



• PHYSICIAN WORKFORCE 2000 •
ALL LICENSED PHYSICIANS

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THE FIRST IN A SERIES

THIS PHYSICIAN WORKFORCE SERIES

- ALL LICENSED PHYSICIANS
- PRIMARY CARE PHYSICIANS
- LICENSED MD PHYSICIANS
- LICENSED DO PHYSICIANS
- GRADUATE MEDICAL EDUCATION
- DATA REFERENCE AND SOURCE BOOK

Introduction

The Year 2000 has significance concerning Physician Workforce issues. State public policy concerning physician workforce focuses upon medical education enterprises. Therefore, this analysis is using the federal Council on Graduate Medical Education (COGME) discussions and policy recommendations as benchmarks for examining the Oklahoma workforce in 2000.

Other than being the beginning of a new millenium, there are real timeline milestones to be considered.

- The federal Council on Graduate Medical Education (COGME) was formed in 1986. COGME has made comprehensive policy suggestions. The Year 2000 was a target date for some.
- Oklahoma created a Physician Manpower Training Commission more than 25 years ago. The year 2000 represents a natural calendar milestone against which to measure progress.
- Oklahoma established two new medical education enterprises in Tulsa in order to educate, train and produce primary care physicians.

Given these critical policy initiatives, it is important to accurately and comprehensively measure and document benchmarks this year.

Data Sources

Unless otherwise specified, these data are the adjusted 2000 census of allopathic and osteopathic physicians in Oklahoma. Databases were adjusted to insure that only active physicians are included. Retired and resident/fellow physicians have been excluded from the counts. MD data were cited from the Oklahoma Board of Medical Licensure and Supervision. Osteopathic physician data were provided by the Oklahoma Board of Osteopathic Medical Examiners. Both agencies are the official licensing authorities for the state of Oklahoma.

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This Analysis

This study is unique in that it combines the physician workforces of both the osteopathic and allopathic physician groups. Also, it only includes licensed practicing physicians who have completed all graduate medical education and training. It is imperative that the professional [MD and DO] data bases be consistent and comparable.

Summary Findings

Oklahoma has been very successful ... either by design or accident ... in creating a "system" that pursues and meets the long range statistical goals of COGME.

The state has created a physician production system that affords all in-state graduates an in-state GME position; and these GME positions are of an appropriate specialty mix. Oklahoma has almost the ideal number and mix of generalist and specialist physicians per the early 21st century goals of COGME.

There is significant mutual reinforcement and interaction between the MD and DO professions throughout the physician production process. None of it is per public policy or by conscious design. It is the product of market forces and collective individual actions of students acting in their professional best interests.

The result is a well synchronized and balanced set of results for Oklahoma.

These findings do not assess the quality of either of the systems or the physician products.

Benchmarks for 2000

Federal Goals

The work of COGME, and a host of other policy groups, may be distilled to four quantitative recommendations against which we may measure Oklahoma's physician workforce. They are:

- COGME Goal #1: The residency positions available should total 110% of the number of graduates from the nation's MD and DO schools of medicine.
- COGME Goal #2: Half of all graduating physicians should enter practice as "generalists" ... that is the specialties of Family Medicine, Internal Medicine or Pediatrics.

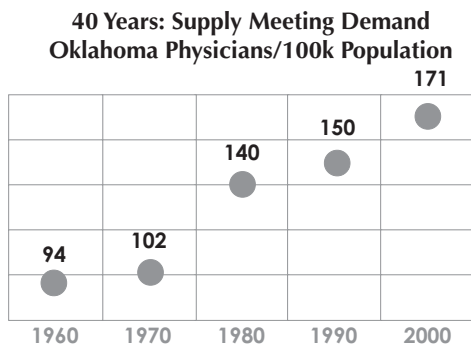
This is referred to as the "110:50/50" recommendation. It was recognized that the "50/50" recommendation could not be reached by 2000 because of the existing mix of specialties. Therefore an interim goal was established for 2000 as below:

- COGME Goal #3: The practicing physician ratio for the early 21st Century should be 42% generalists and 58% specialists
- COGME Goal #4: The physicians per 100,000 population ratios should be 60-80 for generalists and 85-105 for specialists.

