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Listening to the proponents of “business as usual” on the funding of graduate medical education (GME), one is reminded of a passenger on an escalator who, enjoying the ride, cannot understand why the man climbing the stairs next to him is short of breath. For the veteran escalator passenger, the mechanized ride upward has become a natural state, an entitlement, while the energy provided for the escalation is a forgotten investment.

So it is that when Spencer Foreman extols the current GME system in the United States and advises policymakers to keep “hands off,” he quickly passes over the existence of $6 billion of public funds that Medicare contributes to the system annually.1 These monies are the legacy of the decision made at the outset of the Medicare program that Medicare should reimburse teaching hospitals for its share of the costs associated with the training of residents. Those rather trivial costs of the mid-1960s have grown dramatically over the years because of increases in both the number and the cost of residents and, especially, because of the 1983 implementation of a more explicit and generous system of direct and indirect GME payments. This system couples direct payments for the salaries and associated teaching costs of residents to “indirect” payments to hospitals for the greater costs that teaching hospitals incur. The indirect funding was intended to help academic institutions stay in the black despite their traditionally heavy share of complex and uncompensated care. Both direct and indirect payments, though, are made to hospitals based on the number of residents they choose to employ, making Medicare graduate medical education, in effect, an uncapped entitlement—a residency support fund that pays teaching hospitals an average of more than $70,000 per year per resident for as many residents as they choose to hire.2 In New York, where a state-mandated, all-payer system governs hospital reimbursement and requires GME payments from all insurance carriers, hospitals receive an average of $190,000 per resident per year.3

Graduate medical education in this country is a heavily subsidized enterprise. The GME “market” is not a “free market” in any classical sense but rather a publicly supported work-study program, with tax dollars enhancing the already significant labor value of residents. Hospitals have responded to these incentives as one might expect, by increasing the number of residency positions by 25 percent since 1988.4 One can argue that Medicare GME funding is good policy or bad policy, but it is hard to make the case that it is not a very “hands-on” federal policy that provides major financial incentives to U.S. teaching hospitals. As such, it is expensive, influential, and a fair subject for public scrutiny and modification.

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Medicare funding in context. A number of other aspects of Medicare graduate medical education are important to note. Six billion dollars is a great deal of money. It represents some 0.6 percent of the nation's trillion-dollar annual expenditures for health care. Medicare graduate medical education dwarfs all other federal spending for medical education. It is ten times more than the Department of Veterans Affairs spends on its entire GME system, forty times more than Title VII medical education funding, and sixty times greater than the National Health Service Corps budget. Although state spending in this arena is hard to pin down, Medicare graduate medical education is roughly equal to all of the revenues that U.S. medical schools report receiving from state governments. Moreover, the magnitude and extent of federal GME sponsorship are unequaled anywhere else in professional education. Federal funds are not given to law firms or engineering companies to cover the costs of their young professionals who, like resident physicians, are learning to apply new knowledge while providing basic professional services. Nor do state and local public health departments receive federal subsidies for the salaries of their recently trained epidemiologists or sanitarians.

Then and now. Medicare GME support and its open-ended character were put in place at a time when the economics of the health care sector was not at the center of national controversy and when a national consensus existed that the United States suffered from a physician shortage. Few medical educators and health care policymakers were, in fact, aware of Medicare graduate medical education and its magnitude until the health care reform movement of the 1990s brought all aspects of the system under scrutiny. The need to contain the cost of medical training and medical practice, combined with a growing recognition of a specialty-dominated physician surplus, led all reformers inexorably to Medicare GME funding. As Foreman observes, there have been a spate of proposals, including President Bill Clinton's Health Security Act, to limit the number of residency positions funded and to redirect the medical training system toward primary care.

The political and educational appeal of these reform-minded ideas should not come as a surprise. Two factors bore them aloft and continue to do so. The first is the purely civic notion that Medicare GME funds are public funds that could be used more effectively to achieve a better balance in the U.S. physician workforce. The second is the strategic idea that if teaching hospitals are not willing to modify their training programs to address the needs of the country, they are likely to lose the privileged support they have enjoyed to date. If the "entitlements" benefiting welfare mothers and Medicare recipients are being pared back, can teaching hospitals hope to be immune? The Council on Graduate Medical Education (COGME) has led the national debate in this area, producing several generations of GME reform concepts, starting with a proposal for a tightly managed system overseen by a national council controlling an "all-payer" GME fund. This plan served as the basis of the Health Security Act's GME plank. In recent months COGME has proposed reform based exclusively on incentives and disincentives within Medicare graduate medical education-decreasing support for GME slots occupied by graduates of non-U.S. medical schools to discourage the further importation of additional physicians and the up-weighting of GME payments for primary care positions.

