utilizing them. Examples of attitudinal barriers are: lack of education, fatalism, obstructive mores, fear, etc. Examples of organizational barriers are: lack of finance, transportation, health insurance, health providers, health facilities, etc. The extent to which these barriers operate for an individual or group determine their risk status; hence, the risk status and the quality of services provided determine health care outcome. Very clearly, an individual at low risk who receives superlative care will have the best chance of good outcome, and reciprocally, individuals at high risk who receive poor care will most likely have the poorest outcome. Hence, as health care providers, we must contribute to lowering risk factors while increasing health services to those most in need — a status that, unfortunately and disproportionately characterizes rural populations.

The clearest organizational barrier to health care access to which citizens of Macon County, Alabama can relate is the absence of a hospital. Unfortunately, this characterizes many rural areas where the rate of hospital closings has been excessive. However, you are more fortunate in Macon County in that you do have physicians.

According to the Lower Mississippi Delta Development Commission and the Mississippi State University Social Science Research Center, the top six barriers to the development of rural counties in the deep South were:

1. Inadequate education.
2. Inappropriate leadership.
3. Lack of economic development and infrastructure.
4. Poverty.

5. Poor health.
6. Poor race relations.

It is noteworthy that these conclusions were reached independently by these two organizations. Also, farm safety is another rural health hazard that is compounded for the black farmer, according to Dr. Richard Enochs at Meharry. Most of their equipment is old, ranging in age from 12 to 15 years, because it is difficult for them to purchase more modern machinery.

In 1986, the Council on Graduate Medical Education (COGME) was authorized by Congress to provide an ongoing assessment of physician supply trends and to recommend appropriate responses, both federal and private. The Council's findings have special pertinence for rural America; there were seven striking findings.

Finding #1: The nation has too few generalists and too many specialist physicians.

In 1961, half of all U.S. physicians were generalists. Since then, the percentage has dramatically declined, and now there are two specialists for every generalist.

Finding #2: Problems of access to medical care persist in rural and inner city areas despite substantial increases in the physician supply.

Physician geographic maldistribution remains an intractable problem despite a doubling of the physician supply during the past 25 years.

Finding #3: The racial/ethnic composition of the physician workforce does not reflect the general population and contributes to access problems for minorities.

Although African Americans, Hispanics, and Native Americans constitute 20% of the total U.S. population and will constitute almost

one-fourth of all Americans by the year 2000, they represent only 10% of entering medical students, 7% of practicing physicians, and 3% of medical faculty.

Finding #4: Shortages exist in General Surgery, Adult and Child Psychiatry, Preventive Medicine, and among generalist physicians with additional geriatrics training.

The future growth in general surgical services is projected to exceed the growth in the supply of general surgeons. Aging of the U.S. population will increase demands for surgical services.

Finding #5: The nation's current physician-to-population ratio is adequate; further increases in the ratio will do little to enhance the public health or to address access to care problems and will hinder efforts to control cost.

The sustained growth in physician supply largely resulted from national policies initiated in the 1960's in response to a perceived physician shortage. Medical schools doubled class sizes, and between 1960 and 1988, the total number of physicians doubled, and the physician-to-population ration increased by more than 70%.

Finding #6: The nation's medical education system can be more responsive to public needs for more generalists and minority physicians, fewer specialists, and more physicians for medically underserved inner city and rural areas.

In the past, the nation's undergraduate and graduate medical education system responded effectively to national needs to increase the number of physicians, but it has failed to do so in recent years; hence, measures of redress must occur.

Finding #7: The absence of a national physician workforce plan combined with financial and other disincentives are barriers to health care reform.

The nation has neither a workforce nor a medical education financing strategy to meet the current and projected health care needs of U.S. citizens.

COGME has made known its finding — now what can be done? The intervention that clearly will have the most beneficial effect is passage of the Health Security Act with universal access as its embodiment. But, it is just the first step. Expansion of the National Health Service Corps is an absolute must. Its expansion addresses two very problematic issues simultaneously. It assures a workforce in underserved areas, and it indemnifies that workforce from the rampant medical/legal crisis — a crisis which, in fact, is a real deterrent to practice in rural settings. The National Health Service Corps also presents a rare opportunity to provide medical education for qualified individuals wishing to practice in underserved areas as a method of satisfying their educational financial obligations. The previous eight years have been difficult. In 1976, \$22,500,000 was appropriated by Congress for the National Health Service Corps. In 1989, not a single dollar was appropriated, thus reflecting the political mindset of that era.

Lastly, with respect to manpower, this country in the past has had a doctor's draft. If we could send our physicians 12,000 miles to the other side of the earth to make conditions better there, then certainly we should do no less for our own.

Another significant potential intervention for redress is that of hospital access for Macon County citizens. The issue of establishing a partnership between some Veterans Administration (VA) hospitals in rural communities must be revisited. The earlier effort to effect this during the previous administration was laudable; unfortunately, poor communication and planning and general ineptness in attempting to implement this excellent idea doomed it to failure. Tuskegee, Alabama, as many of you know, was one of the two hospitals which had been scheduled for this intervention. Hence, your county and you as citizens are without a medical facility while a hospital built and sustained with public funds sits with many empty beds.

Other measures to be utilized to improve health care access include greater use of indigenous workers, better health promotion/disease prevention practices,

improved communications for your health providers using state-of-the-art interactive video/audio communication and maximizing your use of the political system is paramount. The strongest leadership available must be tapped. You must try and expand the utility of the Tuskegee Area Health Education Center — it can serve as a catalyst to improve health care access.

In conclusion, my goal tonight was to speak to three broad aspects of family health and well-being in rural America:

1. The relative health status of rural America.
2. To examine the genesis of poor rural health care outcome.
3. To present some of the intervention paradigms that hold promise for improvement.

To ultimately subdue this basic problem of lack of access to health care for rural populations, there has to be a major change in our medical education approach. The medical education teaching environment must shift a greater portion of medical training from hospitals to physicians' offices, health maintenance organizations, community health centers, health departments, and other community-based outpatient sites that provide most medical care. With this last thought in mind, it is my strong conviction that the basic role of medical schools should be increased from three functions to four: The three current functions are teaching, patient care, and research. The time has now come that we add a fourth which is community outreach.

Once we as medical educators become imbued with this community outreach academic ethos, the major problem of maldistribution of our health care providers will begin to ebb.

Again, I thank you for inviting my participation; it has been indeed my honor.

July 25, 1994

ASSOCIATION OF PROFESSORS OF GYNECOLOGY AND OBSTETRICS

PRESIDENTIAL ADDRESS

Presented by

Henry W. Foster, Jr., M.D.

**Opryland Hotel
Nashville, Tennessee**

March 4, 1994

and, in fact, this has become the organization's *raison d'être*. But, with our role clearly defined, this that has in no way lessened the increasing challenges being hurled in our path. To remain strong as an organization, we must analyze just how tenuous is our fate and determine proactive interventions that will best secure our position.

The functions of APGO can be subdivided conveniently into two broad categories — programmatic and operational. Our programmatic activities represent our goals, whereas our operational activities equate, with our objectives, the measures that effect achieving our goals. We face a clear and present danger to both functions.

In the time allotted for my presentation, I will address three issues:

1. Programmatic threats and recourse.
2. Operational challenges and opportunities.
3. The outlook for the future of our organization.

A menacing programmatic challenge has been advanced by the AAMC. I have to pause when that body recommends abolishing OB/GYN as a required clerkship for American medical students. It is known that the U.S. ranks somewhere between 19th and 21st, depending upon who's counting, in infant mortality in western nations. Further, an African American child born today in the U.S. is less likely to survive its first year of life than a baby born in Cuba, Jamaica, Trinidad, or Tobago. Officials of the AAMC have expressed their deep discomfort in

the fact that, for the first time in this country, life expectancy has declined for a population group — African American males. Those of us who are obstetricians and gynecologists must inform the uninformed that one of the best ways to increase life expectancy, which is set at the time of birth, is to lower infant mortality.

