Executive Summary

Health care in the United States is in the midst of a dramatic transformation that has major consequences for physicians. Any changes in supply and demand for physicians have important implications for public policy because physicians play a pivotal role in the utilization of health care resources and because federal and state governments subsidize medical education more heavily than education in any other health profession. Current physician workforce trends indicate a need to reform federal graduate medical education (GME) policy to better align policy with market signals and the public interest. The transformation of health care is affecting other health professions as well, but in no other case are the gaps between supply and demand so evident nor the deficiencies in current policy so glaring.

Recent reform efforts have focused on the Medicare program because Medicare constitutes the largest federal source of expenditures for GME and because Medicare is the source of federal funding most poorly aligned with the nation's physician workforce requirements. The Balanced Budget Act of 1997 represents the first major overhaul of Medicare GME policy since the early 1980s and contains a number of important provisions. However, further reforms are necessary to align educational programs' financial incentives with market realities. This report is intended to offer Congress, the Administration, and others concerned with federal GME policy a road map for moving beyond the Balanced Budget Act of 1997.

RATIONALE FOR FEDERAL GME SUBSIDIES

Any effort to change the federal policies that surround payments for graduate medical education must be grounded in a thorough understanding of where and why these policies began and how they have evolved over the past three decades. Payment for residency training in medicine was a part of the landmark legislation for Medicare and Medicaid passed in 1965. As the legislation expanded health coverage first for the elderly and then for the poor, it rightly anticipated that the demand for physician services would grow. To account for this growth the legislation created a mechanism by which hospitals that were

engaged in training would be compensated for both direct and indirect costs of GME. As time passed, it became evident that many of these training institutions were responsible for providing a large share of complex and expensive care, especially for persons without health insurance. To compensate them for providing a disproportionately large share of this care, government subsidies were increased.

These policies happily coexisted for nearly 30 years. Physicians' incomes grew steadily despite large increases in the numbers of US and international medical graduates enrolled in US residency programs, suggesting that the nation needed more physicians. Few questioned the reliance on teaching hospitals' emergency rooms to provide care to the uninsured in many communities. More recently, however, there are signs that the supply of many types of physicians exceeds demand and growing recognition that health services to the poor might be provided more effectively through other means.

In the long run the country needs a policy structure that can ascertain the numbers and types of physicians that are needed and design subsidies that will produce such outcomes. The implications of GME reform for access to care for the uninsured must be addressed in the most efficient and effective manner. Teaching hospitals should receive separate subsidies for other special contributions they make to the public's health and well being.

Federal GME subsidies must be revamped to focus in six major areas critical to ensuring that beneficiaries of federal programs and the public at large have access to an appropriate complement of physicians.

- Training physicians in appropriate clinical sites;
- Adequate distribution of physicians by specialty;
- Adequate geographic distribution of physicians;
- Improving the racial/ethnic distribution of physicians;
- Preparing physicians with the skills to practice as members of multi-disciplinary teams; and
- Promoting acquisition of the knowledge, skills, and competencies necessary for physicians to provide appropriate, high quality care.

Teaching hospitals produce three additional "public goods" as joint products of their educational activities.

- Uncompensated care;
- Highly specialized health care services; and
- Research.

Under current market conditions, teaching hospitals cannot provide appropriate quantities of these goods without some sort of federal subsidy, nor will other entities provide them in place of teaching hospitals. This is particularly true of uncompensated care. The growth of managed care is reducing the amount of discretionary revenue that teaching hospitals have available to subsidize uncompensated care and other social missions. Public teaching hospitals are particularly at risk because a large percentage of their patients are uninsured. Funding for other federal and state programs that support uncompensated care, such as community health center grants, has not kept pace with demand.

However, teaching hospitals must be accountable for appropriate use of subsidies provided for these purposes. Most federal and state GME subsidies have given teaching hospitals financial incentives to hire residents to provide services with little regard for demand for physicians. A new social contract is needed to align funding for these three public goods and ensure that teaching hospitals respond to the public needs in all of these areas. Reform is needed but not because teaching hospitals are receiving too generous a subsidy for uncompensated care and other non-educational public goods. Rather, these public goods are being subsidized illogically in the guise of payments for education with little accountability for outcomes in any of these arenas.

SHORTCOMINGS OF CURRENT MEDICARE GME POLICY

Significant reforms in Medicare GME policy were enacted as part of the Balanced Budget Act of 1997. However the Balanced Budget Act focused on curbing Medicare expenditures rather than on aligning Medicare GME policy with the nation's physician workforce requirements.

