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Graduate Medical Education: A Proposal For Reform
by Dan Quayle

Graduate medical education is an integral and necessary component of the education of the physician in preparation for clinical practice. The system of graduate medical education which has evolved in this country has produced a large number of skilled, highly trained practitioners in all of the specialties and subspecialities of medicine. As a result, modern advances in medical practice have become readily accessible to patients across the country, generally improving the health of the nation.

Despite the fact that the system of graduate medical education has served the country well, I believe it is now necessary to reform the system. I believe that this is important both for reasons of policy—to make the system more responsive to the nation’s physician manpower needs—and as a matter of fiscal prudence. As Congress moves toward action on specific legislative proposals, it is very important that attention be paid to both of these goals. We must not, in the interest of cost savings, seriously disrupt the existing system. In this essay I discuss some of the general principles that I believe demand our attention as we enter into public debate of this issue.

To begin, I believe that government should take the lead in reestablishing in an explicit manner the principle that the costs of graduate medical education (GME) should be paid from hospital revenues generated by providing patient care services. GME programs have always operated on the premise that the patient care and educational components of the clinical training experience are completely interwoven and thus all program costs should be accepted as a part of the cost of providing patient care. This principle was accepted when the Medicare program was established in 1965, and for the past twenty years Medicare has paid its proportional share of the costs associated with GME programs from the Hospital Insurance Trust Fund. Indeed, until recently, all third-party payers accepted this general principle and contributed to paying the costs associated with these programs. However, during this time payers have exercised no influence over the number of training positions, the amount of the stipend associated with each position, or the

Dan Quayle is a Republican senator from Indiana and serves on the Labor and Human Resources Committee which holds responsibility for health manpower issues.
distribution of positions among the various medical specialties. At present, therefore, there is “open-ended” funding for GME programs. Each hospital can determine if it wants to establish GME programs, the kind of specialty training it wants to offer, and the number of positions to offer without any consideration of the costs involved.

Financing Mechanisms

The impending insolvency of the Medicare Hospital Insurance Trust Fund and concern with escalating health care costs in general have focused attention on the appropriateness of the educational costs incurred by teaching hospitals. Indeed, the 1982 Social Security Advisory Council recommended that the Medicare program discontinue paying educational costs from the Hospital Trust Fund. However, the council recognized that simply terminating funding for GME programs would severely disrupt the medical education system that exists in this country and thus recommended that Medicare continue to pay these costs until an alternate source of funds could be identified. Along similar lines, the Inspector General of the Department of Health and Human Services has recommended that the Medicare Hospital Insurance Trust Fund should pay for only the first year of clinical training. According to this recommendation, residents would support themselves in subsequent years by billing patients for the services provided. This approach would present considerable difficulties for attending physicians who admit their patients to teaching hospitals. Since they would be unable to bill for the services provided to their patients, their income would fall significantly. As a result, they would likely decide to admit their patients to nonteaching institutions. This would seriously undermine the capability of the teaching hospital to fulfill its teaching and research missions.

I do not believe that either of the approaches indicated above are practical if we wish to maintain a system of high quality graduate medical education for the training of physicians in this country. I believe that it would be inappropriate to divorce the funding of GME programs from the revenue that hospitals receive for providing patient care services. Accordingly, I believe that all third-party payers should continue to pay their fair share of the costs of appropriate graduate medical education programs. This principle should be reaffirmed in order to stabilize the funding sources for GME.

In my view, then, the issue for the federal government to address is not whether Medicare will continue to pay GME costs, but whether Medicare will continue to pay in an “open-ended” fashion, regardless of the appropriateness of the GME system that exists in this country at the present time. In this context the focus of the debate shifts from a concern with financing mechanisms to a concern with physician manpower issues.
Since publication of the report of the Graduate Medical Education National Advisory Committee in 1980, attention had focused increasingly on the excess supply, and geographic and specialty maldistribution of physicians in our society. As a result, there is a growing consensus that a larger percentage of medical school graduates should be trained in the primary care specialties, rather than the medical and surgical subspecialties. In this context the federal government has attempted during the past decade to promote primary care training, using several different approaches with little success. Currently, the Public Health Service (PHS) provides grants to help fund primary care GME programs. However, the amount of money distributed by these grants is inadequate to affect significantly the distribution of GME positions among the various specialties.

