

AMA Center for Transforming Medical Education and
AMA Advocacy Resource Center

Critical condition: The call to increase graduate medical education funding



To ensure an adequate physician workforce and better access to care, proper GME funding is a must.

Many authorities agree that by 2025 the United States will face a shortage of physicians to meet the needs of a growing and aging U.S. population. Since 2000 at least 26 states and 17 medical specialties have reported physician workforce shortages, and an additional five states and five medical specialties predict coming shortages.

While new U.S. allopathic and osteopathic medical schools are opening and many medical schools are expanding their enrollments to meet the need for more physicians, **graduate medical education (GME) core training programs are experiencing minimum growth due to limited funding.** This imbalance is exacerbating the shortage of physicians.

Background: From Flexner to the Patient Protection and Affordable Care Act

After the Flexner Report was published in 1910, a single model of medical education became the norm in the United States. A number of substandard medical schools were closed, which caused the number of physicians per capita to decrease in the first half of the 20th century. This trend reversed in the second half of the century as the number of medical schools expanded and as Medicare became law in 1965. Growth continued until the 1997 Balanced Budget Act capped the number of Medicare-funded GME positions.

With the number of medical school graduates increasing and competition for entry level residency slots intensifying, the cap has made it difficult for institutions to expand training programs. The 2010 Patient Protection and Affordable Care Act (PPACA) authorized redistribution of unused GME residency slots and allowed greater flexibility for GME programs to count training in outpatient settings. Although other minor provisions in the PPACA may increase the number of resident physicians in primary care and general surgery, these changes will not be enough to build a fully trained medical workforce.

Completion of an accredited core residency program is required for certification by a member board of the American Board of Medical Specialties, and board certification is becoming a standard for physicians to practice in hospitals or to be included in insurance plans. Given the long pipeline for physician training (at least seven years post-college), combined with the years required to build and accredit new residency programs, expanding GME now will not have a major impact on the doctor-to-population ratios for several decades.

Objectives: Better data, flexibility and innovation

At a November 2010 summit, the American Medical Association (AMA) Center for Transforming Medical Education and the AMA Advocacy Resource Center, in collaboration with leaders from GME programs, state medical societies and national medical organizations, discussed state-based GME funding options. The summit's goal was to develop successful strategies that state and regional stakeholders could embrace for political action to expand GME funding to meet state and regional medical workforce needs.

The consensus process was guided by four main objectives:

- 1. State-level physician data is essential to show the need to expand GME in underserved areas throughout the United States.**
- 2. Additional sources of GME funding must be identified, and current sources must be preserved.**
- 3. Innovative methods to distribute GME funds in states and regions must be developed.**
- 4. Flexibility in GME training methods, venues and sites will be required to meet future patient needs.**

Recommendations

Collect meaningful data that shows the need to expand GME to meet state and regional workforce needs.

Health workforce planning should be a shared federal-state responsibility. Each state should determine the medical workforce needs of its communities while the federal role should focus on developing data collection guidelines, and on providing guidance through national data collection and analysis. Federal grants can provide incentives to states looking to expand their training programs. These investments can provide an important platform for expanding the primary care workforce and creating more opportunities to prepare physicians to practice in community-based settings. States also play a significant role in supporting education and training, licensure and regulation of practitioners, state and local public health, scholarships and loan repayment programs, tracking of employment and regulation of practice.

Identify current and potential sources of expanded funding for GME.

All payers for health care—including the federal government, the states and private payers—benefit from GME. Therefore, the AMA advocates that all payers, including private insurance companies, should directly contribute to its funding. In addition, current sources of funding must be preserved. These include Medicare, which provides \$9.5 billion in funding; Medicaid, through state appropriations and matching federal payments (nearly \$2 billion); and the Department of Veterans Affairs (VA), which provides \$1 billion. In addition to sustaining current GME funding and requiring contributions from all payers for health care, new funding streams (such as trusts created by the conversion of not-for-profit entities) could be developed to increase residency positions. Preferably, these new programs would be located in or adjacent to physician shortage/underserved areas and in undersupplied specialties and subspecialties.

Identify successful methods to distribute GME funds to meet state and regional needs.

Several states and the VA are using innovative GME financing approaches that take into account regional or national physician workforce needs in allocating GME funding. Successful state models are also moving toward new and renewable funding streams. Some models include combining funds from Medicare, Medicaid, and private insurers to collectively support GME growth in needed geographic areas and/or specialties.

Support funding for training in non-hospital sites.

The current funding mechanisms for GME are largely tied to hospital settings, whereas most medical care occurs in ambulatory settings. The demands on resident physicians to provide hospital services leaves little room for developing innovative GME programs featuring interdisciplinary care across all settings, including physicians' offices, hospital outpatient and inpatient services, nursing homes and community-based programs. If physicians are only educated in practice models defined by inpatient care, the future physician workforce will lack adequate experiences to meet the nation's needs and expectations. Centers for Medicare & Medicaid Services rules must create flexibility for funding GME in community-based sites and settings.

Strategies supported by the AMA

Strategies for expanding GME to support community workforce needs

- Expand GME as needed geographically to address the future workforce needs of the nation
- Encourage training programs to better prepare physicians to care for a diverse patient population with chronic diseases
- Ensure adequate GME opportunities for U.S. medical graduates to complete core training programs
- Broaden the definition of “training venues” to include non-traditional training sites (e.g., teaching health centers) to deliver patient-centered, coordinated, inter-professional, and interdisciplinary care
- Ensure that all resident physicians who enter GME programs have access to completing their training in an accredited core residency with appropriate supervision by experienced faculty

Strategies state/regional stakeholders can embrace for political action

- Collect state-level physician data to support the need to expand GME in underserved areas
- Support incentives for students to choose specialties/careers to meet societal needs
- Explore alternative sources for GME funding (e.g., private payers)

Solutions supported by the AMA

- Ensure adequate GME opportunities for qualified applicants, including international medical graduates
- Ensure a well-trained, competent medical workforce entering practice
- Encourage appropriate medical workforce expansion to correct shortages by specialty and geography
- Seek all-payer funding for core residency programs leading to initial board certification
- Align federal and state incentives through:
 - All-payer GME system (federal or state mandates)
 - GME funds to meet broader community needs
 - Reduced disparities in medical access and quality
 - Support of GME in innovative health care systems (e.g., patient-centered medical homes and accountable care organizations)



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www.ama-assn.org/go/gmenews

