



Graduate Medical Education: An Untapped Tool for Primary Care Workforce Expansion

As the country searches for ways to reduce rising health care costs, policymakers must consider ways to increase the supply of primary care physicians caring for the adult population. Strong evidence links higher concentrations of primary care doctors to better quality care at lower cost.¹ Currently in the U.S., one third of all physicians are primary care doctors; in other industrialized nations, at least half of physicians are primary care providers.² Part of the explanation is the way the U.S. pays for graduate medical education (GME).^{*} Redesigning GME could help expand the number of internists, family practitioners, and other adult primary care providers and enable us to deliver better care at lower cost.

Why primary care is critical to fixing health care system

Primary care plays a prominent role in high quality and cost effective health care.

- **Primary care reduces health care spending:** Studies show that a higher concentration of primary care physicians results in higher quality, lower cost care. One recent study shows that a 10 percent increase in primary care physician to patient ratio results in a 7 percent drop (\$369) in per Medicare beneficiary spending, on average.³ This is significant savings. Although this reduction in health care spending does not solve *spending growth*, it does shift the cost curve out in the short-term, enabling other efficiencies to surface.
- **Primary care increases quality:** There is ample evidence that having a primary care provider leads to an increase in the quality of patient care. Higher concentrations of family physicians, on average, lead to lower hospital readmissions.⁴ Readmissions are a \$17.4 billion problem for Medicare alone, a sign of lower quality care for patients.⁵ The Dartmouth Atlas project demonstrates that lower spending is attributable to a greater reliance on primary care providers instead of specialty care, yielding the same or higher quality outcomes for patients.⁶ In sum, primary care is the foundation for lower cost, higher quality care for patients.
- **Primary care is the cornerstone of delivery system reform:** Many provisions in the Affordable Care Act (ACA) rely on the primary care provider as a key stakeholder in delivery system reform. For example, the move toward medical homes and Accountable

*It is important to distinguish GME from the [Children's Hospital Graduate Medical Education Payment Program](#) (CHGME) which is an entirely separate program originally created in 1999 to address the disparity that existed in federal graduate medical education support given to adult teaching hospitals and independent children's teaching hospitals. CHGME already significantly supports the delivery of primary care services to children by supporting the training of 40 percent of all pediatricians across the country. Furthermore, there is a significant national shortage of pediatric specialists and CHGME's support for training 43 percent of pediatric specialists across the country remains essential as well.

Care Organizations (ACOs) promote a culture of integrated and team-coordinated care, spearheaded by a primary care provider. These programs show promising results in increasing the efficiency of the health care system resulting in lower costs.⁷ Delivery system reform is central to bending the cost curve but demands a commitment to strengthening the primary care workforce.

Unfortunately, few medical students are choosing to be adult primary care providers. These resulting physician shortages stem from: high patient workloads, lower compensation than specialists, long hours, and large educational debt.

GME is a billion dollar tool to strengthen the primary care workforce

In 2009 teaching hospitals – the recipients of GME – received \$9.5 billion from Medicare and over \$3 billion from state Medicaid programs.⁸ Other contributors include the Department of Defense and Veterans Affairs. Given the subsidization of medical education, GME is a potential tool to transform the adult primary care workforce – both the number of primary care physicians, and how they are dispersed throughout the country.

In its current form, GME places few restrictions on the composition of physicians trained by hospitals. In turn, GME is criticized as being a general fund subsidy to hospitals with no accountability in how those dollars are directed to address the nation's physician workforce needs. As long as hospitals stay within their residency cap (established by the 1997 Balanced Budget Act), they may train as few or as many primary care providers as they wish. The government, traditionally, has not actively participated in workforce strategy. This is worrisome. A 2010 study reveals that teaching programs bias toward offering specialty residency positions over primary care positions. This translates into Medicare supporting the expanded training of a specialist workforce and then Medicare reimburses specialists at higher rates than primary care providers. As a result, taxpayer dollars are shifted to specialty training and reimbursement – less cost effective health care. The residency positions do not reflect community need but rather reflect the economic needs of the teaching hospital.^{9, 10}

The ACA begins to reshape GME

GME dollars must be tied to a strategy to alleviate a growing workforce crisis in primary care. Currently, the ACA:

- **Redistributes unused residency slots.** The ACA addresses the function of GME by redistributing over 900 unused residency slots, transferring them to teaching institutions that serve medically underserved areas (many located in southern and western states). This should help to redistribute physicians caring for adults to more rural and underserved areas. Additionally, the majority of these slots are slated for primary care or general surgery. Regulations published in November 2010 outlined the application process for teaching hospitals to receive additional residency slots. The applications are now under consideration by CMS and assignments will be published in July 2011. It is

not yet clear how hospitals will be accountable for assigning their newly acquired slots to primary care.¹¹

- **Increases primary care training sites.** Another revision of GME in the ACA is increased flexibility to train medical students off site, enabling more appropriate primary care training in community health centers and similar sites. Newly developed teaching centers can tap grant funds to train primary care physicians in federally qualified health centers, mental health centers or rural clinics (\$230 million over 5 years). This begins to address the deficiency in training residents in community settings, the foci of primary care giving.¹²

More can be done

Three ideas to better leverage GME for adult primary care workforce expansion are: redirect some GME funds to reduce educational debt for *all* primary care physicians; attach performance goals to GME funds; and require residency programs to reflect community need.