While I believe that it is appropriate for the Medicare program to continue to pay the cost of GME programs, I believe that Medicare should pay only when it can be documented that institutions have responded in a responsible fashion to important societal issues regarding the number and specialty distribution of physicians.

There are three general principles which should be considered in any legislative proposal which would link Medicare support for GME programs with institutional compliance with national guidelines reflecting sensitivity to physician manpower issues. First, there should be an opportunity for every graduate of a U.S. medical school approved by a Liaison Committee on Medical Education (LCME) to compete successfully for a position in an approved and funded GME program. Since GME training is required for licensure in almost all states, we must be certain that every qualified graduate has the opportunity to compete for the training necessary to complete his or her medical education. Recognizing the concerns about an oversupply of practicing physicians and the need to constrain Medicare expenditures, it is important that the number of first-year training positions offered throughout the country approximate the number of graduates of U.S. LCME-approved medical schools. Second, there is no requirement that each graduate be able to receive training in the specialty of his or her choice. At present, there is intense competition across the country for positions in the various specialties and in the various teaching hospitals. This is desirable. Individuals who choose to enter medical school must recognize from the outset that society does have a legitimate interest in the specialty distribution of physicians practicing in this country and that the individual may have to accommodate to society’s needs when competing for GME training. Third, education and patient care are completely interwoven in GME programs. Thus it is essential that the educational component of an institution’s GME program must meet uniform standards of quality if the institution is to be eligible for...
Medicare funds for its GME programs. These standards should be developed by appropriate private-sector bodies and applied in a critical fashion when evaluating individual programs. Furthermore, since medical education, in a larger sense, is the responsibility of our nation’s medical schools, each teaching hospital must have an appropriate affiliation agreement with a U.S. medical school that will further attest to the quality of the institution’s GME programs. A hospital must not be able to justify maintaining a GME program simply and solely on the basis of the patient care services provided by the physicians in training.

### A Proposal For Reform

Within the context of these general principles, there are three specific steps which should be taken to address the manpower issues.

First, a larger percentage of graduate physicians should enter training in the primary care specialties of internal medicine, pediatrics, family medicine, and obstetrics/gynecology. In order to be eligible for Medicare funds to support GME programs, the majority of positions offered by a single hospital or a group of hospitals sharing an affiliation agreement with a U.S. medical school must be in the primary care specialties. I do not favor allocating positions by specialty because there is useful and desirable variation in the capability and capacity of the teaching hospitals to provide specific forms of training. I would simply require that some majority of all positions, for instance 70 percent, should be allocated to the primary care specialties and the balance to the nonprimary care specialties, without any concern for the distribution of those positions among the various specialties and subspecialties in each major category. I want to emphasize that these criteria would not be applied in a hospital-by-hospital basis, but would be applied by taking into account all positions in hospitals that share an affiliation agreement with a medical school. All positions funded by patient care-generated revenues, including hospital and physician charges, would be counted in determining compliance with the distribution formula. I believe that a private-sector body, similar to the Graduate Medical Education National Advisory Committee, should be charged with monitoring physician manpower data and making recommendations on the percentage of positions to be allocated to primary care training. These recommendations should be made approximately every five years and become operative only after an appropriate time has expired to allow institutions to make adjustments in their GME programs, probably two years.

Second, in view of the projections that there will be a substantial excess of physicians in this country by the end of the decade, it does not seem appropriate for Medicare to continue providing funds in an open-ended fashion for GME training for graduates of foreign medical schools,
who, by virtue of the training they receive, become eligible to establish practices in this country. However, highly qualified graduates of foreign medical schools clearly should have the opportunity to compete with graduates of U.S. medical schools for GME positions. In order to encourage true competition for positions, Medicare should pay educational costs only when at least 75 percent of trainees in a GME program are graduates of an LCME-approved U.S. medical school.