The AAMC's logic is flawed in recommending abolishing the required OB/GYN clerkship. I am unaware of their recommending eliminating Pediatrics as a required clerkship. The biological inter-relatedness of Obstetrics and Pediatrics makes the two disciplines a continuum functioning not only in tandem, but also in parallel during gestation. The pedagogical separation of Pediatrics from Obstetrics is an artificial uncoupling done primarily to facilitate teaching. Students' ability to best learn Pediatrics will be compromised substantially if they are not taught the biodynamics of intrauterine human development — an integral part of the basic OB/GYN clerkship.

Obstetrics has, in my view, always been undervalued in our country. Look at the labor laws and practices — they single out and often punish expectant mothers. I have read that, during World War II in Great Britain, pregnant women received double food rations — I wonder if this logical and humane thought ever occurred to policy makers in this country. We, members of this organization and similar organizations, must be the protectors of Obstetrics and Gynecology in this country.

In 1986, the Council on Graduate Medical Education (COGME) was authorized by Congress to provide an ongoing assessment of physician supply trends and to recommend appropriate responses, both public and private. One of COGME's recommendations is, "The nation should move toward a system in which 50% of all physicians practice in the disciplines of Family Medicine, General Internal Medicine,

academic health centers change in the face of health care reform. A major method previously utilized by medical schools to help fund medical education will be materially altered with the full advent of health care reform. Heretofore, much of that educational cost has been addressed via university medical practice plan income. It is logical to expect that the general principles of managed competition will strongly influence health care reform resulting in decreased income from medical practice.

A second influencing factor will be the limitations placed on the type of funded GME positions in the effort to bring the specialty mix to a 50-50 ratio between primary care and non-primary care specialties. (Thirty-five new subspecialties have been created just since 1978.) In 1961, the number of generalist physicians and specialist physicians was equal; today, there are two specialists for every primary care physician. To help re-establish this 50-50 ratio, some design similar to the RBRVS (resource based relative value scale) or "Harvard Plan" is likely to be invoked. Under this scheme, hospitals would be paid based on the number and specialty training disciplines of their house officers. A factor of 1.1 would be paid for primary care trainees, a factor of 0.7 for non-primary care trainees, and after three years, that factor would drop to 0.5 for non-primary care positions.

The introduction of managed competition will result in decreased hospital and practice plan revenues for academic health centers due to reduced demand for specialized, high-tech services provided so extensively in such centers. But, this is just a part of what lies ahead — there is a ripple effect. This shift to a high number of primary care physicians and a decrease in subspecialty practitioners, as just stated, will cause a decrease in revenues generated by specialist faculty members, leading to lower income, lower salaries, and the potential for faculty attrition. Academic health

We must use our collective political strength to infiltrate, and I don't mean that pejoratively, the policy making bodies that determine funding priorities. As a discipline, OB/GYN must, in my judgment, become much more active in the AAMC and must secure greater representation on NIH study sections.

The APGO Foundation, in light of the changes attendant to health care reform, looms more and more as a pivotal body that will strengthen both our programmatic and operational posture. Programmatically for APGO, I cannot be more reassured. Here, we are on the cutting edge. Last year's annual meeting is a testament to this. That program touted technological innovations in medical education. The program focused on both the application of new technology and patient care, and the use of new technology as teaching tools for medical educators. For the latter, the "APGO Quiz '93," a computerized educational tool, is such an example. A new quiz is presently being developed. This year's program has simply expanded last year's thrust. Our 1994 focus is on new guidelines for teaching OB/GYN, introducing new computer applications for the administration of programs, and highlighting the impact of primary care on the core curriculum as much of my talk has addressed.

APGO will continue to work with AMGO. The extent to which we complement each other greatly influences the quality of services provided to OB/GYN medical students and faculty.

It is obvious that the health care delivery and health education environments are changing. What, if anything, does the significant increase of women entering the medical field portend? We will be short-sighted if we do not try and make this

evaluation. This, too, is a part of the changing milieu in which we are operating. It must be kept in mind that change is not the enemy — it is simply a fact. Change has always been inevitable; it is only when we fail to anticipate and to function proactively that the effects of change harm us most.

As stated earlier, we must seek new opportunities and they do exist. If one were to ask all 126 American medical school deans, what are the fundamental functions of a medical school, almost by rote, they would answer patient care, teaching and research. They would be correct; but, as you should discern from what is occurring in health care today, a fourth fundamental medical school function desperately needs to be added — that being "community outreach." As much of our health care delivery continues to shift from the hospital setting to that of ambulatory care, medical schools must become imbued with an outreach ethos.

In closing, as stated above, I am reassured about the future of our organization. I will refer to my first President's Column in "APGO's *Quarterly Report*." There I stated, "APGO continues to re-invigorate itself by utilizing the rich reservoir of talent residing in its membership." This organization also is supported by a most efficient and hard-working staff. Hence, herein lies the source of my optimistic outlook for APGO. It is the right organization at the right time for the right purpose run by the right people.

I am sincerely appreciative to each of you for affording me the honor of serving as your president during this past year. I thank you very much.

March 9, 1994

Testimony of

Henry W. Foster, Jr., MD.

Acting President
Meharry Medical College

before the

Appropriations Subcommittee
on Labor, Health and Human Services, Education, and Related Agencies

Thursday - May 5, 1994

Chairman Smith, Members of the Committee: I am Henry Foster, Professor of Obstetrics and Gynecology, acting president for Meharry Medical College, member of the Institute of Medicine, and a member of its Council.

On behalf of Meharry Medical College, I am grateful for this opportunity to appear before you today.

I am proud to represent and speak for a special institution which, for nearly 118 years, has fulfilled a very special role in our country.

Meharry Medical College has been a national leader in the training of physicians, dentists and other health professionals to meet the needs of the poor and underserved . . . and in affording cost-effective care to those at greatest risk in both urban and rural settings. By the 1980's, Meharry had trained forty percent of this nation's African American physicians and dentists. Further, three out of four of our graduates return to underserved inner-city and rural communities - compared to just one in four of majority graduates.

Our role in training minorities for the health professions has long been recognized by Congress. We appreciate this recognition and are ready to continue in our mission, but we need your help.

Meharry has a unique opportunity and challenge as a result of the historic merger of Nashville's city hospital and Meharry's Hubbard Hospital. The merger is not only consistent with national health care reform . . . in all the ways it has been

proposed in Congress . . . but also in the key role we are poised to play in making health care reform a reality.

The fundamental goal of the hospital merger in Nashville is to provide quality health-care delivery, especially for the poor and underserved, and to contain costs. In implementing this merger of two hospitals, Meharry has successfully met all of the stringent staff recruitment benchmarks. This included recruitment of 56 full-time-equivalent physicians who are Board-certified or Board-eligible.

This particular requirement generated an immediate financial cost that must be paid. About half of this additional annual cost is not covered by our contract with the city. Therefore, our most immediate need relates to covering the difference in the compensation costs for these more qualified health professionals.

The commitment of Meharry Medical College and the City of Nashville to ensure that this venture is successful is consistent with President Clinton's national health care reform agenda, other proposals now before Congress, and with Governor McWherter's reforms of the Medicaid system within our own state.

The recruitment of strong clinicians, teachers, and researchers has already begun to strengthen our undergraduate medical education program. The inpatient and outpatient bases are expanding, which will help ensure the reaccreditation of three of Meharry's residency programs thus bringing the total to eight.

Meharry's medical students and residents, as a consequence of the merger, will benefit from increased exposure to health care challenges. This exposure will better equip them to serve patients in your districts as they go on to practice medicine, dentistry and other health professions across our country, which currently includes 42 of our 50 states. The merged hospital facility in Nashville therefore is an important national initiative. And yet, Meharry cannot accomplish this and maintain our historic mission of serving the underserved without your initial assistance.

We respectfully ask therefore, that you join with us in this vital initiative, and help us make it successful.

Our request is for interim assistance of six million dollars in Fiscal Year 1995 and a like amount in each of the following three fiscal years.

This assistance is essential to Meharry as we strengthen our financial stability through development of private practice and research opportunities that can meet our financial deficit. A period of three to five years will be required to put these essential elements in place, and to place Meharry and the city hospital on a much firmer financial footing for the long term.

