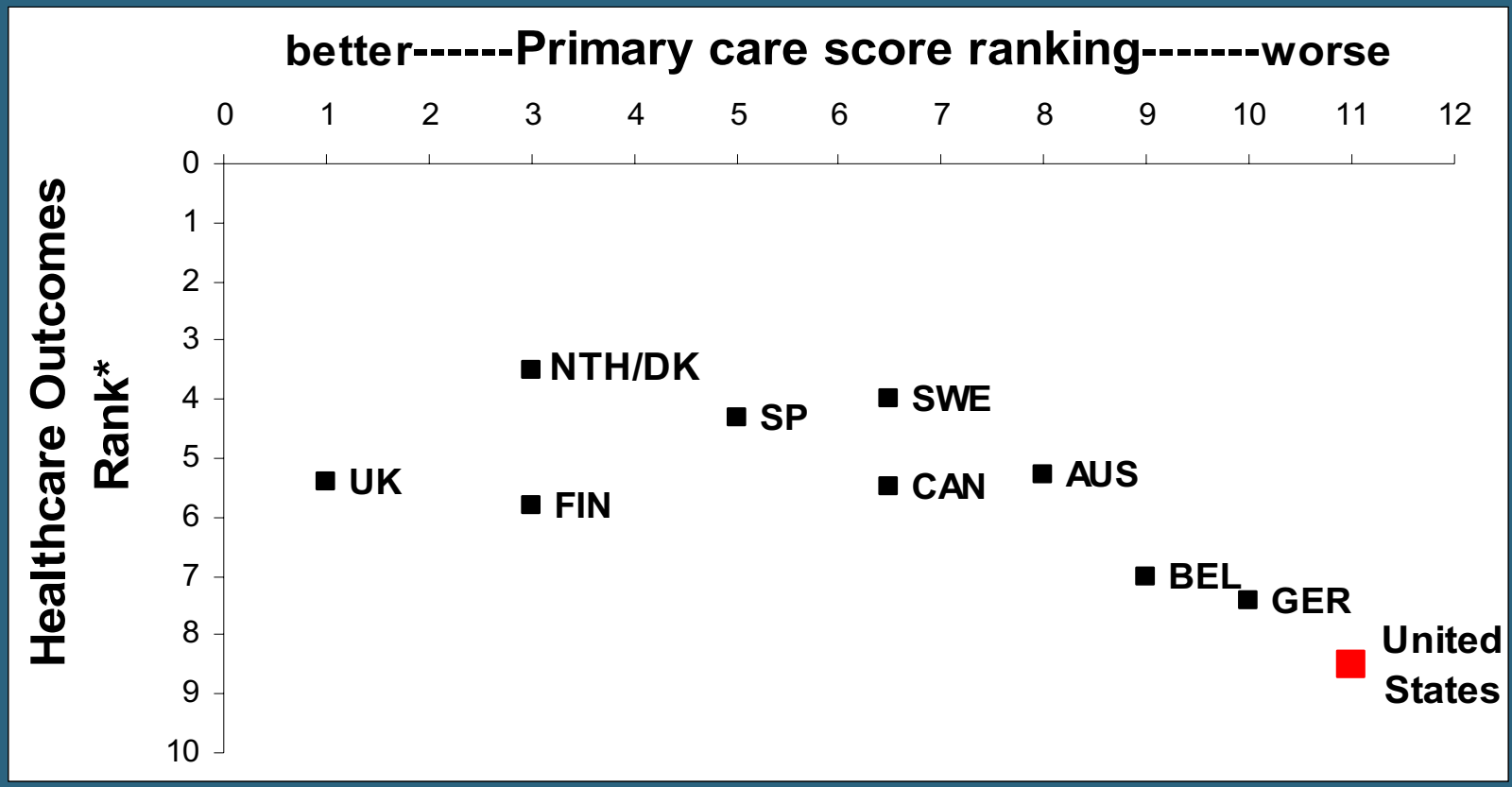
Are Medicare GME policies adequate to meet the rising need for primary care physicians?

