AcademicHealthCenter
UNIVERSITY OF MINNESOTA

"The Role of the Federal Government in Graduate Medical Education"

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Summary
Academic Health Centers (AHCs) are vital to the nation's health delivery system, research and education enterprise, and economy, but their survival is being threatened by forces in the health care marketplace, major reductions in public and private funding, and the information/communication revolution. The University of Minnesota and other AHCs across the country are responding to these challenges, but federal help is critical to assure high quality education for health care professionals and to enhance the vitality of AHCs for the future. These initiatives include a national trust fund for graduate medical education, demonstration projects, centers of excellence, investments in information systems and databases, access to capital funding, work force benchmarking, and increased accountability.

The Challenges
The University of Minnesota is a public land-grant institution and major research university. The University's AHC serves over 5,000 professional and graduate students in two schools of medicine and schools of nursing, pharmacy, dentistry, public health and veterinary medicine. As one of America's most comprehensive AHCs, our mission is the acquisition and dissemination of knowledge through education, research and service.

The forces operating in health care sector at the national, state and local levels are having a profound affect on our ability to meet our mission and to provide the essential public good we have in the past. These challenges can be summarized as follows:

1) Decreased access to patients for education, research, and faculty practice.

2) Limited competitiveness in contracting for patient care due to the overhead cost of education and research.

3) Reduced clinical revenues for the medical school.

4) Increased demand for major curriculum redesign to reduce the length and cost of education of health professionals and to add new or expanded areas of study such as medical informatics, business skills, preventive health and wellness, epidemiology, outcomes assessment, and quality improvement.

5) Decreased public and private funding for health professional education, particularly at the graduate level.

6) Increased demand for distance communication and network services for education, clinical care, and research.

7) Increased emphasis on outcomes, health systems, and therapeutic effectiveness research without adequate funding and with limited ability to pool data across health systems.

To begin to meet these challenges at the University of Minnesota, we have formed a single integrated group practice for the medical faculty, sold our hospital to Fairview Health Services, a non-profit health system, and developed a preferred education and research affiliation with Fairview.

With respect to education:

1) We recognize the need to train fewer physicians, particularly specialists and subspecialties, nationally. We also recognize the need to train more clinical pharmacists and nurses. In 1996, we instituted a three-year plan to reduce both medical student and graduate medical education (GME) enrollments by 25%. We are strengthening our pharmacy and nursing programs. Over 50% of our graduates enter primary care, and we are nationally known for our rural health training programs.

2) We recognize the need to shift education and training from being primarily hospital-based and focused on individual patients to being more community-based (such as providing training in clinics, nursing homes, and other community sites) and focused on populations and groups as well as individuals. We are redesigning our curriculum to increase the number of clinical pharmacists and nurses we train, promote greater interdisciplinary education and interdisciplinary team care, and incorporate into all the health care disciplines the latest medical and public health technologies and research discoveries.

3) The cost of training a GME physician is approximately $100,000 per year at the University of Minnesota. Medicare and Medicaid pay about 40% of these costs. Our medical students pay $30,000 per year for their education and graduate with an average of $75,000 in debt.

4) The patient care revenues earned by the Medical School clinical faculty pay 35% to 40% of the cost of training a GME physician. Because of the effects of managed care, these revenues are declining at an alarming rate. We estimate a 33% decline between FY1996 and FY2000 in funds available to support

education and research.

5) Managed care is also increasing the costs of GME, as the health systems are starting to request payment for their pro bono teaching work. These costs, estimated at $40,000 per year, would increase the cost of training a GME physician to $140,000 annually.

6) The State of Minnesota currently pays about 20% of the cost of training a GME physician. The 1997 Minnesota Legislature established a state trust fund, administered by the state Commissioner of Health, to help pay for medical education. Additional state funds, however, are very limited.

Current and Future Federal Role

The recently enacted Medicare legislation will reduce health professional education resources even more over the next few years. For the University of Minnesota alone, we estimate the cumulative loss to be in the range of $35 to $40 million for our programs.

The federal government, through the Medicare program, has long recognized its obligation to support graduate medical education. This support has enabled direct access to University specialists and subspecialists and provided quality care that is the best in the world. With the planned budget reductions, who bears the responsibility and accountability for the losses that will occur? This is a particularly important question for states like Minnesota, which have met the primary care challenge, are reducing their enrollments in specialties, and have large rural areas to serve.

Stated another way, who is responsible for paying for medical and health professional education? The State of Minnesota is already providing substantial support, but additional state support is limited. Despite being one of the primary beneficiaries, the managed care industry, with few exceptions, has shown no interest in funding medical education. The sole exception is the Fairview Health Services which, through its new relationship with the University of Minnesota, is making a significant direct contribution to funding medical education in Minnesota.

It is the federal government, however, which has the greatest vested interest in funding medical education to ensure quality care, consistent standards, and a highly trained health care work force. Reductions in federal funding cannot, or will not, be uniformly offset by other sources of support such as state appropriations. These reductions put the U.S. medical profession and various populations throughout the country at great risk.

AHCs have a vital role to play in training, developing, and supporting the nation's health professions work force. Achieving the goals of reducing cost, enhancing curriculum, adjusting the mix and size of the health care work force, and changing the health care delivery paradigm cannot be accomplished without the direct involvement and leadership of the nation's AHCs. But, the current impediments are significant: insufficient resources; a lack of appropriate models for partnering with the community and the health systems; inadequate infrastructure including information systems and networks, and inadequate mechanisms for funding medical education.

Recommendations

We offer several recommendations:

1) Establish a national trust fund for education of health professionals.

2) Maintain GME support through the Medicare program to assure a stable, federal source of funding.

3) Oppose efforts to subject GME programs to an annual appropriations process. This would pit GME against other important federal priorities and could result in a reduction in the federal commitment to GME.

4) Consider options that allow for private as well as public sources of financing to help support GME. Broadening the base of those responsible for funding health professional education, including the managed care industry, recognizes that all patients benefit from the training of physicians.

5) Create a process to match the number of training slots with U.S. health professional work force needs.

6) Create a process for setting benchmarks for the mix and number of the health professional work force.

7) Establish demonstration projects in health professional education, e.g., consortia, public-utility models.

8) Establish centers of excellence for vulnerable, underserved populations and for special services.

In addition, AHCs have always played a major role in basic, clinical, and biomedical research. Reductions in medical education funding will also seriously erode our ability to conduct medical research and translate our discoveries into new and improved treatments.

The current health delivery system has increased the emphasis on health systems, outcomes, and effectiveness research. Continued strong federal financial support through its research granting agencies is essential.

In addition, we recommend the federal government:

1) Permit combined databases that maintain individual confidentiality while allowing aggregate data analysis.

2) Fund major investments in information networks, databases, and systems. These investments are equally essential for education and would also facilitate clinical care.

3) Establish centers of excellence in clinical care and research --centers that include an AHC and one or more health systems.

4) Provide incentives to promote AHC-community-industry research relationships.

5) Provide access to capital for major capital expenditures such as for refurbishing/replacing facilities and for building information systems and networks.