We believe this funding would constitute a modest short-term investment by our country in an institution that has contributed so uniquely to American medical

education for almost 118 years. Receiving this support will allow Meharry to continue to train health professionals who serve Americans who are in greatest need and who might otherwise not be served.

We appreciate your consideration of our request. (I am providing a copy of my statement and a copy of the full text for inclusion in the record.)

Mr. Chairman, I thank you for allowing me to make this statement on behalf of Meharry Medical College. I will be delighted to answer any questions.

INTRODUCTION: U.S. CONGRESSMAN HAROLD FORD
MEHARRY MEDICAL COLLEGE
ONE HUNDRED AND NINETEENTH COMMENCEMENT
NASHVILLE, TENNESSEE
MAY 22, 1994

It is my distinct pleasure today to introduce our speaker for Meharry Medical College's 119th commencement exercise. Now clearly, I recognize that it is a trite statement to say that our speaker for today "needs no introduction." That is true, he does not, however, this notwithstanding, I will nonetheless introduce him to you.

U.S. Congressman Harold Ford represents Tennessee's 19th congressional district. This district, which includes Memphis, is the birthplace of Congressman Ford. His formal education is comprehensive; he received his B.S. degree in Business Administration from Tennessee State University, the A.A. degree in Mortuary Science from The John Gupton College and his M.B.A. degree from Howard University.

Congressman Ford is active in numerous civic and community causes. His board memberships and achievement awards are multitudinous.

Prior to his election to congress, where he is now serving his 10th term, Congressman Ford served two terms in the Tennessee Legislature. As a consequence of his congressional longevity and the superlative quality of his work, such as his authorship of The Family Support Act of 1988, he now serves as the ranking member of the powerful and prestigious House Committee on Ways and Means which has jurisdiction over all tax revenue raising legislation, as well as Social Security, Medicare and Public Assistance Programs. A few days ago, Congressman Ford introduced me when I testified before the House Sub-Committee on Appropriations on behalf of Meharry; the respect and high regard which he commands in our National Capital is openly evident.

In conclusion, there is one other distinction held by Congressman Ford which I believe he and I both hope will be short-lived and that is --he is the only African American Tennessean ever to be elected to congress. Ladies and gentlemen, without further ado let us all give a rousing round of applause to our 119th commencement speaker U.S. Congressman Harold Ford!!!!

Henry W. Foster, Jr., Acting President

Recognition of Meharry's Golden Achievers

To you our Golden Achievers, thanks for honoring us with your presence today; you are to be congratulated. Meharry Medical College presented you an opportunity to acquire a solid education at a very difficult time. As African Americans, 50 years ago you were living in a country imbued with government sanctioned segregation and a climate that overtly denied fairness, justice and equal opportunity. The world was immersed in the greatest tragedy in the history of humankind--World War II which cost no less than 60 million human lives. However, in spite of this horrific milieu, you seized your educational opportunity and you have persevered.

We salute you. Thanks for being Meharrians!!

Henry W. Foster, Jr., M.D
Acting President
Commencement
May 22, 1994

HOW CAN WE PROVIDE GOOD HEALTH CARE FOR EVERYONE?

Presented to the

**Lonnie S. Burnett
Vanderbilt OB/GYN Society**

at

Destin, Florida

June 18, 1994

by

**Henry W. Foster, Jr., M.D.
Professor of Obstetrics & Gynecology
and Acting President**

**Meharry Medical College
Nashville, Tennessee**

- **How Can We Provide Good Health Care for Everyone?**

- The presumption in the question, "How Can We Provide Good Health Care For Everyone?" is that we do provide good health care for some; that presumption is correct. In fact, the health care system in this country delivers not just good care, it delivers superlative care. The question is can we or will we make this coverage all-inclusive. Without question, change will occur -- the American populous is demanding it. Why is this so?
- It is not just uninsured Americans that are calling for change. All Americans are aware and concerned about exclusion from coverage resulting from pre-existing illnesses, catastrophic events leading to loss of coverage, and the loss of employment leading to the loss of health insurance. In fact, during the last presidential election, exit polls revealed that fear of losing health insurance was a major determinant for many who voted the democratic ticket. You have all heard of the 35 million Americans so often referred to that are uninsured. These are mostly working individuals whose earnings disqualify them from Medicaid eligibility, but the level of their income is too meager for them to purchase health insurance on the open market. However, in actuality, this 35 million figure is deceptive. It is a cross-sectional figure looked at in a given point in time. If the uninsured are looked at in real-time over the period of one year, the figure then rises to near 55 million individuals. These are people going in and out of employment, thus gaining and losing their health insurance.

- Further, America's system of health care delivery does not provide a good return for our spending when compared to other western nations. At our current rate of spending for health care in this nation, expenditures will exceed one trillion dollars annually by 1998 – this represents a quadrupling of expenditures since 1980. Health care spending represents 14.5% of our GDP (gross domestic product). Other western nations, however, spend only 6-8% of their GDP on health care, their coverage is inclusive, and their health care outcome data are superior to ours in almost every category. The time frame in which health care reform will occur is unknown, but it will occur. For those who listened carefully to President Clinton's 1994 State of the Union message, while asserting in unequivocal terms that universal access must and will be a part of any health security act, very adroitly he avoided the issue of the time frame in which this will occur.
- To provide good health care coverage to everyone calls for a redistribution of both human and physical resources. If we examine the model in other western nations, the most notable dissimilarity is our high ratio of specialist physicians to generalist physicians. In 1961, the number of our primary care physicians and specialists was equal. There are today two specialists for every primary care physician. Just since 1978, 36 new subspecialties have been created in this country. And, a similar type pattern is seen with the distribution of physical resources. For example, in all of Canada, a nation of 27,000,000 people, there are just 26 MRI machines. By contrast, in 1992 in Middle Tennessee with a population of just over one million, there were sixteen such units, which cost \$1.5-2 million each.
- The effort to provide good health care for everyone will, in my view, be driven simultaneously by three major imperatives: (1) Legislation; (2) medical education

funding, and (3) market place forces. Legislation will, in great part, determine the range of services but not their specificity. Universal coverage ultimately will evolve and this coverage will include pre-existing conditions and catastrophic illnesses. However, I cannot see how universal coverage can be successful without having employer-mandate as a component.

- With respect to medical education funding in an effort to help re-establish the 50-50 ratio between primary care and specialist physicians, some design similar to the RBRVS (Resource Based Relative Value Scale) "Harvard Plan" is likely to be invoked. Under this scheme, teaching hospitals would be paid based on the number and specialty training disciplines of their house officers. A factor of 1.1 would be paid for primary care trainees; a factor of 0.7 for non-primary care trainees; and after three years, that factor would drop to 0.5 for non-primary care housestaff. The need for this redistribution of specialists is made quite clear from the findings of COGME (Council on Graduate Medical Education), in their congressionally authorized study to assess physician supply trends as they relate to health care reform and to recommend interventions. This study has now been concluded and has been published; it appears in the *Journal of the American Medical Association*, Volume 270, Number 9, September 1993 authored by Marc Rivo and David Satcher. Further there are those who argue rather convincingly that an adequate cadre of primary care physicians already exists, given the appropriate use of allied health personnel, i.e., nurse practitioners, physician assistants, nurse midwives, etc.
- Ultimately, market forces are likely to be the major impetus for bringing about a health care system that is affordable. This is not just conjecture; it is already occurring. Prepaid plans and capitation are the driving forces. A typical example,

which may not be popular with this audience, could be obstetrical care for a given population for a fixed dollar amount. But please be reminded that I present these views in the spirit, not to evoke polemics, but rather to evoke creative objective discussion. Under our current fee-for-services system, let us assume five obstetricians would ordinarily be used to serve a specified population group. Perhaps the obstetricians can be recruited for \$220,000 each or \$1.1 million annually. However, with a capitated fixed dollar amount, this group in its negotiations may conclude that it can safely provide the required services with three obstetricians (rather than five) plus three certified nurse midwives being paid \$75,000 each. Hence, this new package involving nurse midwives totals \$885,000 annually compared to \$1,100,000 or a \$215,000 lower annual cost. Health economists project that by the year 2000 70% of the U.S. population will be in managed care, if not totally capitated, systems