Robert Phillips MD MSPH
The Robert Graham Center

NO


ATTENTION
All passengers and their items are subject to continuous search
Transportation Security Administration

What does GME output do for us?



*Rank based on patient satisfaction, expenditures per person, 14 health indicators, and medications per person in Australia, Belgium, Canada, Denmark, Finland, Germany, Netherlands, Spain, Sweden, United Kingdom, United States

Adapted with permission from Starfield B. Is primary care essential? Lancet 1994;344:1129-33.

What does GME output do for us?

U.S. Health System Performance: A National Scorecard

The United States would have to improve its performance on key indicators by 50 percent or more to reach benchmark rates.

by Cathy Schoen, Karen Davis, Sabrina K.H. How, and Stephen C. Schoenbaum

US is last among industrial nations in preventable deaths (ranked 19th)

Could prevent 100,000 deaths Every Year!

Health Affairs, Sept, 2006

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What does GME output do for us?
World Health Organization, 2000 Report

Country	DALE Rank	Overall Rank
France	4	1
Japan	9	10
UK	24	18
Cuba	36	39
Canada	35	30
US	**72**	**37**

Level of Health=25% Distribution of Health=25%
Level of Responsiveness=12.5%
Distribution of Responsiveness=12.5% Fairness of financing=25%

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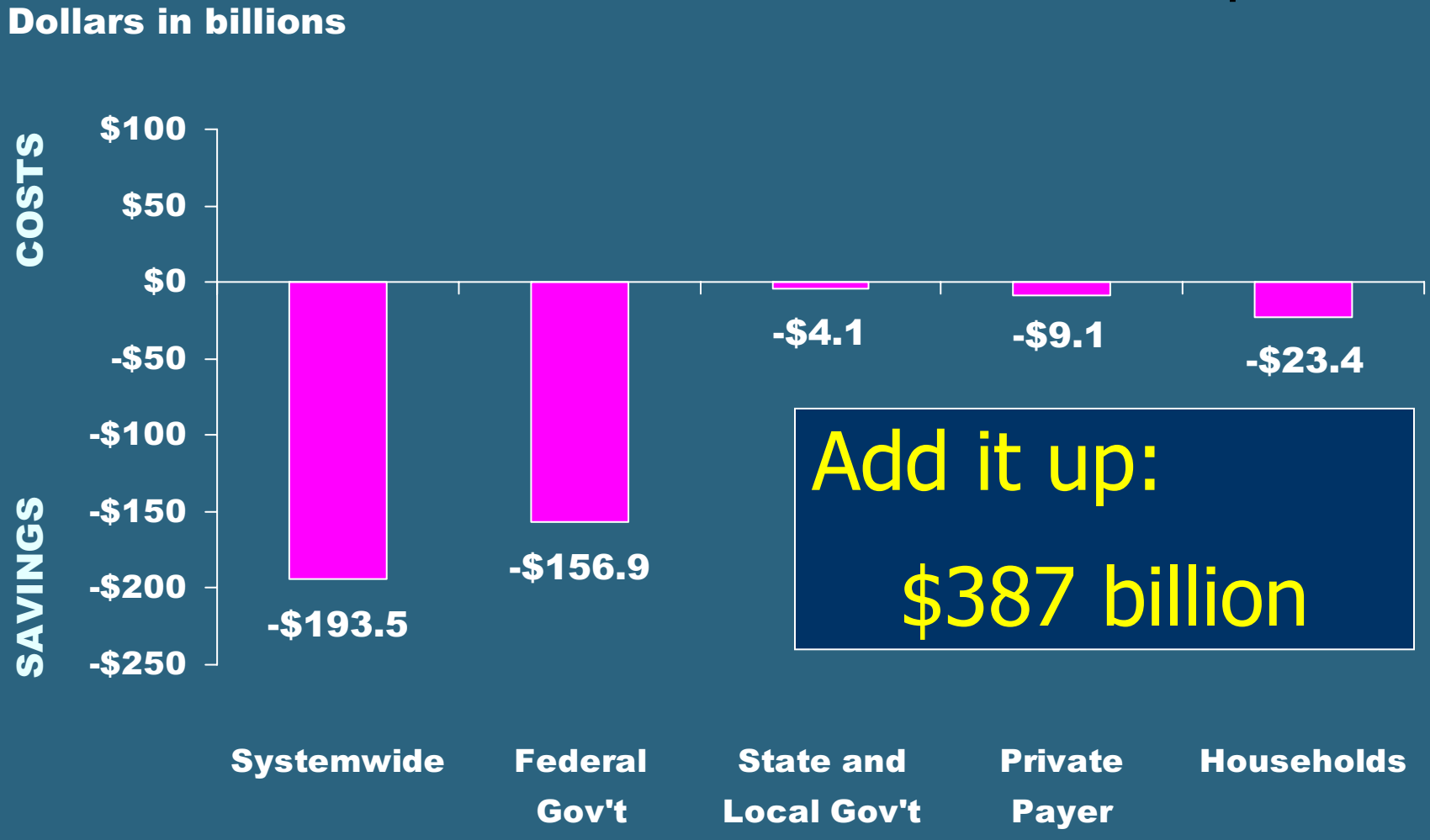
Strengthening Primary Care and Care Coordination in Medicare: Distribution of 10-Year Impact



Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, The Commonwealth Fund, December 2008.

Insuring Everyone & Primary Care for Everyone

- Massachusetts cost model
  - Cost of care for all people currently without a usual source of care

    $125 billion - $145 billion annually
- Enhanced PC cost model
  - Give everyone cost of Best 5 states: Save $70 billion to Medicare annually
  - Give everyone cost outcomes of Community Health Centers: Save $450 billion annually

Why is GME policy failing primary care?

- No accountability for the product
- Legislative authority
- Regulations
- Political lock

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Erosion of Primary Care Training Capacity: No Accountability

- Since 1996 GME cap was put in place in 1996, positions in the annual student Match have fallen by
  - 57% for primary care internal medicine
  - 34% for primary care pediatric positions
  - 18% for family medicine

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Primary care not replacing itself: No Accountability

- Between 2002 and 2006
  - Residency positions grew +7.9%
  - Subspecialty positions grew +24.7%
    - (33% between 2001 and 2008)
  - Primary care positions grew +2.3%
  - Family Medicine positions fell -2.8%
    - **However…the estimated number of graduates going on to practice primary care fell 15%** (from 28.1% to 23.8%)

Currently 35%!

E. Salsberg et al. US Residency Training Before and After the 1997 Balanced Budget Act. *JAMA.* 2008;300(10):1174-1180.

Loss of Primary Care Positions

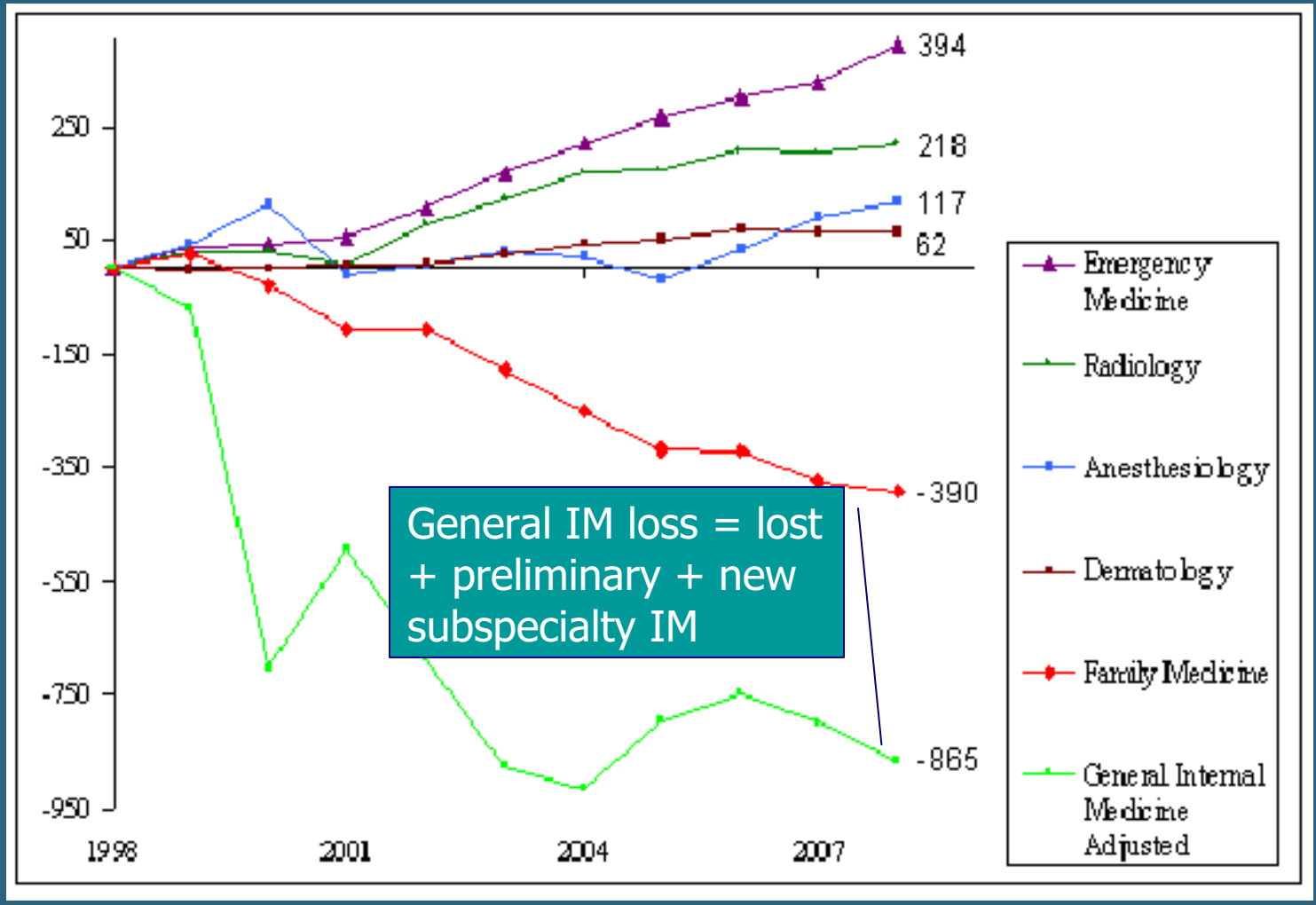
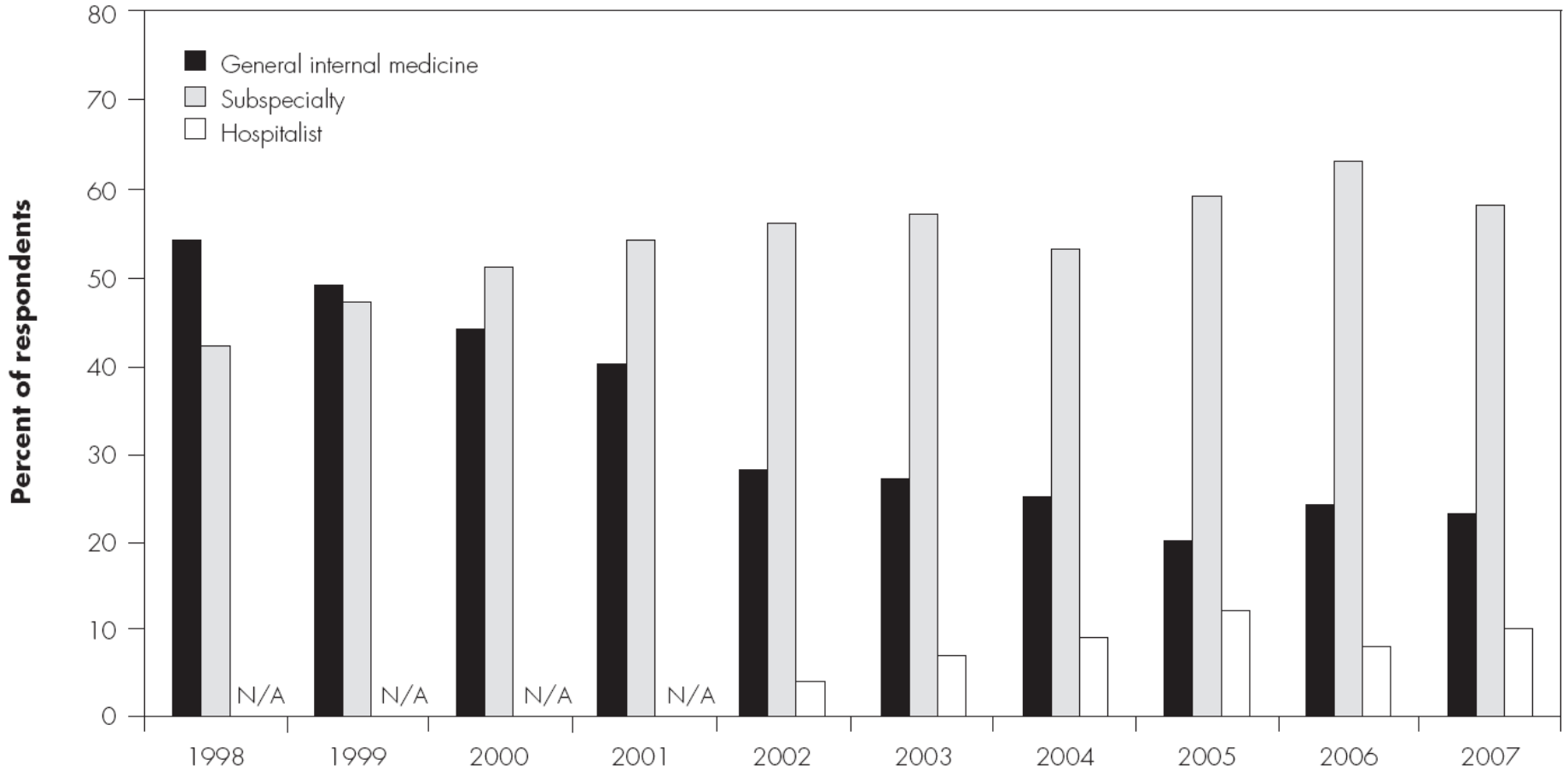


