

Health Care Reform and Primary Care: A Mandate for Graduate Medical Education Reform

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The current consensus around the urgent need for health care reform has focused on the expansion of primary care services. The experiences of other developed nations and managed care organizations that provide universal access to populations for a lower per capita cost strongly suggest that an emphasis on primary care is prerequisite to affordable health care.¹⁻⁴ Primary care delivered by generalists is simply the care that addresses most of the problems that most of the people experience most of the time. A base of strong, competent generalist physicians will provide the foundation for a restructured health care system that meets the needs of the population.

Health care costs now account for over 13% of our gross domestic product,⁵ and the size of the physician work force has doubled over the past 20 years. Physician availability (as measured by the ratio of physicians to the population) has increased by 50% during that same period.⁶ Physicians generate between 70% and 90% of the nation's personal health care expenditures.⁵ Therefore, without some strategy to contain the growth in overall physician supply, it will be difficult to rein in health care costs.

Efforts to solve problems of access to health care by simply increasing the total physician supply without regard to specialty mix have proven largely unsuccessful. In 1931 more than 80% of US physicians were engaged in primary care, but currently, two thirds of physicians practice in nonprimary care specialties in a health care system dominated by increasingly high-technology services. Our specialist-based system is characterized by delivery of fragmented care at increased costs, decreased access to care, and increased utilization of many health

care services that are unlikely to improve health outcomes sufficiently to warrant their costs.⁷ The erosion of student interest in generalist medicine in favor of nonprimary care specialties over the last decade is reflected by the match rates to residency programs as well as by responses to Association of American Medical Colleges surveys of medical school graduates and medical school matriculants.^{8,9}

Recently, there has been an increase in the percentage of graduates expressing an interest in generalist careers.¹⁰ In particular, encouraging signs have appeared with regard to student interest in family practice. In the 1994 National Resident Matching Program (NRMP), 83% of family practice positions were filled, up from 77% in 1993 and up from a low of 65% in 1991.¹¹ (1994 NRMP, unpublished data). After reaching a low of 88% in 1991, the final fill rate for family medicine was 95% in 1993, the highest percentage since 1987.¹¹ Also, student membership in the American Academy of Family Physicians reached an all-time high of more than 20,000.

Despite 1994's record number and percentage of students matching in family medicine, students who selected family medicine residencies still represented only 14% of all US medical school graduates who matched (1994 NRMP, unpublished data). Currently, only 25% to 30% of 1987-1989 allopathic and osteopathic medical school graduates are engaged in generalist practice,¹² far below the 50% generalist goal of family medicine and other organizations. Consequently, despite current controversies surrounding almost every aspect of health care reform, there is great public and professional agreement about the persistent physician work force problems in the United States: oversupply in the face of continued maldistribution and inappropriate specialty mix to meet the health needs of the nation.^{6,13-15}

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Coordinated Physician Work Force Planning

With likely future increases in enrollments in managed care arrangements, a pervasive unmet demand for pri-

primary care physicians is anticipated, superimposed on the long-standing shortage in rural and underserved urban areas. The pipeline of medical education is lengthy, and therefore provides many opportunities for interventions to decrease the rate of growth in physician supply and alter the specialty mix. Proposed strategies for increasing the proportion of generalist physicians in this country span the continuum of medical education and practice. Undergraduate medical education levers for increasing generalist physician output include targeted medical school admission policies; community-oriented, primary care-based medical school mission statements; problem-based curricula; early clinical exposure; and ambulatory primary care clerkships. Another important predictor is a strong family practice presence reflected in the existence of a department of family medicine and a required third-year family medicine clerkship. At the other end of the spectrum, strategies have been proposed to enhance the primary care practice environment through reimbursement mechanisms and administrative, regulatory, and malpractice reform. Finally, some advocate retraining specialists for primary care practice.

However, the current debate is intensely focused on the graduate medical education (GME) training period, which literally and figuratively is the middle ground between medical education and practice. Most proposed federal legislation targets GME, at least in part because it is the segment of medical education that currently receives significant federal support. Concern about the public accountability for those dollars has stimulated consideration of GME reform to achieve national work force policy targets. However, a coordinated effort to influence all phases of the medical education continuum is necessary to achieve the goals of generalist and overall physician supply.

Federal Support for Graduate Medical Education

Nationally, the largest explicit financial support for GME is provided through the Medicare program. In 1992, Medicare expenditures for graduate medical education were over \$5.2 billion.¹⁶ The Medicare program provides two separate types of GME support to hospitals: direct medical education (DME) payments (\$1.6 billion) and indirect medical education (IME) payments (\$3.6 billion). DME covers the costs of residents' salaries and benefits, faculty supervision, conference space, and other costs directly associated with training residents. The DME payment that a hospital receives for each resident is based on the costs that were claimed in fiscal year 1984, with adjustments for inflation and the portion of charges

associated with the care of Medicare patients. No incentives are given to generalist physician programs, yet specialty programs can supplement these payments with higher practice income than that of primary care. In contrast, support from the Health Resources and Services Administration, through Title VII of the Public Health Service Act, provides only approximately \$150 million to train generalists and to support participation of disadvantaged and minority students.¹⁶

The IME payments of Medicare, amounting to more than double the DME payments, are adjustments to the diagnosis-related group (DRG) case payments system. These adjustments are intended to account for the higher costs of teaching hospitals, such as expenses associated with the training of residents, increased severity of illness in the patient population, and other indirect factors that increase the cost of care in teaching hospitals. The IME adjustment is a percentage added to hospital DRG payments. The formula for determining this percentage is dependent on each hospital's ratio of interns and residents to patient beds, the IRB ratio. IME reimburses only for resident time in hospitals, providing a major disincentive for hospitals to engage in community-based generalist physician training.