- As these forces play out, I see a system existing in this country by the early part of the next century that provides good, but not necessarily optimal care for essentially everyone. There will be universal coverage with no health care condition exclusions and coverage for catastrophic illness will be provided. But, there will be a two-tiered system. Let me provide an example.
- This twenty-first century, new health care paradigm may cover kidney transplants to the age of 62-1/2 years. Now, this is good news and bad news. The bad news is, if you are over 62-1/2, need a kidney transplant and you have inadequate resources to purchase supplemental coverage, you are in dire straits. The good news, of course, is all of those who are less than 62-1/2 needing such transplants irrespective of their resources are provided for. Stratification of care of

this type occurs in countries with long-standing universal access health care systems. In the United Kingdom, annually 25% of their population obtains health care from the private-fee-for-service sector. Even in America, we are seeing stratification of care in our Medicare population. For those patients with adequate resources, many purchase additional coverage through the private health care system to supplement their Medicare coverage. And, in a free market economy, this is as it should be. I believe that adequate housing should be available to everyone in this country, but to have a Beverly Hills type home can only accrue through maximizing the free enterprise system.

- In closing, I believe it can be safely concluded that health care reform will occur and will include universal access. The time frame in which this takes place, of course, is uncertain. The forces that bring about these changes will occur through legislation, educational funding sources and market place forces. What remains to be seen is the time frame of its occurrence, its extent, and its cost.
- Thank you for inviting my participation in this assembly.

Henry W. Foster, Jr., M.D.
 Clinical Professor of Obstetrics and Gynecology
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 Professor of Obstetrics and Gynecology
 and Acting President
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 Nashville, Tennessee

Presented at the
 Lonnie S. Burnett
 Vanderbilt OB/GYN Society
 Destin, Florida
 June 18, 1994

Reaching Parity for Minority Medical Students:

A Possibility or a Pipe Dream?

Presented to

the 105th Annual Meeting of the

Association of American Medical Colleges
Boston, Massachusetts

November 1, 1994

by

Henry W. Foster, Jr., M.D.
Senior Scholar in Residence
Association of Academic Health Centers
Professor, Obstetrics and Gynecology
Meharry Medical College

Reaching Parity for Minority Medical Students: A Possibility or a Pipe Dream?

Drs. Cohen, Nickens, staff of the AAMC and colleagues, it is indeed my honor to have been asked to give this keynote address for this Minority Affairs Program at the 105th annual meeting of the Association of American Medical Colleges. Also, I must extend my special congratulations to Mr. Abdul Harris, Ms. Kealani Holloway, and Ms. Dara Thomas for being the recipients of this year's National Medical Fellowships, Inc. awards. This is a signal accomplishment for you at this juncture in your professional lives.

Reaching parity for underrepresented minorities in our medical schools is an essential requirement if significant improvement in health care outcome in this nation is to occur. This topic on achieving parity personifies the theme for this year's program, "Pushing the Boundaries of Traditional Medical Thinking." The involvement and commitment being put forth by the AAMC to increase the number of underrepresented minority medical school matriculants is most laudable. In the time allocated to me for this presentation I will address the following:

- 1) genesis of the problem
- 2) rationale for its redress
- 3) an assessment of our current status
- 4) mechanisms for reaching parity.

I believe it essential to have a familiarity with the history of a problem we are trying to solve. Not having this familiarity is akin to wanting to be an expert on ice but knowing nothing about water. So, with respect to the genesis of the problem, let me start with a quote:

"Education is a companion which no misfortune can depress, no crime can destroy, no enemy can alienate, no despotism can enslave. At home a friend, abroad an introduction, in solitude a solace, and in society an ornament. It chastens vice; it guides virtue; it gives, at once, grace and government to genius. Without it, what is man? A splendid slave, a reasoning savage."

This quote written by Joseph Addison appeared in the *Spectator* in November of 1711 -- nearly 300 years ago. I commence with this quote about education because education or the lack thereof is central to the problem we face in achieving parity for underrepresented minorities in the medical education process. A previous president of the AAMC spoke to this topic in a plenary session at the 102nd Annual Meeting of the AAMC; with respect to problems confronting underrepresented minorities he stated, "Today the major barrier to success [for medical school parity for underrepresented minorities] is a lack of education."¹ What is the history of this problem?

For African Americans it began, in fact, 400 years ago. Keenly aware of the power of education, to teach slaves how to read and write was virtually a capital offense -- a status which ignobly held *de facto* existence for 300 years. Although the Emancipation

Proclamation occurred in 1865, a generation later virtually all African Americans and most Mexican Americans were functionally if not totally illiterate. The schools that did exist with few exceptions were staffed by individuals with poor preparation and the physical facilities and supports were barren. Access to educational opportunities for underrepresented minorities was truncated by oppressive laws maintained by a legacy of racial prejudice emanating from the fabricated myth of racial supremacy.

This dismal state of affairs began to mitigate slightly after World War I. Although nothing approaching parity in general education occurred, there was nonetheless substantial improvement in basic educational opportunities that occurred under the "New Deal" era of President Franklin Roosevelt. Also, some of my contemporaries here may remember the Julius Rosenwald Fund which, in a separate-but-equal atmosphere, provided access to higher education for thousands of minority teachers, primarily from southern states. In fact, on a personal note, my mother received a Rosenwald Fellowship in 1941 and studied at the famed Cranbrook Academy of Art just outside of Detroit, Michigan. As a college teacher, this calibre of education was essential to her career, and what it meant for her students.

The educational progress, albeit slow, continued. World War II was another watershed. At this war's conclusion hundreds of thousands of returning veterans, many of whom were underrepresented minorities, obtained education through the GI Bill of Rights. Further, America now in its expanded role as the "Bastion of Democracy," was finding it increasingly more difficult to justify the hypocrisy of its racist actions at home, towards its own citizens. The climate was changing and America was acquiescing not just to the word but also to the deed of fulfilling the promise of democracy. This was poignantly evidenced in 1954 when the U.S. Supreme Court ended *de jure* school segregation when it rendered its unanimous decision in *Brown v. Board of Education*. A taste of justice is infectious; after that high court decision, the quest for full freedom was inevitable and the sit-ins and the freedom rides followed in a very dramatic manner. America was beginning to come of age and act out its pronouncement of justice under law for all of its citizens whose capstone was passage of the 1964 public accommodation Act. *De jure* inequities were disappearing but *de facto* inequities persist, particularly in our inner cities.

Hence, it is from this backdrop that the educational deficit for underrepresented minorities emanates and whose residual plagues us today. This deficit is abating but at much too slow a pace. The current disparity of underrepresented minority medical students will be virtually interminable unless new measures are taken to improve their educational preparedness. More about this subsequently.

Let us now turn to my second point, the rationale for increasing the number of underrepresented minorities who enter our medical schools. The reasons for doing so are both altruistic and pragmatic. First, altruism. This nation has a moral obligation to effect equal access to educational opportunities for all of its citizens. This concept is the embodiment of democracy; it constitutes the very underpinnings for a free society. For this reason alone, the greater society must strive to make equal access a reality. Failing to do so

will only cause further polarization of the races; a trend that is particularly ominous at a time when our nation is becoming ethnically much more heterogeneous.

Pragmatically, there are very compelling reasons to increase the number of underrepresented minority medical students. As stated, the ethnic construct of this nation is changing dramatically. Between 1980 and 1990 (the most recent census) the Mexican American population increased by 54.5% which was more than nine times that of the 6% increase shown by whites. For African Americans, it was 13.2%, for Puerto Ricans 35.4%, and for other Hispanic groups, 59%. Forty years ago, 90% of all Americans were of white European descent. Today, that majority is down to less than 75% and one-third of all children in America today are not of European descent.

In the early 1980s, the Robert Wood Johnson Foundation showed unequivocally that physicians who are most likely to practice in underserved areas are those individuals who themselves come from these areas. At that time, three out of four physicians graduating from Meharry Medical College chose to practice in inner city or in rural settings. For majority graduates across the nation, only one in four chose such practice sites.

