US Government pays hospitals not to train doctors . . .

Twenty years ago, the United States government decided that the country faced a shortage of doctors, even though the ideal size of the physician pool is notoriously difficult to predict. Through a series of financial incentives, medical schools and teaching hospitals were encouraged to expand. Now, having concluded that there is a doctor glut, the government is offering a new set of incentives to reduce the number of physicians-in-training.

In a plan approved by President Clinton that is part of the federal budget agreement between both houses of Congress, hospitals that agree to reduce the number of new doctors by 20 percent over the next five years may join a reimbursement scheme that will pay them millions of dollars just as if the resident physicians were still there.

Hospitals are paid roughly $100,000 from Medicare funds for every resident. This is used to pay residents' salaries (around $40,000 a year) and contributes to the cost of teaching, research and the care of patients who lack insurance. This money has been particularly vital to the country's big teaching hospitals, many of which are located in city centers and treat a disproportionate number of poor patients. By subsidizing the training of residents, the government was, in effect, providing hospitals with a cadre of inexpensive young physicians who take care of the poor. Without this new budget scheme, many hospitals would have no incentive to reduce the number of residents they employ.

The plan to continue resident funding while reducing the number of residents was originally devised by hospitals in New York State under the auspices of the Greater New York Hospital Association, and billed as a "demonstration" project (*Nature Med.* **3**, 372; 1997). New York hospitals voluntarily agreed to reduce the number of residents overall by 2228 positions in exchange for a federal commitment to phase out reimbursement over six years rather than cut it off all at once.

Forty-two hospitals that train two-thirds of the state's 15,000 residents agreed to the terms, which comprised 100 percent payment in the first year, 95 percent in year two and a graded decrease to zero in the sixth year.

Now that the same plan has been extended to medical centers nationwide, it is not yet clear how many hospitals will choose to participate. The plan provides a similar incentive to the New York system, but it also includes strict penalties and payback provisions for failure to meet goals. Since it is planned to measure residency reduction from June 1997, hospitals such as Massachusetts General and Brigham & Women's in Boston and Emory in Atlanta say that they probably will not participate. They have already initiated their own programs to reduce resident numbers and may not be able to achieve a further 20 percent reduction of their already reduced staff.

Many hospital officials also predict the cuts will have a particularly noticeable effect on the number of residents from medical schools outside of the United States. The expectation is that American medical graduates will be attracted to residency programs in areas they previously shunned, as the number of available positions goes down. Only those foreign medical graduates who are academically competitive will continue to be among the residency pool.

Altogether, the Medicare residency fund comes to around $7 billion per annum. Barring future legislation, that money will end by the year 2003, and some concern has been raised for the long-term consequences of losing this funding.

If teaching hospitals are considered the financial equivalent of a large conglomerate, in which the fiscal health of one section of the company has a cascade effect on the health of another, then reducing the overall pot of money at the hospital's disposal may have a knock-on effect for other programs such as research. In this way, the Medicare payment policy may have a negative effect on the academic mission of the participating medical centers.

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. . . and Japan proposes physician cutbacks

Japan's plans to restructure and streamline its government in preparation for the next century could radically affect the country's provision of medical care by reducing the number of medical students entering university and restricting the number of those who pass the national medical exam. The new measures are an effort to increase efficiency by reducing wastage, needless testings and the over prescription of drugs that has been a lucrative side business for some Japanese doctors (*Nature Med.* **2**, 258; 1996).

Japan currently has around 18.4 doctors per 10,000 people — more than the UK but less than the United States and France, on a per capita basis. Although a 10 percent reduction on 1984 numbers is already planned, health officials are still predicting a surplus of 23,000 physicians in 2015.

There are also plans to reduce the overall number of hospital beds in a country that has nearly four times the number of beds per capita than the US, and 50 percent more than France or Germany.

The cutbacks are linked to a series of government reforms initiated by Prime Minister Ryutaro Hashimoto, including a planned merger between Japan's beleaguered Ministry of Health and Welfare, the Environment Agency and the Labor Ministry to form two new ministries called the Employment and Welfare Ministry and the Environment Safety Ministry. This merger should be completed by the year 2001.

Although details of how the changes will be implemented have not been announced, medical departments and colleges are not expected to be closed down. And despite the prime minister's directive to introduce these measures, the debate is still continuing at ministry level. A committee attached to the health ministry's Health Policy Bureau is discussing the appropriate number of doctors needed in Japan, and there is resistance from some bureaucrats to using the national medical examination as a tool to reduce the number of individuals qualifying each year.

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