

HEALTH POLICY CORNER

How Does SGIM Set Educational Policy Priorities?

Robert B. Baron, MD, MS, and Mark Liebow, MD, MPH

Dr. Baron is associate dean for Graduate and Continuing Medical Education and faculty in the Division of General Internal Medicine, Department of Medicine, at the University of California, San Francisco. Dr. Liebow is associate professor of medicine and a member of the Division of General Internal Medicine, Department of Medicine, at the Mayo Clinic.

You may be asking yourself why SGIM puts more work and resources into supporting a \$39 million program for primary care training (Title VII) than a \$10.6 billion program for graduate medical education (GME). The simple answer is that the smaller program is more vulnerable and has fewer supporters, so it needs our help more.

No one said health policy was intuitive. Medicare has now supported graduate medical education (GME) for 50 years, but it doesn't use the money to direct training toward the workforce we need but instead pays the money to hospitals. Many residency programs don't even know how much money is paid to their own hospitals on their behalf.

People figured out within a few years after Medicare started that paying money to hospitals to support inpatient training was not a good way to encourage training in primary care specialties, especially as those specialties increasingly shifted to outpatient work. Consequently, Congress created a program to support residency training in general internal medicine, general pediatrics, and family medicine. A few years later, faculty development grants for general internists were added. The program, later known as Training in Primary Care Medicine and Dentistry (TPCMD), has been funded ever since but at levels far lower than Medicare GME spending. Typically, for every dollar spent on primary care training, \$250 is spent on Medicare GME funding.

Why the imbalance? Medicare GME payments come from the

Medicare Hospital Trust Fund (Part A), which is funded by the Medicare payroll tax—an extraordinarily stable source of tax revenue. Also, Medicare GME payments, like the rest of Medicare, are automatic, which means that they are made on the basis of formulas established by law. Changes literally take an act of Congress, which is never easy, particularly when almost all members of Congress have teaching hospitals in their districts or states. Those hospitals are often large employers as well as major providers of care in their communities, so their claims of major injury from proposed cuts in GME funding are taken seriously by legislators. Those claims even have some validity. Many urban academic medical centers depend on their GME payments to keep themselves from going into the red. SGIM doesn't oppose Medicare GME funding, though we have recently suggested in a position paper¹ that changing the rules for how the money is paid would better serve the country. However, our voice in favor of significant reforms faces opposition from organizations that stand to lose out if GME is better aligned to meet national workforce needs.

TPCMD, usually known as a Title VII program because it is authorized under Title VII of the Public Health Service Act, is dependent upon annual appropriations from Congress. That means that Title VII programs compete with every other federal program that doesn't receive automatic funding. This so-called discretionary funding is al-

ways limited but especially so in the current fiscal climate. In the name of deficit reduction, in 2011 Congress set even more stringent spending limits on discretionary spending—limits that stretch to 2023. Furthermore, Congress set separate limits for defense and non-defense discretionary spending so that increasing funding for a health care program, for example, means cutting a K-12 education program or money for the national parks. The fact that Title VII programs put money into fewer Congressional districts or states than GME funding does means fewer legislators hear from constituents or organizations advocating for continuing or growing the Title VII programs, making Title VII an easier target for budget cuts. SGIM's voice, offered as part of a coalition for Title VII funding as is typical in Washington, is much more influential here.

Our advocacy is not always for the program as it is. For years the Title VII program had a pronounced bias toward funding family medicine programs, which made particular sense in the 1970s when most were new and needed support to thrive. More recently the program has also strongly emphasized the training of physician assistants. At SGIM, our efforts are to ensure that funds are allocated as the law intends—to produce a workforce that is aligned with national and regional needs. We strongly believe this includes training primary care general internists—as well as family physicians and other health profession-

continued on page 2

HEALTH POLICY CORNER

continued from page 1

als—to care for the underserved. While Congress has the ultimate say on how much money annual appropriations programs get, it's not the only say. While the president asked for the same amount for the TPCMD program for fiscal year (FY) 2016 as Congress appropriated in FY 2015, which is a cut in real dollars because of inflation, for years different administrations wanted to eliminate the program and did not include any money for it in the president's budget proposal. While Congress need not implement what is

in that proposal, what the president suggests matters. It was much harder to get funding for Title VII programs when the administration did not ask for any money for them.

What our Health Policy Committee recommends SGIM advocate for depends not just on whether we think the program is good for Americans and for general internists but also whether the program needs annual renewal or is at risk for being changed for the worse. We also consider whether our advocacy will make a difference. Our experience

with funding primary care training shows we can make a difference with carefully targeted work.

Reference

1. Jackson A, Baron RB, Jaeger J, Liebow M, Plews-Ogan M, Schwartz MD. Addressing the nation's physician workforce needs: the Society of General Internal Medicine (SGIM) recommendations on graduate medical education reform. *J Gen Intern Med* 2014; 29(11):1546-51.

SGIM