With an audience of your sophistication, I am not going to inundate you with known statistics; you are aware that health care outcome data are much more adverse for underrepresented minority populations. Hence, it becomes imperative that we assure access and utilization of superlative health services for at-risk populations. The ramifications are multi-dimensional -- however, as an obstetrician I would be remiss if I failed to remind you that the United States ranks 17th, 19th, or 21st, depending upon who is counting, in infant mortality among developed nations. This is worse than some third world countries. America can and must do better. Also, be reminded that for the first time since records have been kept the life expectancy for a group of Americans has actually decreased; this group being African American males. We all are cognizant of the role that violence plays here, but be reminded that one of the means of increasing life expectancy is by reducing infant mortality, since life expectancy is set at the time of birth. In sum, we must train those people who are most likely to attack the problems indigenous to underrepresented minorities.

Now let us turn to the third point -- Where are we with respect to effecting greater access to medical school matriculation for underrepresented minorities? Let me have you recall Project 75. In the late 1960s, Project 75 was structured such that by the year 1975 10% of entering first-year medical students would be African American, thus reflecting their percentage of the overall population. There was an initial spurt: The percentage increased from 2.7% in the 1968 entering class to 7.5% in the 1974 entering class, which was its peak. This 7.5% level was not again attained until the entering class of 1990 and now continues to rise, especially in the past five years (Table 1). For the five-year period 1988-89 to 1993-94, the number of African American first-year students increased from 1,015 to 1,480 -- an increase of 46%! For Mexican American students there was an increase from 250 (1988-89) to 441 (1993-94) for an increase of 76%! During this same time frame, there was an increase for other Hispanics (excluding Mainland Puerto Ricans) from 277 (1988-89) to 302 (1993-94), an increase of 9%. For Asian/Pacific Islanders, an increase from 2,006 to 2,662 for a 33%

increase. On the down side, the number of Puerto Rican students (Mainland and Commonwealth) decreased by 3% from 333 to 324 for entering students for the year 1993-94.

The figures that I have just presented are derived from the AMA and are presented by Jonas et al.² This notation is salient for in that article Jonas and his colleagues state, "In the 1993-94 academic year, 5,352 first-year students (31.3% of total enrollment) were members of minority groups . . ." Now those of you familiar with Project 3000 by 2000 will recognize this 31.3% minority of total enrollment exceeds the 20% threshold sought by the AAMC who created Project 3000 by 2000. The explanation for the higher figures reported by Jonas, et al., as might be expected, is definitional. The Jonas figures speak to all minorities whereas the AAMC figures speak to underrepresented minorities. The AAMC, for the purpose of its Project 3000 by 2000, defines underrepresented minority groups as African Americans, Native Americans, Mexican Americans, and Mainland Puerto Ricans (Table 2). These four groups make up 2,161 students of the 5,352 in the Jonas article. Thus, of the total 17,121 first-year medical students, 12.6% are underrepresented minorities.³ Included in these 2,161 underrepresented minority medical students are the matriculation categories of the first-year students, repeating students, and deceleration students. The repeating and deceleration students total 298 or 13.7% of the 2,161 underrepresented minorities.

Most of the preceding comments can be viewed as positive. Progress is clearly being made. Now, what is the downside? As might be suspected it relates to the rate of academic progression. If one out of five underrepresented minority medical students is taking five years to graduate, then this retards reaching a threshold by 20%. Most recent data on the topic from the AAMC are quite revealing (Table 3). Academic progression for underrepresented minorities was followed for four years for students in the graduating class of 1993; 77.9% graduated with their class. For majority students, this percentage was 91.8%. Factors listed as accounting for the attrition were voluntary withdrawal, death, dismissal, and official leave. By far, the prime factor effecting dismissal was inadequate academic = performance.

The academic script for students for the most part is predictable based on their admission profiles (Table 4). Academic progression data on the same cohort of students just mentioned revealed the following: for students with low MCAT and low science GPA scores, only 64.8% graduated in a timely fashion, for students with high MCAT's and high basic science GPA's, 83.8% succeeded (Figure 1). By ethnicity, the academic profile of 1988 matriculants revealed an average science GPA of 2.83 for African Americans, 3.01 for Mexican Americans and 3.4 for whites. Interestingly, this figure was highest for Asian/Pacific Islanders at 3.42. Essentially, the overall GPA parallels that of the science GPA (Figure 2). For African Americans it was 3.23, for Mexican Americans 3.31 and for whites 3.54. Again, Asian/Pacific Islanders were highest at 3.55. This deficit in performance by underrepresented minorities emanates primarily from being inadequately prepared educationally for the rigor of the premedical curriculum, usually starting in kindergarten and progressing through college. This is, therefore, the current state of the underrepresented minority medical school applicant pool.

Now to my fourth and final point, "What are the mechanisms for reaching parity?". What is needed will not likely occur and that is a domestic "Marshall Plan." The best teacher-pupil ratios should exist in the inner city rather than the reverse. The welfare system which now exists should be scuttled forthwith. Failing to see these sweeping changes occur however, does not render it impossible for our goal to be achieved. There are numerous other areas of progress.

From previous speakers, you have heard about Project 3000 by 2000. This educational paradigm sets forth a methodology for increasing the number of underrepresented minority students such that by the year 2000 20%, or 3,000 entering first-year medical students will be underrepresented minorities, thus reflecting their percentage of the overall population. Project 3000 by 2000 contains both short-term and long-term interventions. Those who conceptualized and are now implementing this project realized that a few weeks of remedial work prior to entering medical school is insufficient to compensate for years of faulty preparation. The bedrock concept of project 3000 by 2000 is that academic health centers are an integral part of communities in which they reside and serve. The success of this type program requires the Total Quality Management (TQM) concept utilized so well by industry. It must be a top down effort. If leadership at either the academic or community level is not fully imbued with a total commitment to this effort, it cannot succeed. Conversely where this commitment exists, it will not fail.

Short-term efforts have intensified the recruitment of underrepresented minority students already in college. Specifically this involves expanding cooperation between medical schools and undergraduate colleges. This relationship calls for curriculum coordination and innovative admission policies. Boston University was one of the first schools to become fully involved in this approach. This short-term program "decompresses" the pre-med curriculum allowing students to gradually become acclimated to the academic demands of medical school matriculation.

Another short-term strategy being used by project 3000 by 2000 involves identifying groups of college students who are being lost from the "pipeline." Each year more than 200 underrepresented minority students pass the MCAT with scores that would qualify them for admission to medical school, but for various reasons they do not apply. Further annually more than 100 underrepresented minority students are admitted to medical schools but do not matriculate. These students are targeted and referred immediately to medical school recruitment and financial officers.

The AAMC has bought into several long-term strategies. One is the identification or creation of magnet health sciences high schools with high minority enrollments. These high schools then seek partnerships with colleges and medical schools to create an integrated educational pathway.

A slightly different long-term approach has been the development of health sciences high school programs and placing them in existing schools, both urban and rural. The Josiah Macy Jr. Foundation has taken a lead here. The National Science Foundation and other

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A slightly different long-term approach has been the development of health sciences high school programs and placing them in existing schools, both urban and rural. The Josiah Macy Jr. Foundation has taken a lead here. The National Science Foundation and other philanthropies have created a program called Ventures in Education to disseminate the Macy model. With this model the basic responsibility for teaching continues to reside appropriately with the local school system. However, medical institutions have important input in the variety of areas, e.g., (1) curriculum planning, (2) supplemental teaching, (3) teacher training, (4) summer and after school jobs, (5) formulation of admission agreements, and (6) tracking academic progress. The importance of this long-term approach is borne out by the fact that most medical students, minority and majority, made their decision to go to medical school prior to graduating from high school.