FIGURE 2–2

Proportion of third-year internal medical residents becoming subspecialists or hospitalists is growing



Note: MedPAC June 2008

Source: Bodenheimer, T. 2006. Primary care–Will it survive? *The New England Journal of Medicine* 355:861–864. *Copyright © 2006 Massachusetts Medical Society. All rights reserved.* Updated to include years 2006 and 2007, supplied by Thomas Bodenheimer, who obtained the relevant data from The American College of Physicians.

Residency expansion

- Growth of specialty/subspecialty spots is bleeding primary care
- PC grads could fall to 17% of residency grads in next 5+ years
- COGME: Hospital incentives all wrong, bending GME to their financial needs

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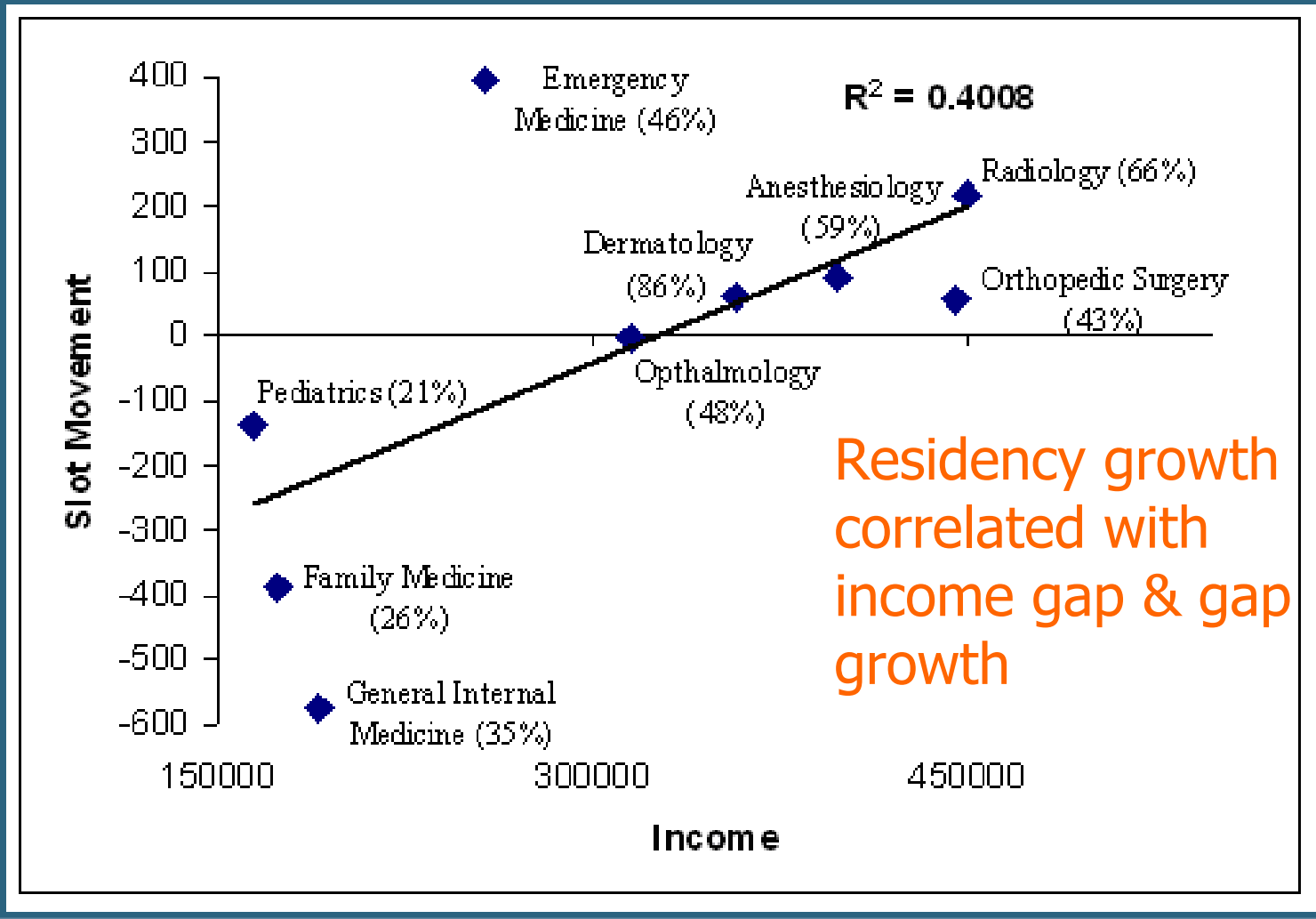
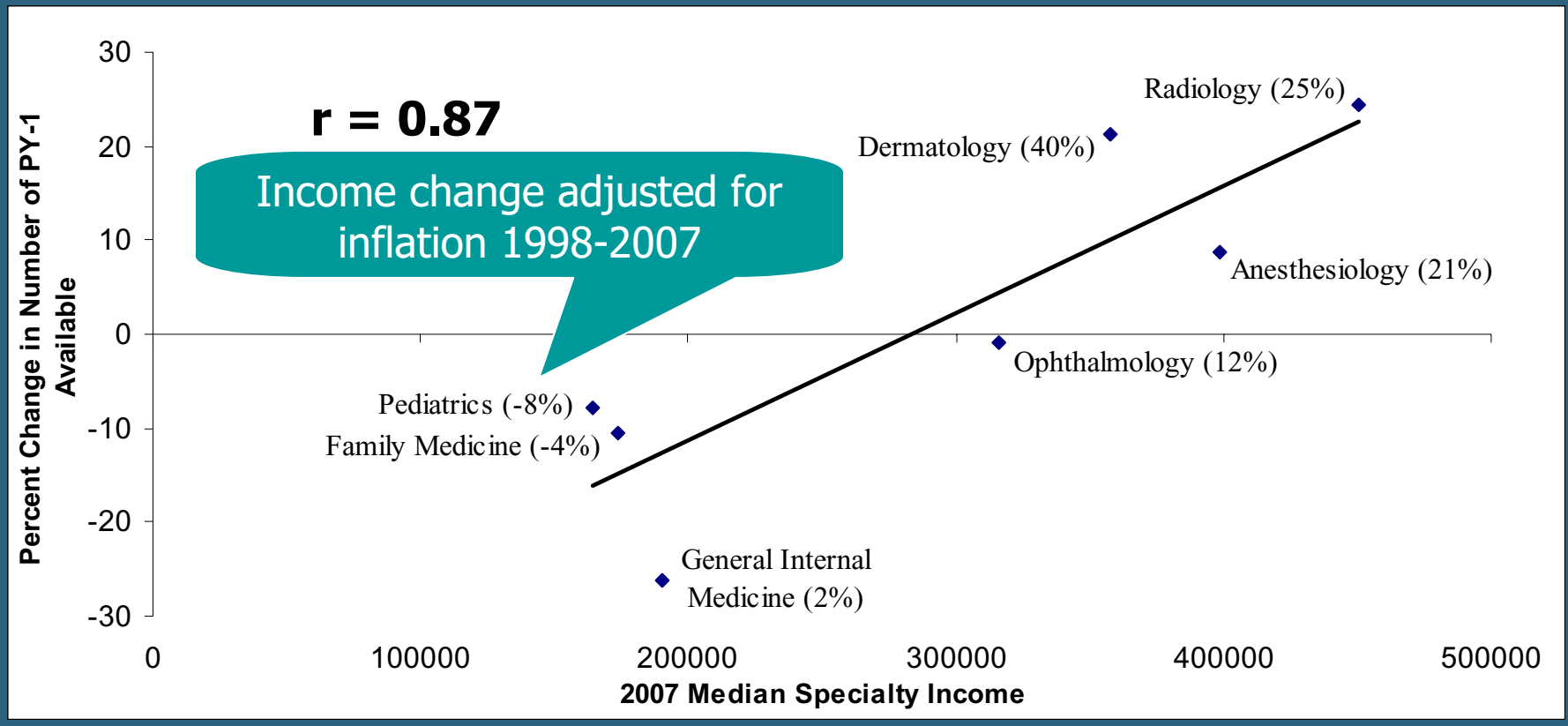
Accounting, not Accountability: follow the money