Oversight of Graduate Medical Education

Currently, the governance of GME is diffuse and fragmented.¹⁷ Responsibility for determining the number of training programs in each specialty and subspecialty, their locations and curricula, and the number of residents in each program is distributed among a small number of organizations controlled by various groups within the medical profession.

To correct physician work force imbalances through changes in the system of GME, two schools of thought have emerged at opposite ends of the continuum: one school would rely on market forces and another would impose a "managed" approach. Those who support a market approach believe that the market will adjust to solve the problem and do not believe that overseers can accurately predict future need for physicians to ensure an adequate supply and proper mix. They view the managed approach as a threat to the long-standing heterogeneity of a system that is essential to maintain the system's tradition of creativity and excellence.

Those who support a "managed" approach believe that market responses cannot occur swiftly enough to match the pace of health care reform. They view the "educational" market as different from the "health care" market, resulting in the current mismatch between GME

production and national physician work force needs. They believe that one of the fundamental failures of GME is its nonresponse to public need in the absence of coordinated oversight and control of the entire GME system.

Over the past 50 years, studies commissioned by professional organizations and government agencies have repeatedly identified the need for a single, national authority to provide effective direction and control. Nevertheless, GME remains self-regulated and responsive principally to the service needs of hospitals, the interests of medical specialty societies, the objectives of residency program directors, and the career preferences of medical students. Advocates of a managed approach feel that the physician work force requires such substantial and pervasive changes, in terms of both numbers and specialty mix, that management through targets will move the system in the appropriate direction.

At this time, the relationships linking GME policies, composition of the physician work force, and the potential for health care reform are evoking intense academic and public debate. Professional organizations, including the American Academy of Family Physicians, Association of American Medical Colleges, and American College of Physicians, have recognized the need for a central planning body to monitor the physician work force and to guide policy. Similar recommendations have been embraced by advisory commissions, including the Council on Graduate Medical Education (COGME), the Physician Payment Review Commission, and the Pew Health Professions Commission.

Pending Federal Legislation

In response to this intense dialogue and public concern, five legislative proposals targeting GME reform have been proposed. All are designed to achieve two major national workforce policy goals in the context of comprehensive health care reform:

- Reduction in the growth rate of physician supply
- Increase in the percentage of physicians trained as generalists.

GME proposals under consideration include: Rockefeller/Waxman (S.1315), Kassebaum/Simpson (S.1215), Cooper/Breaux (S.1579), Wellstone/McDermott (S.491), and the President's Health Security Act (S.1757). The political "diversity" of the authors of these bills reflects the widespread bipartisan congressional consensus on the importance of increasing generalist physician production accompanied by decreasing specialty training.

To achieve national physician work force goals by altering resident supply and specialty mix, most pending federal legislation proposes a commission or advisory board to the Department of Health and Human Services to provide oversight and monitoring. Although such advisory boards would vary in composition, strength, and scope of responsibilities, in general they would engage in physician work force surveillance, projections and planning, and make recommendations about work force goals and policies to be achieved through the GME system.

Despite similar policy goals, the bills propose varying limits in the number of first-year residency training positions and specifications regarding the specialty mix among physicians entering practice. The most explicit proposal (Rockefeller/Waxman) would limit GME entry positions to 110% of the number of US medical graduates, as proposed by COGME and others. The Health Security Act calls only for the number to reflect the relationship between residency positions and graduates. Rockefeller/Waxman would also require that at least 50% of entry positions be as generalist physicians, defined in the bill as: general internal medicine, general pediatrics, family medicine, preventive medicine, or geriatrics. With the exception of the Cooper/Breaux proposal, in which GME positions would meet national health needs (presumably increasing generalist training positions), all bills propose training *at least* 50% physicians as generalists to meet national health care needs.

To fund the direct costs of GME, the bills propose that Medicare funds be redirected to GME positions that meet explicit national work force goals. To further distinguish the needs of the physician work force from those of hospital service and to eliminate ambulatory and primary care training disincentives, the Health Security Act proposes an all-payer GME pool and financing system for direct GME costs.

To fund the indirect costs of teaching institutions, most plans would continue the IME payment under Medicare, albeit with a reduction in the percentage of "add on" to DRG payments. The Cooper/Breaux bill would eliminate these payments entirely to pressure teaching institutions to maximize efficiency. On the other hand, the Health Security Act proposes a new all-payer academic health center pool that replaces IME and provides ongoing financial support for the costs of research and technology, as well as care for extremely ill patients. This pool is designed to protect teaching institutions at the forefront of research and technology by reimbursing them for the care of sicker patients and providing a level playing field in a system of managed competition.

Conclusions

Although American medical expertise is unsurpassed, the nation does not have a well-integrated, accessible, and affordable health care delivery system. Differences in health status between subsets of our population continue to be a national embarrassment. Physician oversupply and specialty maldistribution both contribute to these problems and are the results of unfocused health care and medical education policies.

Although GME alone does not support or drive changes in the health care system, it must evolve in concert with shifts in the health care marketplace and the progression of health care reform. Training programs must be configured to meet health care needs. Otherwise, the competency of providers can be called into question. Managing our GME system is, therefore, a fundamental part of rebuilding our nation's health care system in the public interest. Current major legislative proposals for health care reform all reflect this perspective. As the complicated congressional debate unfolds, we must ensure that the consensus about the need for physician work force and GME reform maintains a strong voice.

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