CONFERENCE SUMMARY

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Ensuring an Effective Physician Workforce for America: Recommendations for an Accountable Graduate Medical Education System

The graduate medical education (GME) system in this country is largely responsible for the nature of the physician workforce that exists today. Over the years, the system has produced a workforce composed of physicians who are well prepared to enter clinical practice in the specialty of their training, and one that has generally been considered to be appropriate both in its size and its specialty mix to meet the needs of the American public for medical care.

More recently, concerns have been expressed from both within and outside the profession that the training being provided within the GME system is not adequately preparing residents for practice in the modern health care system. At least four major specialties—internal medicine, pediatrics, family practice, and surgery—have been engaged throughout most of the past decade in initiatives intended to redesign the nature of residency training provided in their specialty to better prepare their residents for practice. Furthermore, several federal government agencies and advisory bodies [i.e., Agency for Health care Research and Quality (AHRQ), Medicare Payment Advisory Commission (MedPAC), and Council on Graduate Medical Education (COGME)] have called for modifications of the training being provided. These reports have focused attention on the need to ensure that residents are being trained to provide safe, evidence-based, high-quality health care; that they learn the importance of providing team-based care that incorporates the participation of nurses, nurse practitioners, pharmacists, social workers, physician assistants, and other health care professionals in the care of patients; and that they learn to work in integrated delivery systems that focus on the care of populations as well as individuals. Finally, the Institute of Medicine (IOM) and a number of foundations have issued reports expressing concerns that residency programs are not adequately covering certain issues that relate to how the country's health care system functions. To date, while these efforts have lead to some changes, substantive reforms in training are required.

In addition there are concerns that the GME system may no longer be optimally configured to create a workforce that will be able to meet the population's need for medical care. Changes occurring in the health status of the population due to aging and other factors contributing to the incidence of chronic disease, as well as a substantial increase in the number of insured individuals as a result of the Patient Protection and Affordable Care Act, suggest that the size and specialty mix of the workforce will become increasingly insufficient over time.

Recent reports issued by the Health Resources and Services Administration (HRSA), COGME, the U.S. Department of Labor, and the Association of American Medical Colleges (AAMC) project that the current supply of new physicians entering practice each year (those completing residency training) is not adequate to avoid a significant physician shortage in the years ahead. A recent report from the Association of Academic Health Centers (AAHC) calls for substantial changes in health care workforce training to better meet the needs of patients and society. There are also

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a variety of reports indicating that the specialty mix of the physicians entering practice is not in keeping with the needs of the population. Due to a number of driving forces, physicians currently being trained and those that are entering the workforce are increasingly choosing to pursue subspecialties rather than the core specialties of general internal medicine, family practice, general pediatrics, and general surgery. In the past decade, the number of those training in subspecialties has grown at five times the rate of those training in core specialties.

The Josiah Macy Jr. Foundation designed a series of two conferences to develop recommendations regarding the future of GME in the United States. The first conference, held in October 2010 and jointly sponsored by AAHC, was entitled "*Optimizing the Structure, Support, Oversight, and Accountability of GME to Best Meet the Needs of the American People*." The goal of the meeting, which was held at the Emory Conference Center in Atlanta, Georgia, was to review the current status of GME from a policy perspective, including the regulation, financing, and "sizing" of GME. Because a second conference in May 2011 will focus on the content and format of GME, these topics were not discussed in detail. The conference was chaired by Michael M.E. Johns, MD, Chancellor of Emory University. Twenty-two invited individuals, representing a cross section of the academic community, participated in the conference.

The conference began with individuals holding leadership positions in the Accreditation Council for Graduate Medical Education (ACGME), MedPAC, COGME, AMA, AAMC, and the U.S. Department of Veterans Affairs (VA), who provided the perspectives of their respective organizations on the state of the GME system. Following these presentations, meeting participants gathered to discuss the experts' testimony and the background papers that had been commissioned for the conference. The larger group then broke into small groups to discuss potential ways for creating a more accountable GME system and then reconvened to discuss and synthesize their findings. The conclusions and recommendations of the group are summarized below.

CONCLUSIONS

Conclusion I: GME is a public good.

The GME system serves the public interest in two extremely important and distinct ways. First, it is responsible for ensuring that medical school graduates are prepared to provide high quality care in one of the specialties of medicine when they complete their residency training, thereby contributing to the overall quality of the medical care provided in the country. Second, the system is the critical determinant of the number and specialty mix of the cohort of physicians that enter practice each year, thereby contributing to the size and composition of the physician workforce that is required to meet the public's needs for medical services.