Also, there are other groups at work to increase the number of underrepresented minority medical students. The improvement in race relations has effected this input. Many question whether or not any real progress has been made in race relations in this country. This is a complex question whose answer cannot in my judgment be couched in a simple yes or no. Clearly, in some areas minorities are better off: The significant increase in the number of elected minority public officials in every level of government is a prime example. But more specifically is the emergence of a sizable black middle class which has occurred since World War II. The black middle class is now actively reaching back to assist less fortunate blacks. This no doubt is occurring to some degree for other underrepresented minorities. A national group of middle to upper income African American women LINKS, Inc. has programs throughout the country that are located in middle schools that identify, direct and strengthen underrepresented minority students academically, especially in the sciences. Similar programs are being conducted by black sororities, fraternities, churches and many other organizations. Long-term intervention of this type at this level is absolutely critical in developing a "pipeline" for the production of future underrepresented minority physicians. This early intervention is the foundation of any long-term strategy. This has been made clear by the National Assessment of Education Progress ("NAEP") survey of science skills for 17 year olds and scholastic aptitude tests ("SAT").

As for short-term measures, successful minority business people are providing loans to help lessen the financial burdens which too often prevent underrepresented minorities from seeking careers in medicine. This represents a key short-term intervention. Also, it is laudable that over the past three years funding for the National

Health Service Corps. (NHSC) has been increased from \$49 million to \$101 million annually. This program, as you know, finances medical education for qualified individuals willing to practice in underserved areas as a method of satisfying their education financial obligation. Here, though, I must inject a caution; in our effort to expand primary care we must concomitantly provide underrepresented minorities with tertiary training opportunities in such areas as nephrology, otolaryngology, neurology, orthopedics, ophthalmology, and other subspecialties. These particular areas of post graduate training have and remain difficult for minority medical trainees to secure--especially for African Americans.

Let me conclude with a sterling example of what top-down commitment can accomplish. When I was admitted to medical school at the University of Arkansas, I was the only African American in a class of 96 students. Subsequent to this, the state of Arkansas experienced the Little Rock Central High School debacle -- the effects of which are still being felt to this day. However, a few years ago there was a conscious commitment by the University of Arkansas at every level -- the Board of Trustees, the Chancellor, the Dean, faculty, students and alumni -- to admit and graduate an increased number of qualified African American students. This was an arduous task but it is succeeding. In September of 1993, the University of Arkansas had 61 African American students in its four classes! Even more noteworthy is, this was achieved in a state with a total population of barely 2 million and, for a southern state, an uncharacteristically small percentage of African Americans, about 18%.

In response to the question raised by the title of my presentation: Yes, I am sanguine that parity for underrepresented minority medical students can be reached. Trends over the past five years lead me to be optimistic. The percentage of first-year underrepresented medical students in the 1988 was 9%, for the 1993 class, 11.4% and 1994, 12.6%. The favorable trend we are now seeing in great part has resulted from the dedication and commitment of the AAMC; a ripple effect has occurred -- others are joining the fight. This organization, with its strong leadership, its excellent staff, and you as medical school faculty and administrators is most uplifting. Yes, I am highly optimistic parity is not a pipe dream, it is, indeed, a reality.

Thank you for allowing me to share these thoughts with you.

ENDNOTES:

1. Petersdorf RG. Not a choice, an obligation. *Proceedings of the 102nd Annual Meeting of the Association of American Medical Colleges*. 1991:1-13.
2. Jonas HS, Etzel SI, Brazanski B. Education programs in U.S. medical schools, 1993-1994. *JAMA*. 1994;272:694-701.
3. Personal communication. AAMC, Division of Minority Health, Disease Prevention and Health Promotion. October 1994.

**Minority Trends in First Year Medical School
Enrollment 1988-89 to 1993-94***

Ethnic Group	5 Year ↑↓ In Number	5 Year ↑↓ In Percentage
African American	1015-1480	46%
Mexican American	250-441	76%
Other Hispanics (Excluding Puerto Rican)	277-302	9%
Puerto Rican (Mainland + Commonwealth)	333-324	(3%)
Asian/Pacific Islanders	2006-2662	33%

**Jonas et al, JAMA, Sept 7, 1994, Vol. 272 No. 9*

TABLE 1

**Underrepresented Minorities
1st Year Students 1994 - 95***

Total 1994-95 1st Year Students	17,121
Total 1994-95 UR Minorities	2,161 (12.6%)
Repeating or Decelerated UR Minorities	298 (13.8%)