Third, to assure nationwide compliance with these manpower criteria, it is essential that responsibility for coordinating GME programs be vested with institutions that can negotiate with teaching hospitals to reallocate positions in their GME programs. I believe that undergraduate and graduate medical education should be better coordinated and that this responsibility should be placed upon the nation’s medical schools. The medical schools already have substantial influence over the teaching hospitals by virtue of supplying graduate physicians to fill GME positions and by maintaining a degree of supervision and control over the clinical faculty teaching in GME programs. By requiring each teaching hospital that wishes to be eligible for Medicare funds for GME to have an affiliation agreement with a medical school, the school will be appropriately armed to negotiate with each institution to alter GME programs. Similarly, this arrangement will provide an incentive for the school to work constructively with the teaching hospitals in developing new sites for primary care training to accommodate the additional students that will be required to enter primary care GME programs. I believe that it would benefit both the medical schools and the affiliated teaching hospitals to work in a cooperative manner to achieve the appropriate distribution of positions required by this proposal.

If public debate of these issues leads to a consensus around which specific legislative proposal might take shape, I believe that a more rational system of graduate medical education would evolve in this country. My proposal would address as a matter of public policy the most important physician manpower issues facing our country. As a result of incorporating what I have outlined, the percentage of graduate physicians training in primary care specialties will increase as medical schools and teaching hospitals work together to reallocate GME positions to the primary care specialties. Furthermore, the number of physicians completing training will decrease as hospitals are forced to discontinue because of a lack of funds for those programs which are unable to attract U.S. medical graduates to fill 75 percent of available positions.

Although the principles I have outlined focus primarily on the physician manpower issues, I believe that they will also produce cost savings for the Medicare program and other third-party payers by resulting in a decrease in the total number of GME positions needing funding. There are several features of the proposal which will lead to a decrease in GME
positions. First, as a general rule, there are fewer years of training required in the primary care specialties than in the medical and surgical subspecialties. Thus increasing the percentage of physician training in the primary care specialties will result in a decrease in the total number of individuals in training at any given time.

Second, and more important, a number of programs will probably cease to exist because of their inability to attract graduates of U.S. medical schools. There is no way to accurately predict this number. Suffice it to say that at the present time there are a number of programs which would not be able to meet the criteria required by my proposal.

I would like to emphasize that it is not my primary intent to force any GME program out of existence. I believe that the quality of the program is the major determinant in attracting graduates of U.S. medical schools and that those programs which are unable to meet quality standards should discontinue preparing physicians to enter clinical practice. If each program that is in jeopardy is able to improve its quality and attract graduates of U.S. medical schools to fill the majority of its positions, I feel the public will be well served. However, if they cannot improve their quality sufficiently, they should cease to exist. It is my belief that the patients receiving care in those teaching hospitals and the future patients of the physicians being trained in those programs will benefit in the long run.

Additionally, although not integral to the proposal I have outlined, I think that it would be prudent for the Medicare program to establish stipend levels for GME positions to avoid price competition as the primary means of attracting graduate physicians into competing GME programs. Stipends for attending, hospital-based physicians were established under TEFRA, and I believe that this precedent should be extended to include hospital-based physicians in training. This approach would provide the Medicare program with a mechanism for controlling inappropriate increases in stipend levels negotiated by hospital and GME program administrators.

Finally, since the proposal I have outlined would result in a reallocation of GME positions in favor of the primary care specialties, there would be no reason to continue to fund Public Health Service grants designed for the same purpose. As I stated previously, the amount of money provided by these grants is really inadequate to shift significantly the distribution of training positions. They have been only marginally helpful in the context of national physician manpower policy and should not be continued if the proposal I have outlined were implemented. Discontinuing these grants would not produce a cost savings for the Medicare program, but would produce a savings for the PHS budget.

In summary, I believe that it is appropriate to reform the system of graduate medical education that exists in this country to produce a system that will be more responsive to society’s needs and more fiscally
prudent. Given the fact that the medical schools and teaching hospitals have not responded voluntarily to help resolve the problem of a physician excess and specialty maldistribution, I believe it is appropriate to use Medicare funds to leverage the system to conform to socially desirable goals. The principles that I have outlined will stabilize the funding sources for graduate medical education, reallocate GME positions to the primary care specialties, and produce cost savings for the Medicare program and other third-party payers by decreasing the total number of GME positions eligible for funding.