Conclusion II: Because GME is a public good and is significantly financed with public dollars; the GME system must be accountable to the needs of the public.

The medical profession and the federal government share the responsibility for ensuring that the GME system is meeting the public's needs in the following ways:

- Ensuring the competency and skills of its trainees to care for a diverse patient population with an increasing burden of chronic disease and their readiness to practice in a changing health care environment;
- Ensuring that the training of physicians involves a broad range of patients with appropriate supervision by experienced faculty in settings that mirror the health care venues and models in which they will practice (for example, ambulatory settings and team-based care); and
- Providing a specialty mix and distribution of physicians that meets the public's needs.

Conclusion III: There is a need to ensure that an adequate number of physicians are trained.

The magnitude of the physician workforce shortages projected in several reports emphasize that there is a need to determine how best to restructure the GME system in order to increase physician supply, particularly in targeted core specialties. Although the number of medical students being trained in the United States is increasing due to the opening of new medical schools and expansion of class size in existing schools, no increase in the number of practicing physicians will occur unless the number of residency positions is increased. The number of entry-level positions in the country's GME system (PGY-1s) is the critical determinant of physician supply in this country. Given this, an increase in the number of PGY-1 positions will not actually have an impact on physician supply for a period exceeding 4 years—the average time required for the residents filling the new PGY-1 positions to complete training to first board eligibility and enter practice. Thus, in recognition of the need to increase the size of the physician workforce, it would be highly desirable to begin the process immediately without waiting for an agreement on the ultimate number needed.

Conclusion IV: There is a need for an independent review of the governance and financing of the GME system.

Because prior calls for the reform of the GME system have not been effective in bringing about sufficient change and because the needs for the alignment of the system with the public's needs are greater than ever, there is an urgent need for an external, independent review of the GME system, including its governance, financing, and regulatory functions. The goal of such a review would be to produce an accountable GME system—one that allows for flexibility and facilitates innovation in order to ensure that it is responsive to the public's needs.

RECOMMENDATIONS

Recommendation I: An independent external review of the governance and financing of the GME system should be undertaken.

Members of Congress should charge the IOM to perform the review, and public and private entities should be requested to provide the funds required by the IOM to ensure that the IOM is able to complete its duties. This IOM committee should review and make recommendations as to the structure and function of the accreditation body (ACGME) and accreditation process. In addition it should provide ongoing guidance and assessment of the number of residency positions, appropriate training sites, and optimal funding mechanisms, including Medicare GME funding recommendations, public accountability mechanisms, and accreditation performance.

The IOM Study Committee would be composed of medical professionals, medical educators, other health professionals, health care delivery systems experts, health economists, distinguished members of the public, and appropriate government officials who would conduct the external review, which should include what is necessary to achieve recommendations II to V.

Recommendation II: Enabling GME redesign through accreditation policy.

The external review should make recommendations to ACGME to ensure that the accreditation process is structured and functions in a way that best serves the interest of the public, the training programs, and the trainees.

Given the challenges facing the GME system, it is critically important that the program and institutional requirements adopted by the ACGME for accreditation purposes are not excessively burdensome, and that they result in residents being trained in the most efficient way possible to provide high-quality care in the modern health care system. It is similarly important that attention be paid to the specific clinical experiences that programs are required to provide, and the impact that individual requirements have on the length of training. Special attention should be focused on the evaluation of whether there is a continued need for the transitional year program or the preliminary year experiences required by some specialties. In addition, the ACGME should ensure that existing requirements encourage the development of innovative approaches for training residents, which might lead to more efficient or effective ways of preparing residents for practice, regardless of their specialty. Furthermore, the composition of the Resident Review Committees that determine the requirements for the program accreditation should be optimized. The certification requirements of the specialty boards should be responsive to the accreditation process and the recommendations of the external review.

Recommendation III: Ensuring adequate numbers and distribution of physicians: implications for funding of GME.

A thorough review should be conducted of the policies that determine how GME is currently being financed for the specific purpose of developing recommendations for how the GME funds provided by the Medicare program and other funders (e.g., VA, states, and others) can be better used to address the current challenges facing the GME system.