- **Incent medical students to pursue primary care through reduced educational debt.** Under the ACA, the National Health Service Corps is expanded. This program is an umbrella for loan repayment programs and scholarships that place primary care providers in underserved areas. More can be done to expand the primary care workforce. An additional incentive would be to offer some education loan forgiveness to *all* physicians that opt to practice primary care regardless of location; GME funds could be used to reduce educational debt for those that choose careers in primary care. A 2010 study demonstrates the economic challenges for pursuing a primary care career – in the first 3-5 years of practice, a primary care physician's expenses will exceed their income, resulting in lengthier pay back periods and creating a disincentive for choosing primary care.¹³
- **Shift a portion of GME to pay for performance.** The receipt of huge sums of public money should be accompanied by hospital accountability for responding to the primary care workforce shortage. The Medicare Payment Advisory Commission (MedPAC) recommends to Congress that a portion of GME payments be shifted to a pay-for-performance model. They suggest using a diverse advisory council to develop performance standards that focus on the skills needed to improve the delivery system (practice-based learning and improvement, interpersonal communication skills, professionalism, and systems-based practice – including the integration of community-based care with inpatient care).¹⁴ Performance incentives would accelerate training innovation by teaching institutions and hold them financially accountable. MedPAC recommended putting \$3 billion into pay-for-performance payments.¹⁵
- **Align primary care residency positions with a local, state, and regional workforce strategy.** Currently, residency programs are not reflective of local, state or regional workforce needs. Given that the national workforce commission tasked to design a national strategy is unfunded, Congress could require hospitals to assess workforce needs in their service area. Ultimately, the goal is to use GME to shape the workforce, requiring residency slots to respond to the needs of a region or locality.¹⁶

Simply cutting GME for quick budget line item savings is a missed opportunity. Reforming GME moves the nation toward higher quality health care at lower cost. Getting serious about cost savings means getting serious about expanding the primary care physician workforce.

In past years both the Council of Graduate Medical Education (COGME) and MedPAC have called on Congress to reform GME. Recommendations include cuts to GME, shifting GME to a performance-based system, expansion of educational loan support, and allowing more off-site training in community based settings. These recommendations have never come to fruition. In the past, the hesitancy to touch GME funding has been due to strong support for teaching hospitals and specialty professional organizations; both groups fear reductions in funding and a change in the status quo. Yet GME in its current form is a poorly targeted program. With cuts to GME on the table, it makes sense to consider how the funding is used rather than simply how much funding is available.

¹ <http://content.healthaffairs.org/content/28/5/1327.full> and <http://content.healthaffairs.org/content/29/5/806.full?sid=13961af4-2099-424b-995d-75b1d1f62dfd>

² <http://www.annals.org/content/148/1/55.full.pdf+html>

³ <http://content.healthaffairs.org/content/28/5/1327.full>

⁴ <http://www.aafp.org/afp/2011/0501/p1054.html>

⁵ <http://www.nejm.org/doi/full/10.1056/NEJMSa0803563>

⁶ <http://waysandmeans.house.gov/media/pdf/111/fisher.pdf>

⁷ http://www.chcs.org/usr_doc/Medicaid_Best_Buys_2010.pdf and

http://www.communitycarenc.com/PDFDocs/Mercer%20SFY05_06.pdf

⁸ <http://healthpolicyandreform.nejm.org/?p=3770>

⁹ <http://content.healthaffairs.org/content/early/2005/03/15/hlthaff.w5.97.long>

¹⁰ <http://archinte.ama-assn.org/cgi/reprint/170/4/389> and Weida NA, Phillips RL Jr, Bazemore AW. Does graduate medical education also follow green? Arch Intern Med. 2010 Feb 22;170(4):389-90.

¹¹ <http://www.healthreformgps.org/resources/primary-care-physician-workforce/>

¹² <http://www.healthreformgps.org/resources/primary-care-physician-workforce/>

¹³ <http://www.ncbi.nlm.nih.gov/pubmed/20881829?dopt=Abstract>

¹⁴ <http://healthpolicyandreform.nejm.org/?p=3770>

¹⁵ The GME has two parts: direct medical education (DME) and indirect medical education (IME) payments. The IME payments cover expenses associated with treatment of severely ill patients and the additional costs related to teaching while the DME supports salaries, benefits, and stipends. The \$3 billion recommended by MedPAC is what the commission considers excessive indirect medical education payment.

¹⁶ Testimony before the House Energy and Commerce Subcommittee on Health, Fitzhugh Mullan, M.D.