This legislation is not sufficient to provide the US with an appropriate physician workforce to meet the nation's requirements for the 21st century. The rapid transformation of health care delivery is prompting dramatic changes in the deployment of physicians in the health care system which, in turn, signal a need for further overhaul of GME policies. Specifically, seven major shortcomings in Medicare GME policy must be addressed:

- Lack of a mechanism to ensure that private beneficiaries contribute to subsidization of GME;
- Insufficient incentives to permit market forces to regulate the production of physicians, particularly international medical graduates (IMGs);
- Illogical variation in reimbursement for direct medical education (DME) expenses;
- Insufficient incentives for training physicians in generalist disciplines (family practice, general internal medicine, and general pediatrics);
- Insufficient incentives for training residents in non-hospital settings;
- Lack of incentives for cost control and sound cost accounting; and
- Inadequate support for advanced clinical education of advanced practice nurses (APNs) and physician assistants (PAs).

VISION FOR FEDERAL FUNDING OF MEDICAL EDUCATION

The federal government continues to play a valuable role in subsidizing medical education, but policy must be adapted to ensure that medical schools and clinical teaching sites have incentives to use federal subsidies in a manner consistent with workforce requirements. Options for reform should be designed to achieve nine major outcomes.

- Pay for all public goods currently funded through federal GME subsidies — medical education, research, specialized patient care services, and uncompensated care — in the most rational manner possible;
- Provide a broad and stable base of support for GME;
- Sever link between subsidies for care delivery and education;

- Hold teaching institutions accountable for achieving physician workforce goals;
- Dramatically reduce the number of specialist residency positions;
- Maintain the current number of generalist residency positions;
- Ensure that physicians receive sufficient training in non-hospital sites;
- Strengthen mechanisms to insure access to care for the uninsured in communities that have relied on residents to provide uncompensated care; and
- Promote a multi-disciplinary primary care workforce.

Developing an ideal mechanism for subsidizing education in medicine and other health professions requires an accounting of the true costs of each of the four "public goods" subsidized through current federal "education" subsidies - education, research, specialized clinical services, and uncompensated care. Once these costs are disentangled, mechanisms may be developed to subsidize each of these public goods. Desired outcomes and evaluative measures should be identified for each federal subsidy. Funding should then be based on measures of achievement. Separately financing each public good enables the federal government to allocate funding in the most rational manner possible. This approach eliminates the illogical nature of current policies, which subsidize the non-educational public goods in a manner that exacerbates the imbalance between supply and demand for physicians.

RECOMMENDATIONS FOR REFORM OF FEDERAL GME POLICY

Political barriers and gaps in knowledge about true GME costs pose great obstacles to implementing this vision for federal GME policy any time soon. However, a number of incremental steps can be taken to improve federal GME policy in a manner consistent with this vision. In this report the Pew Commission presents a compre-hensive package of reforms that advance this goal. The Commission recommends an all-payer financing mechanism and a variety of mechanisms for allocating all-payer funds to entities participating in clinical education of physicians, APNs and PAs. While the Commission strongly recommends all-payer financing as

the best mechanism for financing education, many of the same allocation principles could be applied to Medicare GME reimbursement and to other federal and state subsidies for GME.

A. All-Payer Financing

An all-payer pool should be established to ensure that both public and private beneficiaries contribute to the subsidization of clinical education for physicians, APNs, and PAs. This recommendation is consistent with positions the Pew Commission has taken in previous reports.[1,2,3] This pool should be financed via a per-capita assessment on health plan enrollees (managed care and fee-for-service, including self-funded plans) and contributions from Medicare and other federal programs that subsidize GME. Revenues from both public and private payers should be deposited into a trust fund dedicated exclusively to funding clinical education for physicians, APNs, and PAs. All entities providing clinical education would be eligible for all-payer payments (including consortia and children's hospitals).

B. Number of Positions Funded

The Commission believes the Balanced Budget Act of 1997 does not provide sufficient incentives to reduce the number of physicians trained in the US to an appropriate level. Thus, the Commission recommends that more stringent controls be established for allocation of funds from the all-payer pool.

- Set the number of all-payer funded residency positions at a level no greater than the number equivalent to 110 percent of the number of US medical graduates (allopathic and osteopathic) in 1997, a reduction of 25 percent from the current number of federally subsidized graduate year one residency positions. The provisions of the Balanced Budget Act of 1997 that cap the number of Medicare-funded positions at individual teaching hospitals should be applied to all-payer financing.

C. Eligibility for Funding

- Guarantee all-payer reimbursement for all US medical graduates who have passed parts I and II of the US Medical Licensure Examination or the Comprehensive Osteopathic Medical Licensing Examination, and who are admitted to an accredited residency program.