A major challenge facing the GME system and how it will be structured and function in the coming years is determining how resident physician training is to be financed. It is important for all involved to understand that, given the country's current financial situation and the political pressure for decreasing Medicare expenditures, growth in the Medicare funds used to support GME is unlikely. Indeed, Congress took steps to control GME spending by including in the 1997 Balanced Budget Act (BBA) provisions that effectively capped the number of GME positions that Medicare would fund. This policy has also effectively limited the growth of the number of practicing physicians in the United States. Accordingly, a clear, persuasive, and rational argument must be developed for how Medicare and other funders should contribute to the financing of GME and other health professions education in the future.

Possible new sources of funding for GME should be considered, including mechanisms proposed by a variety of stakeholders over the past 10 years. Amid growing concern that an effective physician workforce may not be possible absent new methods for funding GME, new proposals need to be considered. Calls have been made to consider all-payor systems or other alternatives to the current Medicare-based approach. For example, private insurance companies could be required to explicitly fund GME. In a very real sense, many companies do contribute to GME financing by virtue of the payments they agree to make to teaching hospitals for patient care services. It might be possible to have all companies contribute to a financing pool if the companies were allowed to include the contribution in their medical loss ratio.

Many state governments already contribute some funds to support specific GME needs. The states might be able to contribute more if the funds were directed to meet local needs and mechanisms were in place to allow them to recover the funds on an ongoing basis.

Given the limitations imposed on increasing physician supply by the 1997 BBA caps on GME positions and the magnitude of the impending physician workforce shortages projected in a number of reports, it is essential that the consideration of these new approaches proceed with a sense of urgency.

Recommendation IV: Providing trainees with needed skill sets: innovative training approaches and sites.

We propose the beginning of a process that promotes and encourages innovation in the creation of new GME programs and in existing programs, with the goal of better serving the needs of the public and better preparing trainees for a changing practice environment. To better meet the public need, eligible sponsoring institutions for new programs should be broadened to include health care systems, accountable care organizations, teaching health centers, and other new organizational structures that are created to deliver patient-centered, coordinated, inter-professional, and interdisciplinary care. It will be essential that appropriate educational oversight be preserved in these new environments. In order to achieve these goals, we believe a funding mechanism is necessary to incentivize innovation. Some funding is already available to work toward this goal, but other potential sources should be investigated.

Recommendation V: Ensuring a workforce of sufficient size and specialty mix.

Given the impending physician shortage and the changing and growing needs of the public, we recommend an increase in GME slots at numbers that will approach the goal of maintaining the current ratio of approximately 250 doctors for every 100,000 people. This recommendation is made with the recognition that an increased role of other health professionals in the delivery of care may change the target ratio in the future as health care delivery systems evolve. Understanding the current limitations of the available data and resources, and recognizing potential changes in the delivery system, we concur with the recommendation from COGME[1] in its sixteenth report for a one-time increase of 3,000 entry level GME positions in selected disciplines, with a commitment to support the training of those individuals through to completion of requirements for the first board certification.

It is understood that the task of increasing the supply of certain needed disciplines is more complex than simply creating more training slots (though that is a necessary first step). It is also understood that meeting the needs of the public will require increasing the number and skills of other health professionals, such as nurses, nurse practitioners, and physician assistants. Other interventions, including improving the practice environment and infrastructure to make certain disciplines more attractive, improving the educational process, reducing the administrative burden for providers, and addressing the inadequate compensation of physicians in some specialties, will also be necessary.

We recommend that these new positions be added in a targeted fashion to begin to correct the current misalignment of the specialty mix with societal need. While there are data to suggest that there will be shortages in many specialties, we believe the most urgent need is currently in adult primary care (family practice and general internal medicine), general surgery, and psychiatry. However, in recognition that those needs will change over time, we suggest that the targeted disciplines be reassessed at least every 5 years, using data that will then be available from the National Health Care Workforce Commission and the National Center for Health Care Workforce Analysis. Based on these data, additional funding or other incentives may be put in place over time to promote more or different positions, and disincentives or limits may be put into place for certain programs where there is demonstrated excess production.

We recommend that Medicare at least partially fund some new positions by reallocating some of the current Medicare GME funds to the targeted new positions. For example, Congress could decide that Medicare should provide funds to support specialty training in the areas of highest need (e.g., primary care and general surgery) and those subspecialty positions specifically justified based on need, such as geriatrics. Congress could also decide (and provide notice) that it intends to decrease funding for transitional year or preliminary year programs. To some extent, this would be consistent with the decision made over 30 years ago to discontinue internships. Thus, there are possible approaches for providing some of the funds that would be required to fund new PGY-1 positions.

