Guest Editorial

Public Policy Arguments for Government Subsidy of Primary Care Residency Training

William H. Burnett, MA, and David N. Sundwall, MD
Sacramento, California, and Washington, DC

During the 1970s, the federal and state governments in the United States invested in excess of $200 million in primary medical care programs, including both graduate residencies and predoctoral programs. The great majority of this investment funded "primary care medical residency programs," that is, residencies requiring mastery of the fundamentals of practice in several distinct medical and surgical disciplines, taught in part in formally structured ambulatory care clinics. Family practice residency programs, by virtue of their accreditation requirements, all meet this definition. Perhaps an additional 100 general internal medicine and pediatric residency programs also meet this definition.

The budget dilemmas of the federal government and of many state governments have required establishing priorities among public health programs. In view of predictions of a future physician surplus, subsidies to any physician residency program will inevitably be subject to scrutiny. In fact, during the year 1981, a significant decrease of government subsidies for such programs at both the federal and state levels was legislated.

It can be argued that after a decade of governmental subsidies, primary care training programs should have become sufficiently well established to withstand the loss of public funds. Primary care training programs, in the aggregate, may now be better able to absorb losses in subsidies than they would have been in the tentative, early days of their development. Even so, the decline in financial support will likely impose significant hardships on many primary care residencies as well as predoctoral programs that support primary care curriculum development and preceptorship activities. Indeed, many speculate that without government funds a significant number of these efforts will not survive. One may list several possible negative effects of the decreased government subsidies, but two concerns should be considered: (1) interest in primary care will wane in medical schools, and (2) hospitals will be reluctant to further subsidize primary care training.

One of the principal purposes of governmental subsidies was to encourage medical schools to become involved in training primary care physicians, thereby addressing well-documented concerns about specialty and geographic maldistribution. An obvious secondary benefit of these training programs in academic centers is the provision of status and recognition to primary care by the hiring of primary care physician faculty who serve as role models in the medical centers where they were previously absent.[1] Reduced financial support for primary care residency programs is likely to cause many medical schools to reduce their commitment to primary care. Physician output, still representing the mix of departments seen in the prestigious medical schools, is principally focused on those medical and surgical specialties whose services are lucratively reimbursed by third-party payers. Unfortunately, these factors of tradition, coupled with income potential from procedure-oriented medicine, continue to be motivating forces within medical schools with regard to physician specialty output. The relatively poorly reimbursed primary care disciplines are certain to be vulnerable at many institutions if extramural subsidies disappear.

Second, postgraduate medical training, mostly by necessity, but in part by tradition, is centered at teaching hospitals. Some of the most essential

From the California Health Manpower Policy Commission, Sacramento, California, and the United States Senate Committee on Health, Washington, DC. Requests for reprints should be addressed to Mr. William H. Burnett, California Health Manpower Policy Commission, Room 420, 1600 Ninth Street, Sacramento, CA 95814.

© 1983 Appleton-Century-Crofts

skills needed by primary care physicians relate to ambulatory medical practice and the behavioral sciences, which are not likely to be perceived as important activities by many hospital administrators and medical center directors. For example, the hospital administrator of a large county hospital in Los Angeles summarily decided to abolish the hospital's family practice residency program. Faced with sharp budget cuts imposed by the County of Los Angeles, the administrator elected to determine which services of the hospital would survive by using as a criterion how "sick" the patients were likely to be in a service unit. This decision was reinforced by the recognition that higher remuneration from third-party payers would be likely from the more seriously ill patients, who would require medical and surgical procedures and prolonged hospitalization. There would certainly be little financial incentive for the hospital to maintain ambulatory clinics when, in teaching institutions, it is virtually impossible for such clinics to be financially self-sustaining.

From a societal perspective, decisions to establish priorities for hospital services based strictly on short-term finances are short-sighted. The attitude that training primary care physicians is not a core mission of teaching hospitals suggests that subsidies are essential for the long-term survival and success of primary care programs. There is, further, an economic reason for subsidization of the primary care training that takes place at hospitals. Because so much of the income of hospitals comes from charges for the care of the very ill, a broader base of financial support—the whole society—should be enlisted to support the training of physicians whose function in the health care system is to help the broader society stay as well as possible (Thomas L. Stern, MD, personal communication, September 1982).

But why should governments, state or federal, seek to continue to support primary care residency programs, even if it is shown that the programs (which government funds helped create in the first place) absolutely need a continuation of external subsidies to survive? We believe that it serves the interest of the public as well as those agencies within the government concerned with the long-term stability of government finances. If government revenues are to be brought into balance, government outlays for health care—which grow at rates projected to greatly exceed the government budget—need to be more predictable and more efficiently spent. We can safely assume that government will continue to subsidize health care, and although levels of funding will certainly be diminished, total withdrawal seems extremely unlikely. The option of continuing the status quo increasingly appears as unacceptable to virtually all health policy analysts. Significant changes in the way health care is purchased and provided seem inevitable. Because the federal government has become the major purchaser of health services, it has a deeply vested interest in seeking changes that will result in economy.

Those who advocate continued public subsidies of primary care programs should recognize that many of the stated objectives of primary care training—cost-effective patient care, integration of preventive medicine—have never been more relevant to the perceived needs of health care budget makers and policy makers. As a case in point, consider California's principal state program for funding primary care medical training—the Song-Brown Family Physician Training Act. Even though one of its principal objectives was addressing the geographic maldistribution of primary care physicians, another of the act's themes was increasing the number of physicians and primary care providers to help the evolution of a more cost-effective, more prevention-oriented style of medical practice.[2] California's budget crises have made the promise of the provision of less expensive, more cost-effective care an urgent concern. Thus, Song-Brown Act funds have recently been used to support the development of prototype programs for family practice residency programs developing prepaid capitation-funded contracts with the state Medicaid programs.

Primary care residency directors and graduates alike may be called upon to match the rhetoric of cost-effective practice with performance. Primary care training programs should be as committed to implementing ideas that help solve these budget crises as they have been to solving problems of geographic maldistribution. If this can be accomplished, the future of public funds for primary care training may be secure.

References

1. Moritsugu KP, Burnett WH: Federal-state synergy in family medicine education. J Fam Pract 13:83, 1981
2. Burnett WH: Building the primary health care team. Fam Commun Health 3:2, 1980