Transforming the physician workforce through competitive graduate education funding

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Graduate Medical Education (GME) has fallen short in training physicians to meet changes in the U.S. population and health care delivery systems. But a new proposed funding mechanism coupled to a competitive peer-review process may be the best way to reform the process, according to an analysis and commentary in the November issue of *Health Affairs*.

Dr. David Goodman, professor at The Dartmouth Institute for Health Policy & Clinical Practice, and Dr. Russell G. Robertson, dean of the Chicago Medical School, note in their analysis that resistance to change is a long-standing problem in Graduate Medical Education. "The current system is remarkably inflexible – a place where good ideas for improving the physician workforce go to perish," they said.

Graduate Medical Education is the three-to-eleven-year period of physician training that follows medical school, commonly known as a residency or fellowship training. The number of training positions and the content of the graduate education determine the number, specialty mix, and competencies of physicians entering the workforce, for example cardiologists, pediatricians, radiologists.

"Progress by teaching hospitals, accreditation organizations, and Congress has been too slow to meet the workforce challenges of our changing and aging population and our health care delivery system," the

authors said. "If teaching program performance is not linked to funding, recommendations to reform GME will likely remain in a state of inertia."

GME is primarily paid for with more than $13 billion in public money, with the bulk of it coming from Medicare through complex funding formulas. And, the funding mechanism is tied primarily to hospital-based services, ignoring the growing need for competencies that extend beyond acute patient care to improving clinical systems, team-based care, and longitudinal management of patients in the community.

Another deficiency in the funding mechanism is the "inflexible GME pipeline" that is anchored to the number of residents funded at the time of the passage of the Balanced Budget Act of 1997. Some expansion has occurred but mainly in subspecialties, ignoring the need for additional primary care physicians.

To improve the physician workforce, the authors recommend a new system of funding that is responsive to workforce needs, rewards innovation, and uses explicit outcome objectives to evaluate training programs. The funding would be publicly guided and awarded through competitive funding, similar to the process of awarding National Institute of Health peer-reviewed research grants.

"For the physician workforce to change and improve, there must be a trusted public entity that regularly sets overall goals for training direction and pipeline size," the authors said. The entity should be a federal advisory committee composed of the public, public health experts, health care systems, payers and medical educators.

These goals would guide the development of annual requests for funding proposals. Residency programs would be required to apply and compete for GME funding once every 10 years. This means that each year 10

percent of the nation's training programs would be reviewed. New programs would compete for funding. Existing programs that score poorly would receive reduced funding, while meritorious programs could grow. Awards would be for 10 years to enable teaching organization stability.

Applications would be reviewed through study sections. Programs would also need to report performance measures that include educational capacity, processes and outcomes. These measures would be available to the public including fourth year medical students who are choosing residency programs.

Funding would no longer be linked to residents' time caring for Medicare beneficiaries in acute care settings. "Indirect GME funding would no longer reward the very inefficiencies that health care reform is intended to remedy," the authors said.

This new funding mechanism would be an opportunity to transform the health care workforce by incentivizing innovation and a physician specialty mix that responds to the health care needs of the U.S. population. It would also provide financial and educational stability to graduate programs by instituting changes incrementally.

More information: The full article may be found at *Health Affairs* at content.healthaffairs.org/cont … /32/11/1887.abstract

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