- Develop a mechanism for allocating all-payer funding for a number of positions equivalent to the number of US medical graduates plus 10% to subsidize the training of US citizens and permanent residents educated in international medical schools. In developing this mechanism, policymakers must confront a major tradeoff between advancing educational principles and preserving institutions that have depended on IMGs to provide uncompensated care.

- Eliminate GME payments for IMG residents who are citizens of other nations, but continue to permit them to complete GME in the US, provided their training is subsidized via foreign aid, their home governments, or private funds.

- With regard to non-citizen IMGs, the Commission reiterates its recommendation that US immigration laws be tightened to ensure that foreign nationals return to their home countries upon completion of residency training.[4]

D. DME Payment Formula

- Establish a uniform per resident payment formula under which the per resident component of DME payments would vary among teaching hospitals in only a limited fashion by external factors such as regional variation in cost of living.

E. Incentives for Training Physicians in Generalist Disciplines

Two policies are needed to enhance existing strategies aimed at ensuring that the US has an adequate supply of generalist physicians:

- Require teaching institutions that receive all-payer GME payments to continue to offer no fewer than the number of generalist residency positions available at these institutions in 1997.

- Provide DME payments only for residents completing minimum requirements for initial board eligibility.

F. Indirect Medical Education (IME) Payments

The provision of the Balanced Budget Act of 1997 which phases in a reduction in the IME adjustment percentage from 7.7 to 5.5 percent over a five-year period, and caps the number of residency positions and ratio of residents to beds should be applied to disbursement of all-payer funding for IME. Eligibility for IME payments should be consistent with eligibility for DME payments. Two additional modifications in IME policy are needed:

- Create a separate mechanism for payment of IME that is independent of payments for inpatient hospital services. Establish a separate system of prospective payment for indirect expenses associated with medical education under which payments would be divided among teaching hospitals, affiliated academic institutions, and non-hospital training sites. Work should commence immediately to develop formulas for allocating IME to non-hospital sites.

- Base a significant proportion of IME payments to teaching hospitals on historical IME revenues rather than the current ratio of full-time equivalent residents to beds.

G. Preserving Access to Care for the Uninsured

Since its inception, the Pew Commission has advocated for universal access to health insurance for all Americans.[5] Expanding access to health insurance constitutes the most rational and appropriate approach to ensuring access to care.

The Commission is encouraged by recent incremental efforts to address this problem but recognizes that today many persons remain uninsured and that some of them, particularly those living in inner-city areas, depend on teaching hospitals for medical care. Recommendations for reform of federal GME policy must take the needs of this vulnerable population into account. Developing GME reforms that do not compromise access to care for the poor is a formidable challenge but one from which the nation cannot shrink. For too long concerns about institutions providing high levels of uncompensated care have posed a roadblock to major reform of GME policy. As the new millennium dawns, we must pursue strategies that address both sets of concerns in a rational and equitable manner.

The Commission supports the provisions of the Balanced Budget Act of 1997 that provide transition assistance to teaching hospitals that voluntarily reduce the number of residents they train. In addition, the Pew Commission strongly recommends expansion of the National Health Service Corps' loan repayment program and modification of its eligibility criteria to facilitate participation by specialists where needed. This recommendation is an essential component of a comprehensive GME reform strategy because it would provide a replacement workforce for communities that have depended on residents to deliver care to underserved populations.

H. Funding for Clinical Education of Advanced Practice Nurses and Physician Assistants

To promote a multi-disciplinary and flexible primary care workforce and ensure that APNs and PAs have adequate access to appropriate clinical training sites:

- Eliminate the Medicare subsidy for diploma nursing education programs.
- Create a new all-payer subsidy for clinical education of APNs and PAs.
- Cap number of APN and PA positions funded at the number of full-time equivalent students enrolled in 1997.

I. Federal Workforce Policy Commission

Finally, a new commission should be established and sufficient resources appropriated to track health care workforce trends and advise Congress, the President, and the US Department of Health and Human Services regarding the all-payer pool and other health professions workforce policies. This new commission also should collect, analyze, and disseminate data about supply and demand for health professionals. The members should represent a broad cross-section of interested parties, including consumers, health professionals, health professions educators, and organizations involved in the financing and delivery of health care services. The commission should be a public-private partnership, in recognition of the contributions of private payers to the all-payer pool. This new commission is needed because no existing body is equipped to carry out this charge. Although Congress has directed the Medicare Payment Advisory Commission and the National Bipartisan Commission on Medicare to address Medicare GME policy, the mandates of these commissions are too broad to permit them to examine GME policy in depth. Existing workforce policy bodies, such as the Council on Graduate Medical Education are underfunded and focus too narrowly on a single profession.