R.O.A.D Building



Huh?

"Please re-enter your DUNS and select the Send TPIN Letter button. A confidential TPIN letter will be mailed to the CCR POC identified in the TPP for the DUNS number entered. If you are not the POC for this TPP, you should contact the POC or CCR for assistance. Requests for TPIN letters are limited to one per 7-day period."

www.USA.gov

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Why is GME policy failing primary care?

- Legislative authority
  - Funding flow largely tied to Medicare Beneficiary hospitalizations
  - BBA97 authorized DME flow to outpatient settings—but didn't count prior outpatient resident FTE

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Why is GME policy failing primary care?

- Regulation
  - Community preceptor rule
  - No change of hospital for existing programs

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Why is GME policy failing primary care?

- Political Lock
  - No political will to move GME funding into community settings
  - GME expansion bills
    - favor unfunded slots first
    - have loose definitions of primary care

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MedPAC

- "We…find that payments are provided to hospitals without accountability for how they are used or without targeting policy objectives consistent with what Medicare's goals are."
- "Policy makers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them."

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COGME
May 2009 (specific to GME)

- Provide incentives and remove statutory barriers to the establishment and expansion of training venues in non-hospital primary care settings, including rural and underserved settings.
- Mandate accountability for GME funding in order to reshape the incentives for teaching hospitals and academic medical centers to improve the health of the nation.
- Make Graduate Medical Education sites laboratories for innovations in primary care delivery and responsible for producing the next generation of physicians who will work in them.