Surplus of physicians. At issue, of course, is the oncoming physician surplus-a phenomenon that Foreman acknowledges and applauds, reasoning that an oversupply of physicians will drive medical wages down as doctors scramble to stay employed. He says nothing about the employment prospects for physicians as their numbers continue to grow and as managed care continues to limit the number of physicians used. If the training of physicians were not subsidized with public funds, the prospect of under- or unemployed physicians might strike some simply as wasteful of human capital and a problem for the medical community. But the level of taxpayer investment in physician education makes the conscious production of unneeded doctors fiscally irresponsible.
One wonders how the proponents of a physician surplus would feel about a public subsidy to produce a lawyer glut or an architect glut. Does the logic here suggest that to drive down engineering costs we should pour tax dollars into engineering schools to increase their output?

Remodeling Medicare GME policy. There are strong arguments to be made that the current $6 billion in public funding for teaching hospitals is a wise investment in institutions that provide significant public good. The real risk to GME funding of a hands-off policy, however, is that it will eventually fall of its own weight. Hospital beds are being closed at a record pace, and hospital nursing staffs are being downsized dramatically. Unless the proponents of full-service GME funding can point to its specific relevance to the increasingly overpopulated world of medical practice, it seems inevitable that a simple logic ultimately will assert itself: too many doctors; cut funding. The mounting pressures on the federal budget in general, and Medicare in particular, make these monies vulnerable in a way that they never have been before. The common themes of the GME reform proposals embodied in the Health Security Act and articulated by COGME, the Physician Payment Review Commission (PPRC), the Institute of Medicine, and the Pew Health Professions Commission (among others) are to limit the number of residency slots funded and to favor generalist training over specialist training. Incorporating these “hands-on” principles would go a long way toward making Medicare graduate medical education a more defensible investment in the future.

There is one further way in which a remodeled Medicare GME program could provide a tremendous service to the country. Physician maldistribution and, more specifically, the chronic absence of physicians in certain poor communities despite the looming physician surplus is an ongoing health services and a social equity dilemma. In a poorly articulated but widely adopted pattern of employment, hospitals in many of these communities have used teaching programs and the associated GME funds to attract and pay resident physicians for the essential purpose of providing clinical care. In many cases, the circumstances of these hospitals and the quality of their teaching programs have not been sufficient to attract U.S. medical graduates (USMGs). The result is that these institutions have, in effect, turned to the rest of the world, hiring international medical graduates (IMGs) to provide care to uninsured Americans.

Medicare graduate medical education has made this possible, and any limitations on Medicare graduate medical education are likely to threaten this odd system.

A Better System

There is a better way—a way that would staff these institutions with fully trained physicians, provide financial incentives and assistance to medical students and young physicians struggling with the cost of U.S. medical education, and curtail the need to import medical personnel to serve inner-city hospitals. It is the National Health Service Corps (NHSC).

The NHSC is a twenty-five-year-old federal program that offers loan repayment and scholarships to health professions students in return for service in specified underserved communities following the completion of their training. Since its inception the program has eschewed hospital assignments, focusing instead on primary care placements in community-based rural and urban clinics—settings in which its limited number of physicians (some 1,250 now, or about one-fourth of 1 percent of U.S. physicians) could make a difference. Student indebtedness is substantial and climbing; not surprisingly, the NHSC has far more applicants than it can accommodate.

If the program were expanded to include payback service in specialty disciplines in urban hospitals in addition to primary care placements in hospital and community settings, the applicant pool no doubt would increase dramatically. Underrepresented minority medical students have always depended disproportionately on NHSC support. An expanded program would offer additional assistance and opportunities for Af-
American Americans and Hispanics seeking careers in medicine. A goal for the NHSC might be 10,000 physicians on assignment, far fewer than the 25,000 IMGs currently in residency programs but far more medical muscle than is now dedicated to the needs of poor and uninsured populations. This workforce could be augmented by advanced practice nurses and physician assistants, as the NHSC does now. Finally, substantial funding for this expanded NHSC program would be available at no additional cost to the federal budget. For every Medicare GME position not funded, there would be a savings, on average, of $70,000 annually. The reinvestment of this money in NHSC placements in these same institutions would go a long way toward covering the costs of the new program.

An expanded NHSC, then, that adds a hospital and specialty component to the ongoing community-based programs would establish a new and targeted method for dealing with the dilemmas of urban hospital staffing without continuing to increase the size of the U.S. physician workforce by recruiting physicians from abroad. An expanded NHSC would provide efficient, board-eligible and board-certified physicians in the place of residents; it would help students and young physicians to finance their medical education; and it would make sensible and defensible use of Medicare GME expenditures.

These are the potentially powerful and valuable hands of our national investment in graduate medical education. They should be acknowledged clearly and put to work quickly.

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