SUMMARY

Achieving a health care system that is patient-centered, efficient, effective, and adaptable to the ever-changing needs of a diverse population is not possible without an adequate health professions workforce. The impending shortage of physicians, particularly in adult primary care specialties, requires immediate action. A crucial—indeed rate-limiting—step in creating that workforce is the process by which medical school graduates are trained for independent practice in our GME system. Given this, an initiative is needed to encourage the development of a more accountable GME system—that is, a system that functions primarily to serve the public interest.

After careful consideration of the information provided by the expert panelists and the content of the four background papers, meeting participants developed the recommendations above to enable the current GME system to be more responsive to patient care and trainee needs in an environment of changing demography and health care delivery. We emphasize that the responsibility for reshaping the GME enterprise does not rest with a single entity. Governments, accrediting bodies, certifying bodies, training institutions, educators, and trainees themselves will have to work together to bring about the changes we believe are necessary to develop a physician workforce equipped to meet the health care challenges of this century.

[1] Council on Graduate Medical Education. *Sixteenth Report: Physician Workforce Policy Guidelines for the United States, 2000-2020.* Rockville, MD: Department of Health and Human Services, Health Resources and Services Administration: 2005.

GME POLICY WORKGROUP

Michael M.E. Johns, MD*
Chancellor, Emory University
Chair

Molly Cooke, MD
Professor of Medicine,
Director of the Academy of
Medical Educators
University of California,
San Francisco

Linda Cronenwett, PhD, RN, FAAN
Professor, The University of North Carolina at Chapel Hill

Norman Edelman, MD*
Professor of Preventive and Internal Medicine
Stony Brook University Health Sciences Center

Julie Ann Freischlag, MD
Professor and Director, Department of Surgery
Johns Hopkins Medical Institutions

Carl J. Getto, MD
Senior Vice President, Medical Affairs,
Associate Dean, Hospital Affairs
University of Wisconsin Hospital and Clinics

Jennie Chin Hansen, RN, MS, FAAN
CEO, American Geriatrics Society

Eve Higginbotham, SM, MD
Senior Vice President and Executive Dean
for Health Sciences
Howard University

John K. Iglehart
Founding Editor, Health Affairs
National Correspondent, New England Journal of Medicine

Michael Karpf, MD
Executive Vice President for Health Affairs
University of Kentucky

Kenneth Ludmerer, MD, MA
Professor, Department of Medicine
Washington University in St. Louis

Claire Pomeroy, MD, MBA
Chief Executive Officer, UC Davis Health System,
Vice Chancellor, Human Health Sciences, Dean,
School of Medicine, University of California, Davis

Paul Ramsey, MD
CEO, UW Medicine, Executive Vice President for Medical
Affairs, Dean of the School of Medicine
University of Washington

Wayne Riley, MD, MPH, MBA, FACP
President and CEO, Meharry Medical College

William Roper, MD, MPH
Vice Chancellor for Medical Affairs, Chief Executive Officer,
UNC Health care System, Dean, School of Medicine
The University of North Carolina at Chapel Hill

Larry Shapiro, MD
President, Washington University Medical Center,
Executive Vice Chancellor for Medical Affairs, Dean,
School of Medicine, Washington University

Kenneth Shine, MD
Executive Vice Chancellor for Health Affairs
The University of Texas System

Elliot Sussman, MD, MBA
President and Chief Executive Officer
Lehigh Valley Hospital and Health Network

George E. Thibault, MD*
President, Josiah Macy Jr. Foundation

Steven Wartman, MD, PhD, MACP*
President/CEO, Association of Academic Health Centers

Debra Weinstein, MD*
Vice President for Graduate Medical Education
Partners Health care System, Inc.

Michael Whitcomb, MD*
Professorial Lecturer in Health Policy
School of Public Health and Health Services
George Washington University

**Planning Committee Member*

Expert Panelists

Malcolm Cox, MD
Chief Academic Affiliations Officer
U.S. Department of Veterans Affairs

Mark Miller, PhD
Executive Director
MedPAC

Thomas Nasca, MD, MACP
Chief Executive Officer
Accreditation Council for Graduate Medical Education

John E. Prescott, MD
Chief Academic Officer
Association of American Medical Colleges

Russell Robertson, MD
Chair, Council on Graduate Medical Education, Chair, Department of Family and Community Medicine
Northwestern University

Paul Rockey, MD, MPH
Director, Division of Graduate Medical Education
American Medical Association

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JOSIAH MACY JR. FOUNDATION 44 East 64th Street, New York, NY 10065 | www.macyfoundation.org