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HEALTH POLICY CORNER

Shaping our Physician Workforce Through GME

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> *"The medical schools, hospitals, and government… appear as if in a conversation piece, discussing with themselves issues which have been apparent for years."*
>
> —Rosemary Stevens (1978)

One consistent message amidst all of the talk about health care reform has been that primary care is in dire need of an influx of manpower.[1] With the recent passage of the Affordable Care Act and the expected increased demand on primary care, we are likely to hear more regarding strategies to promote primary care; however, the challenge in promoting primary care among physician graduates has essentially been an unresolved problem for years. In 1931, 87% of physicians were generalists, but this rate dropped to 50% in 1960 and 32% in 1994.[2] Much has been written on the factors that have influenced this trend (e.g. preferential reimbursement, greater prestige, better work hours, etc.), and in general most of these issues are somewhat self-evident among physicians. Perhaps less well-known among physicians is the history behind the trends, especially in graduate medical education (GME)—policies that have shaped the physician workforce and at times attempted to shift the balance in favor of primary care.

GME, the final step before licensure and direct function of the physician workforce, is a primary target for physician supply policy. To be licensed to work as a physician in any given state requires either one or two years of residency training, which means that the number and type of residency positions essentially determine the number and type of physicians. The first one-year postgraduate training program began at Harvard in the mid-19th century to the chagrin of medical faculty, but such programs would not become commonplace until the rise of the hospital.[3] Historically, the hospital was a place of care more than cure, so few were built; however, at the end of the 19th century, the hospital, for a variety of reasons, was becoming an acceptable place for the treatment of disease. American Medical Association (AMA) records from 1875 show there were 661 hospitals in the United States. By 1900, that number increased to 2,070, and in 1909 the number had more than doubled to 4,359. (Today, the number of hospitals stands at 5,815.[4])

As hospitals grew, so did the availability of internships. Physician graduates were desperate for the status as well as the experience of internships, and hospitals were eager for the cheap labor. By 1932, 95% of graduates were obtaining internships, the majority of which were in hospitals.[3] This was a dramatic change for a generalist workforce that had previously been entirely community trained. This market-driven marriage of the hospital and physician graduate training had a significant impact on the workforce since it led to the placement of GME in the increasingly specialized realm of bourgeoning academic medical centers.

In 1965, Congress, recognizing the extra burden hospitals took in supporting the educational activities of future physicians, created the direct graduate medical education (DGME) payment as part of the Medicare legislation. The DGME payment provides funding to cover hospital costs for resident salary and benefits. Meant to be a temporary aid, the DGME along with the associated indirect medical education (IME) payment became indispensible sources of income for hospitals. From the 1960s to the mid-1980s, DGME payments were essentially blank checks; hospitals were paid loosely depending on the number of residents they hired. The result was rapid growth in massive academic medical centers as well as a steady increase in the physician per capita ratio predominantly driven by growth in the subspecialties.[5]

Legislation was passed in the 1980s that put in place new strategies to limit the growth of DGME costs and to influence the number and types of GME positions. The COBRA Act of 1986 created what are known as the "per resident amount" (PRA) and "initial training period," essentially refinements of the DGME payment. The PRA defines how much money a hospital will receive for a given resident. Later, additions to the PRA would allow residents to work in non-traditional areas such as nursing homes, free clinics, and prisons during their training and also reimburse GME programs slightly more for residents in primary care. The "initial training period" is the amount of time required to finish the first residency of choice. Anything beyond this initial training period, including fellowship,

continued on page 2

continued from page 1

is only supported at half the standard calculated amount—a clear attempt to incentivize support of primary care in GME administration.[6]

Beyond these specific changes to the DGME there are a variety of other notable pieces of legislation from the 1970s through the 1990s that attempted to promote primary care—examples include Title VII funding for academic general medicine programs, National Health Service Corps funding to promote primary care in underserved areas, and various rural rotation funds across the country that expose medical students and residents to work in rural areas. Despite these resources, the trend among physician graduates to prefer subspecialized care continued, and one major piece of legislation essentially closed the door on any possibility for change.

The Balanced Budget Act (BBA) of 1997 was written and passed at a time when managed care was being actively implemented with the hopes that it would lead to decreased use of medical services, better quality care, and the need for fewer physicians. The legislation "froze" the number of residency positions funded by the federal government at each hospital. Some nuances were allowed based on regional changes in the GME positions, but on the whole the legislation initially accomplished its goal. For the first five years after its passage there was a temporary plateau in the number of trainees, but around 2002 the number again began to rise with the greatest proportion of growth in the subspecialties and a decrease in residents entering primary care from 28% to 24% over the ten years from the start of the legislation.[6]

In considering the continued clamor to promote primary care in our aging society with values shifting toward equitable access to care, it is important to understand some history. The challenge for policymakers over the years has been promoting primary care as a career choice among physician graduates, but how can we expect progress when federal policy limits the number of GME positions? Re-incentivizing primary care through dramatic changes in health care delivery or reimbursement may be necessary as health care reform continues, but still the number and type of practicing physicians have to be managed. No consensus exists on how to reverse the cap on GME and at the same time promote primary care. For now we are left with an agreed-upon deficit of primary care physicians and a set of legislative handcuffs on GME growth that not only hinders our ability to promote primary care but also limits whatever small cumulative effect that millions of dollars and a variety of legislative policies could potentially have on the primary care pipeline.

References

1. Goodman DC, Fisher ES. Physician workforce crisis? Wrong diagnosis, wrong prescription. N Engl J Med 2008; 358(16):1658-61.
2. Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine. Primary care: America's health in a new era. Donaldson MS, et al., eds. Washington, DC: National Academy Press, 1996.
3. Stevens R. Graduate medical education: a continuing history. J Med Ed 1978; 53:2-18.
4. A half-century in retrospect: hospitals, medicine, manners and customs as the association was growing to maturity. Hospitals 1948; 22:56-66.
5. Grumbach K. Fighting hand to hand over physician workforce policy. Health Affairs 2002; 21(5):13-27.
6. Goodman DC. Improving accountability for the public investment in health profession education: it's time to try health workforce planning. JAMA 2008; 300(10):1205-7.

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