Changing National Priorities in Medical Education and Primary Care

John P. Geyman, MD

Fundamental changes are taking place in the nation's priorities in medical education which are reversing established directions of the past 20 to 30 years. There was general agreement throughout the 1950s and 1960s that a physician shortage represented a serious problem in the United States. Federal incentives were initiated during the 1960s through capitation payments to medical schools in an effort to increase the number and output of US medical schools. As a result, current first-year enrollments in medical schools are more than double 1966 levels. The total number of physicians in the United States has increased by over one half since 1960 and by one quarter since 1970. There is now a growing consensus that the physician shortage of past years will become a physician surplus in the 1980s (in terms of the aggregate number of physicians), and that the real problems of physician supply involve specialty and geographic maldistribution of physicians. The Carter Administration has therefore recommended the termination of capitation funding to medical schools in 1980 because these subsidies are no longer needed to increase the physician supply and because these funds are not "targeted to meet the nation's most pressing national health care needs."

The cornerstone of emerging national health care policy involves the strengthening of primary care. Specialty and geographic maldistribution of physicians are being addressed more directly than in the past through a variety of approaches. The 1980 President's Budget, for example, presently calls for the following allocations: Family medicine residencies ($40.5 million); Departments of Family Medicine ($15 million); Primary care residencies (general internal medicine and general pediatrics) ($25 million); Physician's extenders ($9 million), and National Health Service Corps ($79.5 million).

These approaches will inevitably involve major readjustments and reorientation of the existing system of medical education in this country at both undergraduate and graduate levels. It would be easy to underestimate the extent of the changes which will be required within medical schools and teaching hospitals, which traditionally have been oriented to secondary and tertiary care. The magnitude of the changes in progress is suggested by

0094-3509/79/061117-02$00.50

the following observation made by Sheps in 1977: "In 1910, Flexner dealt with the gap between what was then known and what was taught in medical schools. Today, we have a different gap: between what is taught and what is needed for health care to meet public and individual need."[1]

The success of the various primary care initiatives which are being taken today and planned for the 1980s will depend upon the capacity of the medical education system to adapt in support of these initiatives. These changes will necessarily include further restructuring of undergraduate curricula, substantial revision of the "mix" of residency positions by field, contraction of some activities of disciplines in surplus, and reorientation of the teaching efforts of non-primary care specialties to the needs of students and residents training for the primary care specialties.

Major changes will be needed in the health care delivery system if the nation's efforts in primary care are to be successful, such as special attention to the unique problems of rural hospitals so as to assure adequate facilities for patients and physicians living in rural areas. Perhaps the most fundamental change needed, however, which appears to be vital to the long-term viability of all of the primary care disciplines in medical practice and in medical education, is restructuring of the existing reimbursement system for primary care services. Many essential primary care services are either not covered or only partially covered by third-party payors. In order to reduce the income differentials between primary care and other physicians and to encourage primary care practitioners to locate in underserved areas, the Institute of Medicine last year recommended that third-party payors (federal, state, and private) should:

(1). . . reimburse all physicians at the same payment level for the same primary care service: (2) reduce the differentials in payment levels between primary care procedures and non-primary care procedures: (3) institute payments to practice units for those necessary services delivered by primary care providers and currently not reimbursed, such as commonly accepted health education and preventive services: (4) discontinue all geographic differentials in payment levels for physician services within a state.[2]

Urgently needed are demonstration projects for various kinds of funding mechanisms for primary care services which can lead to basic changes in the reimbursement system.

These changes in the reimbursement system for primary care services will also help to assure the survival of residency training programs in the primary care specialties. It is incongruous that teaching programs in the surgical and procedurally oriented specialties (many already in surplus) have little difficulty in supporting their full costs through patient care revenue while teaching programs in the primary care specialties can generate at most only about one half of their costs through patient care. Reimbursement procedures in teaching programs have become progressively more restrictive during the last several years. Federal grants have provided assistance to many family practice residency programs in their startup years, but were not intended to provide ongoing operational support for established programs. It should ultimately become possible to provide a solid base of funding for teaching programs in the primary care specialties through patient care services without compromising the educational experience of the students and residents involved. Policy makers in government and in third-party agencies must resolve this problem if the country's maldistribution of physicians by specialty and location of practice is to be effectively addressed.

References

1. Sheps CG: Education for what? A decalogue for change. JAMA 238:234, 1977

2. A Manpower Policy for Primary Health Care. Washington, DC, Institute of Medicine, National Academy of Sciences, 1978, pp 6-7