**Personal communication from AAMC*

TABLE 2

**Medical Students Academic
Progression by Ethnicity***

Underrepresented Minorities	77.9%
Majority Students	91.8%
Difference	13.9%

**1993 graduating class*

TABLE 3

**Academic Progression
by Admission Profile**

Low MCAT/Low Science GPA	64.8%
High MCAT/High Science GPA	83.8%
Difference	19.0%

TABLE 4

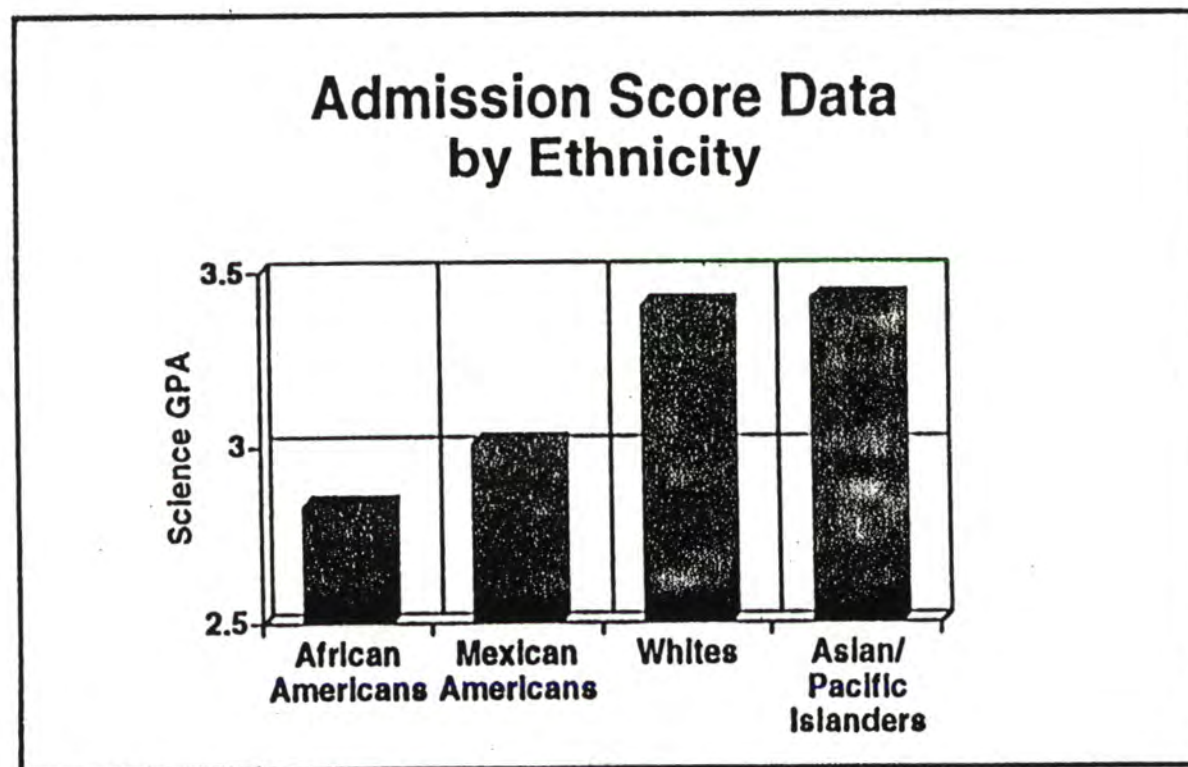


FIG. 1

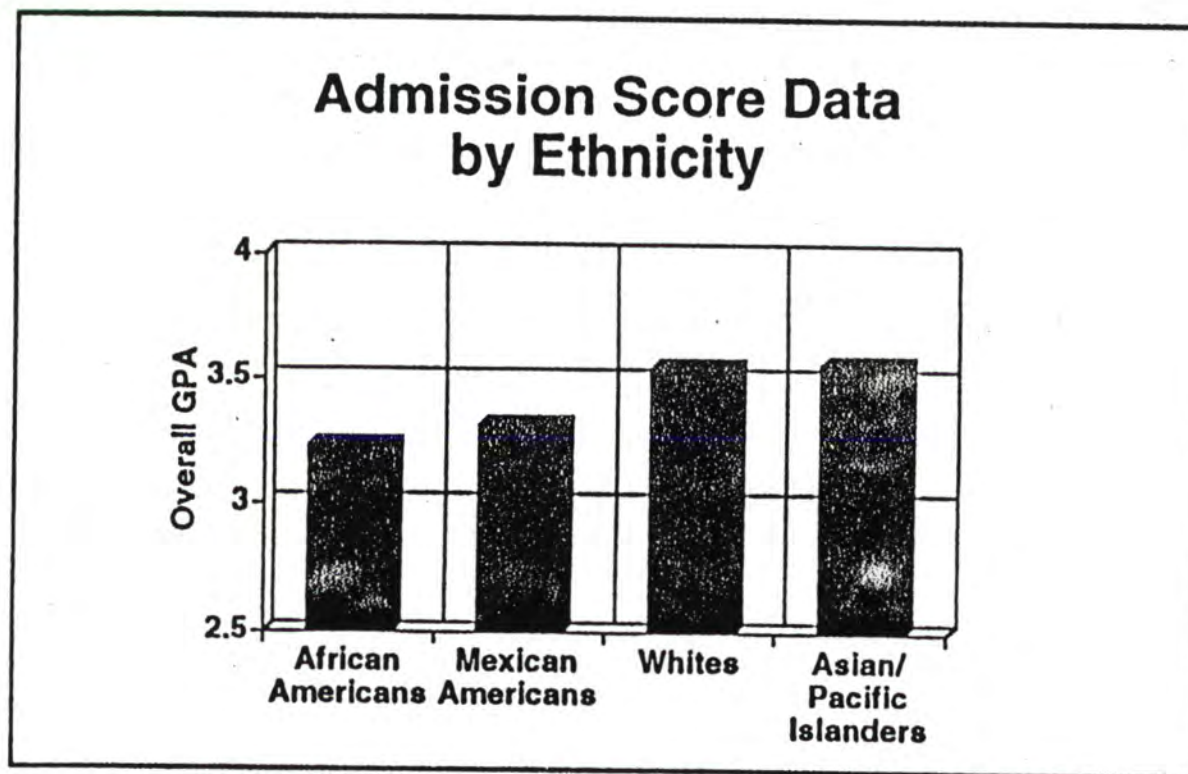


FIG. 2

DESCRIPTION OF PROPOSED PROJECT

SUBJECT: Gender Shift in the Physician Work Force:
Implications for Health Care Reform

APPLICANT: Henry W. Foster, Jr., M.D.

TITLE: Senior Scholar in Residence
Association of Academic Health Centers
Professor of Obstetrics and Gynecology, Meharry Medical College

OVERVIEW

The fundamental purpose of this proposal is to make an assessment of what the dramatic increase in the number of women entering the medical profession implies for health care reform. The effect of this increase holds the potential for having far reaching consequences. Currently, there is little in the literature that examines this gender issue and what it may portend for health care reform. Therefore, the potential effect of this gender shift as it relates to health care reform warrants greater assessment.

Cursory observation of the medical literature revealed virtually no information on this subject. Although the literature is replete with articles relating to various aspects of women in medicine, none focused specifically on health care reform. A research of the American medical literature for the ten-year period 1985-94 utilizing HSTAR, Medline and DataBases was conducted. Using the prompt "Women Physicians and: Trends; Forecasting; Demographics; Patterns; Work Load; Time Factors; and Parental Leave" yielded 125 references. However, none could be linked directly by title to health care reform and the increasing number of females entering the physician work force.

The magnitude of the increase in the number of women choosing medical careers is substantial. This shift is more than evolutionary; in one generation, which is a short period of time in the history of medicine, the percentage of new female medical entrants increased seven fold, from six percent in 1960 to 42 percent in 1993.¹ The final AMA data for 1994-95 are not yet available. However, it is speculated that a plateau is being reached which no doubt will be maintained.²

Irrespective of the recent inaction of the 103rd Congress, health care reform is occurring and will continue to do so at an accelerating rate. Legislation is just one of several very powerful forces driving this changing paradigm in health care delivery. Market place forces responding to high costs and rising costs, although the two are different, are both contributing to this reform.³ In sum, despite lawmakers' failure to act decisively in 1994 on health care reform, a clear public dissatisfaction with health care in this country persists.⁴

In addition to legislation and market place forces, the funding of medical education is yet another very powerful force. That too will catalyze health care reform. The potential strength of this entity is addressed in the 1986 Congressionally authorized Council on Graduate Medical Education (COGME) study to provide an ongoing assessment of physician supply trends and to recommend appropriate responses, both public and private. This study has now been concluded and has been published.⁵

Changes in the funding mechanism of graduate medical education are designed to bring the specialty mix to a 50/50 ratio between primary care and non primary care specialists. (35 new subspecialties have been created since 1978.) In 1961 the number of generalist physicians and specialist physicians was equal; today there are two specialists for every primary care physician. To help reestablish this 50/50 ratio some design similar to the RBRVS (Resource Based Relative Value Scale) or "Harvard Plan" is likely to be invoked. Under this mechanism, teaching hospitals would receive varying reimbursement rates based on the specialty training disciplines of their house officers. A factor of 1.1 would be paid for primary care trainees, a factor of 0.7 for non primary care trainees, and after three years that factor would drop to 0.5 for non primary care physicians. Hence, it seems certain that health care reform will call for a change in the ratio of primary care specialists to non primary care specialists and RBRVS will fuel this redistribution.

STUDY PURPOSE

The fundamental reason for conducting this study is to determine from a national sampling what might be the differences in attitudes between genders and varying age groups towards health care reform. And if differences are found, what is likely to be the magnitude of their effect on health care reform. The increasing number of female health care providers may have a "value-added" effect, thus enhancing the advent of health care reform. We already know that more women choose primary care specialties than do men, but the reasons are not absolutely clear. Hence, procurement of accurate answers to such questions as posed above allows for proactivity as we engage health care reform rather than reactivity.

The fundamental hypothesis being made in this study is the increasing number of females in the physician work force will facilitate the implementation of health care reform. In order to determine meaningful responses, questions must be designed that take into consideration two major positions:

- 1) What are the likely characteristics of physician practice in a "reformed" health care system?; and
- 2) What are the characteristics of our current health care system that are most counter to health care reform?

In an effort to have a modicum of order in exploring these often interdependent issues, four broad categories are created. The questions posed relate to:

- 1) system structure;
- 2) practice setting;
- 3) overall quality of life (QOL); and
- 4) other factors.

System structure questions will address attitudes regarding:

- 1) managed care (HMOs, PPOs, IPAs, etc.);
- 2) gate keeper concept;
- 3) capitation;
- 4) freedom of physician choice (by patient);
- 5) health promotion, disease prevention;
- 6) health insurance purchasing cooperatives (HIPC's);
- 7) practice configuration, e.g., solo versus group practice;
- 8) physician autonomy/decision making;
- 9) method of income (salary versus fee for service);
- 10) capacity for entrepreneurship;
- 11) family-center care; and
- 12) end of life events, e.g., DNR (do not resuscitate).

Practice setting questions will address:

- 1) patient mix, i.e., indigent versus low, mid and upper income;
- 2) volume and scheduling/patient encounters;
- 3) hours of work per week/call schedule;
- 4) patient education by physician;
- 5) allied health personnel as health care colleagues, e.g., nurse practitioners, physician assistants, certified nurse midwives;
- 6) use of electronic communication tools;
- 7) hospital length of stay;

- 8) hospice care;
- 9) in-home health services; and
- 10) birthing centers.

Overall Quality of Life issues relate to:

- 1) child rearing capacity/maternity leave;
- 2) leisure time;
- 3) practice location (urban, suburban, rural);
- 4) level of practice (full-time or partial);
- 5) reentry into the work force;
- 6) retirement age (semi/complete); and
- 7) specialty choice (primary versus non primary).