Oklahoma Goals

The establishment of new medical education enterprises in the 1970s, along with the creation of the Physician Manpower Training Commission at the same time, were based upon unstated goals for Oklahoma. Some included:

- Oklahoma Goal #1: There should be at least one Oklahoma-based graduate medical education position available for each graduate of Oklahoma's medical schools.
- Oklahoma Goal #2: The number of primary care physicians must be significantly increased and appropriately distributed statewide.
- Oklahoma Goal #3: The number of family medicine physicians must be significantly increased and appropriately distributed statewide.
- Oklahoma Goal #4: The distance from patients to well trained primary care physicians should be minimized.



Oklahoma 2000 vs. Benchmarks

Graduate Medical Education

The COGME goals suggest that the ideal number of residency training positions be 110% of the number of medical school graduates. That means there should be a first year graduate medical education slot for every U. S. medical school graduate, plus an additional number to absorb foreign medical graduates. Additionally, it has been unstated Oklahoma policy to provide a slot for each graduate of our state's public medical schools.

Another COGME goal is to have 50% of all physicians entering practice to be primary care physicians.

Oklahoma has had a remarkable success rate in providing the number and mix of GME opportunity.

COGME Goal #1 & Oklahoma Goal #1: In July 2000, there were 228 first year GME positions available in Oklahoma and 212 were filled. The state's two medical schools have a combined maximum class size of 238 medical students. For all intents and purposes, Oklahoma provides a first year training position for each medical school graduate.

Oklahoma Performance: Excellent

COGME Goal #2 and Oklahoma Goal #3: Two-thirds of all first year positions are in primary care specialties. And 50% of all filled positions are in primary care specialties. It can be safely said that about half of all Oklahoma trained physicians are pursuing primary care.

Oklahoma Performance: Excellent

Oklahoma Census

The 2000 Oklahoma physician census lists 5,900 active licensed physicians, excluding those in graduate medical education programs. There were 4,944 MD physicians and 956 DO physicians. A summary table of physicians by specialty group is below: A detailed table is at page 4.

Specialty Grouping	MD	DO	Total	Pct
Primary Care	1,839	591	2,430	41%
Medicine Specialties	592	34	626	11%
Pediatric Specialties	26	-	26	-
Hospital Specialties	936	150	1,086	18%
Obstetrics/Gynecology	284	29	313	5%
Psychiatry	251	27	278	5%
Surgery	881	107	988	17%
Other Specialties	135	18	153	3%
GRAND TOTALS	4,944	956	5,900	100%

Source: MD Physicians - Oklahoma Board of Medical Licensure and Supervision, custom report, Summer 2000. DO Physicians - Oklahoma Osteopathic Board of Medical Examiners, custom report, Summer 2000.

Detailed tables describing the physician workforce may be found at the Physician Workforce 2000 Source Book accompanying this series.

COGME goals concerning physician workforce numbers and composition were developed in 1985. They state "the practicing physician ratio for the early 21st Century should be 42% generalists and 58% specialists" and "the physicians per 100,000 population (PTP) ratios should be 60-80 for generalists and 85-105 for specialists."

COGME Goal #3: Given the above numbers, the COGME goal for 42% generalist physicians has been met in Oklahoma. There are 41% of Oklahoma physicians practicing in the specialties that COGME defines as "generalist care". They are Family Medicine, Internal Medicine and Pediatrics.

Oklahoma Performance: Excellent

COGME Goal #4: Additionally, COGME suggests the ideal primary care PTP ratio of 60-80. The 2000 census suggests a state population of 3,450,654. That yields a 70.4 PTP ratio ... exactly mid-range of the optimum.

Oklahoma Performance: Excellent

COGME suggests the ideal specialist PTP ratio of 85-105. The Oklahoma data reveals that our 2000 specialist PTP ratio is 100 ... within the optimum range suggested.

