THE PRACTICE OF MEDICINE IN CALIFORNIA:

A Profile of the Physician Workforce

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California Workforce Initiative

The California Workforce Initiative, housed at the UCSF Center for the Health Professions and funded by the California HealthCare Foundation and The California Endowment, is designed to explore, promote and advance reform within the California health care workforce. This multi-year initiative targets supply and distribution, diversity, skill base and regulation of health workers, utilization of health care workforce and health care workers in transition.

CALIFORNIA WORKFORCE INITIATIVE

The Center for the Health Professions

The mission of the Center for the Health Professions is to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care workforce capable of improving the health and well being of people and their communities.

The Center is committed to the idea that the nation's health will be improved if the public is better informed about the work of health professionals.

THE CENTER FOR THE HEALTH PROFESSIONS
University of California, San Francisco

The California HealthCare Foundation

The California HealthCare Foundation is an Oakland-based, independent non-profit philanthropic organization whose mission is to expand access for underserved individuals and communities, and to promote fundamental improvements in health status of the people of California.

CALIFORNIA HEALTHCARE FOUNDATION

The California Endowment

The California Endowment, the state's largest health foundation, was established to expand access to affordable, quality health care for underserved individuals and communities. The Endowment provides grants to organizations and institutions that directly benefit the health and well-being of the people of California.

THE CALIFORNIA ENDOWMENT

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EXECUTIVE SUMMARY

This report provides a profile of the physician workforce in California in the year 2000. The first section includes most recent data (primarily from the American Medical Association (AMA) Masterfile) about aggregate supply (compared to requirements estimates), specialty and geographic distribution, demographic characteristics by sex, race and ethnicity, and age, and medical education and training enrollment. The second part of the report focuses on the state of medical practice in California. This section includes references to published literature and to previously unpublished data collected on California physicians. With this information, we present facts and figures and also provide some analysis of practice setting, physician organization, managed care involvement, Medi-Cal participation, financial incentives, earnings and physicians' experience of the practice climate in California.

Highlights of the report include the following:

Aggregate supply

- In 2000, California had almost 90,000 active allopathic and osteopathic physicians. Many of these physicians were still in residency training or working outside patient care. For most of the analyses in this report, the focus is on the approximately 65,000 active, non-federal, patient-care physicians who have completed their residency programs.
- California still has sufficient (to more than enough) physicians overall. The state had about 190 physicians per 100,000 population in 2000. This ratio is higher than the upper bound of the requirements estimate set forth by the Council on Graduate Medical Education (COGME). There is no evidence of large numbers of physicians leaving the state. The ratio of physicians to population has outpaced population growth in California over the past six years, rising from 177:100,000 population in 1994 to 190:100,000 in 2000.

Specialty distribution

- In 2000, slightly more than a third of California's active, patient-care physicians practiced in the generalist fields of medicine (family practice, general practice, general internal medicine, and general pediatrics). The remaining two-thirds were specialists. The generalist supply in California is around the mid-point of the COGME requirements estimate range, whereas the specialist supply is about 20% higher than the upper range of the COGME requirements estimate. Both generalist and specialist supplies have continued to increase over the past six years at faster rates than that of the general population; however specialist growth has been somewhat slower than generalist growth.

Geographic distribution

- Data on physician supply for the state as a whole belie the tremendous variation across regions in the state. The ratio of total physicians to population ranged from a high of 238 physicians per 100,000 population in the Bay Area to a low of 120 physicians per 100,000 population in the South Valley/Sierra. Regions with the state's largest metropolitan areas (Bay Area and Los Angeles) have the most robust supplies of physicians, with physicians even more likely than the general population to choose these urban areas. Three regions composed of a mix of rural areas and small to medium sized metropolitan areas (Central Valley/Sierra, Inland Empire and South Valley/Sierra) have the lowest supplies of physicians.
- Geographic maldistribution of physicians has shown little evidence of abating in recent years.
- Physician supply varies even more widely at the county level. San Francisco has the highest ratio of physicians to population (409 per 100,000 population). Twenty-five of the state's 58 counties have levels of physician supply below the lower bound of the COGME estimate of physician requirements; these are mostly rural counties outside resort areas.
- Even in counties with ample overall supplies of physicians, shortages exist in some communities, particularly those with high non-White populations.