Other factors to be assessed are:

- 1) liability insurance;
- 2) new medical technology;
- 3) continuing medical education;
- 4) credentialing/recredentialing;
- 5) public health's relationship to health care reform;
- 6) practicing physicians' role in clinical education;
- 7) views on RBRVS;
- 8) cost shifting; and
- 9) generic drug efficacy.

STUDY METHODS

The study construct for this proposal will be derived from three principal sources – the literature, a national questionnaire, and personal interviews. Prior and continuing review of the relevant literature is fundamental. A constitutional understanding of the generic economic history of American women is a prime requisite. Their trials, tribulations and triumphs are chronicled by Dr. Claudia Goldin in her text book on this subject.⁶ The Library of Congress, the Institute of Medicine, the Association of Academic Health Centers, and the Association of American Medical Colleges all are accessible here in Washington, D.C., and are being utilized extensively to support this work.

Of the three data collection modalities noted, clearly the gender neutral nationally circulated questionnaire is the linchpin to the success of this proposed work. Its construct, distribution, retrieval and analysis, and interpretation of the findings must be of the highest caliber. For this aspect of the study, the firm of Battelle/Survey Research Associates will be utilized to assist in this effort. I hold

prior experience with this firm, which has provided data gathering services such as those proposed here for an NIH-sponsored epidemiological grant exploring low birth weight in a cohort of African-American females with sustained high socio-economic status (SES).⁷ This Meharry cohort is being compared to a Yale University cohort of white obstetrical patients with high SES.

The population for this gender study proposal will be medical students, residents, academicians, and practicing physicians. We are most fortunate that the American Medical Association (AMA) master files will be made available. Dr. Harry Jonas, AMA Secretary to the Liaison Committee on Medical Education (LCME) has informed that these files can randomize the entire list, or if desired, various subsets (e.g., females, males, ethnic groups, age, specialty discipline, etc.). Also, the AMA master files include medical students, hence, AAMC files will not be needed for selecting potential student respondents. The potential strata should be configured as follows:

Age $\leq$ 40 + majority + female + trainee (student/resident)

Age $\leq$ 40 + majority + female + practitioner

Age $\leq$ 40 + majority + male + trainee

Age $\leq$ 40 + majority + male + practitioner

Age $\leq$ 40 + minority + female + trainee

Age $\leq$ 40 + minority + female + practitioner

Age $\leq$ 40 + minority + male + trainee

Age $\leq$ 40 + minority + male + practitioner

Age $>$ 40 + majority + female + trainee

Age $>$ 40 + majority + female + practitioner

Age $>$ 40 + majority + male + trainee

Age $>$ 40 + majority + male + practitioner

Age $>$ 40 + minority + female + trainee

Age $>$ 40 + minority + female + practitioner

Age $>$ 40 + minority + male + trainee

Age $>$ 40 + minority + male + practitioner

However, by design the 16 cells will not all be of the same size or mix. The data analysis methodology is described in the following section of this proposal.

The third data gathering method to be utilized with this proposed study is that of face-to-face interviews with key women and men whose interests and professional activities relate to the gender shift in our nation's physician work force. Among the individuals to be interviewed will be elected officials, health care providers, health care executives, academicians, foundation officers, trainees, and practicing physicians.

The content of the questions to be used in these interviews will in great part be dictated by the responses obtained via the national questionnaire.

DATA ANALYSIS

A stratified random sample will be drawn from the AMA master file. We hope that there will be a sufficient number of potential respondents to stratify the population by age (<40, 40+), ethnicity (white, other), gender, and professional status (trainee, practitioner) yielding 16 possible cells. The exact number of strata will be determined after examining the AMA master file to assess whether the sample sizes in each of these 16 cells are sufficient to precisely make within cell estimates. If we find that there are insufficient numbers in each of the 16 cells, we will only stratify by professional status and gender.

We propose to use a stratified sample for this study because the resulting estimates will be more precise than if a simple random sample is used. In addition, stratified sampling is particularly useful for this study because it allows separate estimates of population parameters within each cell and also ensures that the sample is representative of the total population.

Appropriate sampling weights will be determined in order to perform the analysis. Battelle/SRA will track the number of possible respondents in each strata, the number who were chosen for inclusion in the study (which may be the same as the number of possible respondents), and the number who actually responded. We will provide this information to the investigators so that they can correctly account for the sampling scheme in the analysis.

BUDGET

- I. Personnel: Henry W. Foster, Jr., M.D.; No Foundation funds requested.
- II. Office Operations: Provided as in kind service by the Association of Academic Health Centers.
- III. Staff/Consultant Travel: None.
- IV. Other: Formatting and dissemination of the nationally circulated questionnaire will be conducted by Battelle/SRA for a total cost of \$26,085 (should this grant be funded, the \$1,085 difference will be born as a personal expense by the project director). The itemized statement for these services follows.
- V. Indirect Costs: None

ENDNOTES:

1. Association of American Medical Colleges. Women in U.S. academic medicine. *Statistics*; 1994.
2. Personal communication. AAMC. Institutional Planning and Development. November 1994.
3. Kaufman R, Naughton J, Osterweis M, Rubin E. *Health Care Delivery: Current Issues and the Public Policy Debate*. Association of Academic Health Centers. Washington, DC; 1992.
4. Ginzberg E. *Critical Issues in U.S. Health Care Reform*. Westview Press; 1994.
5. Rivo M, Satcher D. Improving access to health care through physician workforce: directions for the 21st century. *JAMA*. 1993;270:1074-1079.
6. Goldin C. *Understanding the Gender Gap: An Economic History of American Women*. Oxford University Press; 1990.
7. Foster HW, Thomas J, Semanya K, Thomas J. Low birthweight in African Americans: does intergenerational well-being improve outcome? *Journal of the National Medical Association*. 1993;85:516-520.

PERSONNEL

Co-Director, Dikel	5 hours	\$40.96/hr	\$205
Study Manager, van Dyck	75 hours	14.23/hr	1,067
Study Manager Support, Schultz	75 hours	10.26/hr	770
Programmer, Roth	85 hours	18.46/hr	1,569
Data Preparation Support, Carter	120 hours	10.26/hr	1,231
Word Processor, Treece	40 hours	15.14/hr	606
Subtotal Salaried (Using 1994 Rates)			5,448
Allowance for salary increase of 5% per year after 10/1/94			454
TOTAL SALARIED			5,902

HOURLY STAFF

Mailing preparation			
Intro letter mailing	1250 pieces	2 min/piece 7.75/hr	323
Questionnaire mailing	1250 pieces	3 min/piece 7.75/hr	484
Post card mailing	1250 pieces	1 min/piece 7.75/hr	181
Thank you letter & payment	500 pieces	2 min/piece 7.75/hr	129
Editing/Coding/Data Cleaning	500 cases	8 min/case 8.00/hr	533
Data Entry	500 cases	10 min/case 8.00/hr	667
Subtotal Hourly (Using 1994 Rates)			2,297
Allowance for salary increase of 5% per year after 10/1/94			191
TOTAL HOURLY			2,488

OTHER DIRECT COSTS

Printing/Xerox photocopying			
Letters	2000 pieces	each \$0.10	200
Questionnaires	1500 pieces	each \$0.65	975
Postcard	1300 pieces	each \$0.50	650
Envelopes	3100 pieces	each \$0.50	1,550
Miscellaneous			50
Postage			
Intro letter	1250 pieces	each \$0.29	363
Questionnaire mailing	1250 pieces	each \$0.75	938
Postcard mailing	1250 pieces	each \$0.15	188
Questionnaire return	500 pieces	each \$0.85	425
Thank you letter	500 pieces	each \$0.29	145
Supplies/Miscellaneous			150
Computers	1 month	month \$195.00	195
Telephone			50
TOTAL OTHER DIRECT			5,879

TOTAL DIRECT

Labor overhead - permanent staff 129.0%			14,269
Labor overhead - hourly staff 11.1%			7,614
			276
SUBTOTAL			22,159
INDIRECT 9%			1,994
SUBTOTAL			24,155
FEE 8%			1,932
TOTAL			<u>\$26,085</u>