Oklahoma Performance: Very Good

Primary Care

Primary care physicians are classically described as the specialties of Family Medicine, Pediatrics and Internal Medicine. This is the definition used by COGME and a host of similar agencies. There are a variety of local definitions that are used for specific purposes.

For example, physicians who have not completed a residency training program and opt for Emergency Medicine or locum tenens contract work are sometimes classified as "primary care" physicians. Others include specialties such as Preventive Medicine, Industrial Medicine and other similar specialties. This analysis will only consider the three aforementioned specialties.

Specialty	MD	DO	All	Pct
Pediatrics	313	32	345	6%
Internal Medicine	688	78	766	13%
Family Medicine	828	481	1,309	22%
Primary Care	1,829	591	2,420	41%
Other Specialists	3,115	365	3,480	59%
All Physicians	4,944	956	5,900	100%
Pct Primary Care	37%	62%	41%	
Pct Specialists	63%	38%	59%	

Oklahoma's Physician Production "System"

There is no formal system that oversees statewide physician production processes. Oklahoma does not have public policy that clearly proposes a set of doctrines, ideas or principles intended to provide a specific composition. No state does.

That said, Oklahoma has made overall public policy commitments to achieve general goals of "more primary care physicians" and "a better distribution of physicians". These commitments include:

- State appropriations targeted toward primary care and Family Medicine physician production through the independent Physician Manpower Training Commission.
- New educational operations in Tulsa, Enid, Lawton and Oklahoma City that emphasize primary care.

These major public policy initiatives, left alone and supported over 25 years, have produced an enviable physician workforce to serve the state. These institutions interacted

with market forces, independent student choice and professional incentives to achieve the current results.

It makes one re-examine to what degree excessive public micro-management is necessary to achieve certain goals.

Distribution

Oklahoma apparently has a near optimal mix and number of physicians. But are these physicians distributed appropriately to serve the population? This is a question that requires extensive analysis beyond the scope of this paper. However, the broader public policy issue in Oklahoma may be observed.

The table below indicates an apparent "maldistribution" of all physicians. This is because many specialist and hospital physicians must be clustered and centralized as a matter of professional efficiency and effectiveness. However, Oklahoma policy is to produce primary care physicians, particularly Family Medicine physicians, who should be more evenly distributed along with the population.

Oklahoma Goals #3 & #4: The primary care physicians are reasonably distributed between metro and non-metro areas. The exceptions are Tulsa, with two primary care oriented medical education enterprises; and the Fort Smith (Sequoyah County) area, which relies upon Arkansas based physicians. The Family Medicine physicians are remarkably well distributed in both urban and rural areas.

Oklahoma Performance: Very Good

Physicians to 100k Population

Region	2000 Pop	FamMed	PriCare	All Phys
Enid MSA	57,813	42.1	70.2	209.3
Ft. Smith MSA	38,972	34.3	36.9	48.8
Lawton MSA	114,996	41.3	66.6	161.7
OKC MSA	1,083,346	35.8	76.1	225.4
Tulsa MSA	803,235	45.9	94.1	225.0
Metro	2,098,362	40.2	81.7	218.0
Non-Metro	1,352,292	36.9	57.3	98.0
Statewide	3,450,654	37.8	70.1	171.0

Licensed Physicians

Region	2000 Pop	FamMed	PriCare	All Phys
Metro	2,098,362	817	1,661	4,575
Non-Metro	1,352,292	488	759	1,325
Statewide	3,450,654	1,305	2,420	5900
Metro	61%	63%	69%	78%
Non-Metro	39%	37%	31%	22%

Summary

Oklahoma has met each COGME goal almost perfectly. If other states did the same, the national COGME goals would be met. But other states are not, and the collective effect is that nationally we are likely not meeting COGME goals. But Oklahoma is doing its part.

Also, the COGME recommendations assumed a much larger managed care presence than has emerged in Oklahoma. Managed care models assume fewer physicians being needed. Since the Oklahoma managed care penetration is relatively low, the state could use more physicians than the COGME reports suggest.

Oklahoma's performance is better than OK.