Demographic characteristics

- Most California physicians are male and white. A plurality is between the ages of 45 and 54 years old.
- Women make up less than a quarter of the active patient-care physicians in California. However, the physician workforce is slowly but steadily approaching parity between the numbers of female and male physicians. California is about on par with national estimates that women will constitute more than a third of active physicians in the U.S. in 2020.
- Women physicians are more likely than men to choose primary care specialties and obstetrics and gynecology.
- The state's physician workforce is losing ground in terms of its racial and ethnic diversity. Of California physicians who reported their race or ethnicity in 2000, African Americans and Hispanic/Latinos each comprised less than 5% of the state's physicians although they made up about 7% and 31% of the state's population respectively. The medical education and training pipelines do not show significant advances in recent years in racial and ethnic diversity.
- Physicians of different races tend to choose different practice specialties. In contrast to the 70% of white physicians who are in the specialty fields, other races and ethnicities (such as Asian/Pacific Islander, Mexican American and Other Hispanic) have generalist/specialist distribution ratios that are closer to 50:50.

Location of medical education and training

- Only about a quarter of the physicians practicing in California in 2000 attended medical school in the state. About 50% of the state's physicians attended medical school in another U.S. state and the remaining 25% attended medical school outside the U.S.
- A slight majority (55%) of the physicians practicing in California in 2000 did their residency training in the state. The remaining 45% did their residencies outside California.

Practice organizations and practice settings

- In 1998, one third of generalist physicians and over 40% of specialists in urban California communities worked as solo practitioners. About 1 in 5 generalists and 1 in 8 specialists worked in the Kaiser-Permanente HMO system. Many California physicians practiced in single specialty or multi-specialty group practices. Overall, about one-third of generalists and one-quarter of specialists in California worked in practice settings with groups of 11 or more physicians.
- The rise and fall of new organizational entities among physicians has shaped California health care delivery over the past decade. These organizations include larger medical groups, independent practice associations (IPAs), physician hospital organizations (PHOs), and physicians practice management companies (PPMCs). Over 20 IPAs have failed in the past year. However, there are some examples in California of successful and solvent physician organizations.
- In 1998, more than 90% of the generalists in California urban areas belonged to at least one IPA, with about half participating in 2 or more IPAs. In contrast, only 58% of the specialists participated in one or more IPAs.

HMO Contracts

- In 1998, about half of generalists and one-third of specialists in urban California had the majority of their patients enrolled in HMOs (included private, Medicare, and Medi-Cal HMOs). Sixteen percent of generalists and 20% of specialists had no HMO patients in their practice.

Physician payment and earnings

- In 1998, the median net income for urban California physicians was $120,001 – $140,000 for generalists and $201,001 – $250,000 for specialists. These incomes are comparable to those reported for physicians nationwide.

- In urban California, about half of generalist physicians and one-third of specialist physicians reported in 1998 that they were paid on a salaried basis, with the remainder working under non-salaried arrangements, including self-incorporation.
- About 25% of non-salaried generalists received at least half of their income from capitation. In contrast, the vast majority (85%) of non-salaried specialists received at least half their income from fee-for-service payments.
- In California, almost 40% of primary care physicians with managed care contracts reported that their income was in part based on financial incentives in addition to the basic practice compensation they receive. Some of these physicians reported that financial incentives based on increasing productivity or reducing rates of referral created selective pressures that significant minorities of physicians perceived to compromise care; such incentives were associated with dissatisfaction among physicians. Financial incentives based on patient satisfaction or quality of care were positively associated with job satisfaction.
- National studies have found a negative impact on physician income in areas with high managed care penetration. There is also evidence that managed care penetration affects primary care physicians' income less negatively than it does specialist physicians' income.

Practice satisfaction

- Data from the 1998 California physician survey indicate that most physicians in the state are satisfied with being a physician although a noteworthy minority is dissatisfied.

Practice pressures and clinical autonomy

- In 1998, a majority of California physicians reported pressure to see more patients per day and to limit test ordering. A substantial minority indicated they believed these pressures compromised patient care. Most physicians reported not feeling pressure to limit discussion with patients about treatment options.

- A consensus in the published literature is that, for physicians, a sense of professional autonomy and job satisfaction are virtually inextricable.

Care for Underserved Californians

- A minority of California physicians appear to be providing the majority of care to Medi-Cal and uninsured patients. In 1998, over 40% of California physicians reported not participating in the Medi-Cal program. At the other end of the spectrum are the 20–25% of physicians with relatively heavy Medi-Cal case loads (Medi-Cal patients constituting 10% or more of these physicians' practices). Even more physicians do not have uninsured patients in their practices. About 48% of the surveyed specialists and 58% of the surveyed generalists reported having no uninsured patients.