

Foreword 1

Over the past half century, the Federal government has played an increasingly active role in medical education in the United States. Initially, the Federal government provided financial incentives for the construction of medical schools to train more doctors to address a perceived serious shortfall of physicians after World War II. In addition, specific Federal grant programs were authorized to encourage students to pursue careers in primary care disciplines to achieve more balance in the mix of medical specialties. Several subsequent initiatives dealt with problems related to geographic maldistribution of physicians by attempting to encourage more doctors to serve in certain communities, both rural and urban, which have difficulty attracting and retaining health care providers. The Federal government gradually assumed financial responsibility for a major share of the costs of postgraduate medical education – internships and residencies – by enhancing payments for Medicare patients to teaching hospitals.

As these various government initiatives grew in scope and cost, policymakers recognized the need for ongoing, objective information about physician workforce issues. Mixed messages about the number and specialty mix of physicians needed and the existence of barriers to accessing health care were often conveyed to legislators and their staff. Consequently, in 1986, Congress created the Council on Graduate Medical Education (COGME) to advise it and the Executive Branch about these issues. This brochure is a compendium of some of COGME's major activities, issues addressed, and recommendations made to policymakers since its inception. Some of the first issues considered are still problematic and remain unsolved in spite of governmental intervention. It should be noted, however, that, because of constantly changing demographics and the evolution of new technologies, health workforce needs are not static. Nevertheless, because of the cost of medical education to taxpayers and the need to ensure more equitable access to health care for all Americans, the importance of addressing these issues through public and private measures remains a national health policy priority.

This brochure owes its inception to COGME member F. Marian Bishop, Ph.D., Professor and Chairman Emeritus, Department of Family and Preventive Medicine, University of Utah School of Medicine. Dr. Bishop is a nationally recognized expert in the discipline of family medicine. COGME acknowledges with gratitude her vision and efforts to bring this document to fruition.

David N. Sundwall, M.D., Chair
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Background

COGME was created by the United States Congress in 1986 and was reauthorized through September 30, 2002 to:

- provide an ongoing assessment of trends in the nation's physician workforce;
- explore crucial issues related to the training of physicians and financing of graduate medical education;
- advise and make recommendations on these subjects to Congress and to the Secretary of the Department of Health and Human Services.

COGME addresses issues ranging from the size and make-up of the nation's physician workforce to the need to direct physician training to meet the needs of an increasingly diverse population in a rapidly changing health care environment.

COGME develops official reports and issue papers after consultation with leading experts in health care, medical education, and organizations having a similar interest in graduate medical education (GME).

The COGME reports have been widely recognized as making an important contribution to the understanding of physician workforce issues, the development of policies guiding U.S. GME training, the financing of GME, and the delivery of health care. The Council's recommendations are shared with policy leaders in both the public and private sectors to achieve constructive legislative and institutional changes in GME funding and training.

Among the major issues addressed by COGME are:

- The size and mix of the physician workforce
- Facilitating access to physician care
- Financing physician training
- The role of international medical graduates
- Women in medicine
- Minorities in medicine
- Educating physicians for future needs

Size and mix of the physician workforce

Issues:

The growth in the U.S. physician workforce in recent years has outpaced the growth of the general population.

Numerous studies have concluded that the expanding supply of physicians may exceed the number needed to serve the nation's health care needs.

Much of the physician increase has occurred among medical specialties.

Training and maintaining an oversupply of physicians and an unbalanced specialty mix may contribute to the high cost of health care in the U.S.

COGME Recommendations:

Reduce the overall rate of growth of the U.S. physician workforce and increase the proportion of medical graduates entering generalist primary care practices of family medicine, general internal medicine, and general pediatrics.

Use Federal funding to promote training for generalist primary care practice, especially in underserved areas.

These recommendations are based on several factors, including:

Evidence suggests that many communities currently lack adequate numbers of generalist physicians.

Managed care plans, which are enrolling an increasing number of the U.S. population, tend to use more generalists and fewer specialists than those in traditional fee-for-service systems.

Facilitating access to physician care

Issues:

The central paradox of the United States' health system is a shortage amid surplus.

Despite a general oversupply of physicians, access to quality medical care in rural and inner-city areas continues to be a problem because of a maldistribution of physicians.

Access to health care in the United States is affected by where physicians locate.

The tendency of physicians to practice in affluent urban and suburban areas cre-

ates barriers to health care for people living in rural communities and poorer urban neighborhoods.

An increase in the number of people living in areas designated as Health Professional Shortage Areas (HPSAs) and in the number of such shortage areas while the overall ratio of physicians to population has nearly doubled.

The apparently intractable intertwining of the two issues: the geographic maldistribution of physicians and the availability of health insurance.

COGME Recommendations:

Significantly increase the size and funding for the National Health Service Corps, which supports the training and placement of physicians in underserved areas.

Significantly increase funding for community health centers (as defined under P.L. 104-298, the Health Centers Consolidation Act of 1996) and other "safety-net" programs in rural and urban communities.

Continue support for Federal and state programs that have proven to increase

the number of physicians who choose generalist careers and practice in rural and inner-city areas.

Develop more uniform and rational criteria for designating areas as medically underserved in order to permit the most effective targeting of limited resources.

Continue enhanced Medicare payments to rural providers in underserved areas.

Continue experimentation in rural telemedicine.

These recommendations are based on several factors, including: _____

The absence of a broad-based national strategy to ensure universal health coverage makes crucial increased support for the public health delivery system and for programs that encourage physicians to choose generalist careers and practice in underserved areas.

Advances in telecommunication and other communications technologies may provide an opportunity to mitigate some of the disparities in access to health care.

Financing physician training

Issues:

One of the largest sources of funding for GME has been the Federal government through its Medicare program, which provides enhanced payments to teaching hospitals.

Restricting GME payments to hospital-based residencies inhibits the development of ambulatory and community-based training programs.

COGME Recommendations:

Develop an all payer health care plan that distributes more evenly the costs of GME.

Encourage medical schools and teaching hospitals to finance training programs in non-hospital settings to prepare new physicians for today's health care environment.

Use Medicare Direct Medical Education and Indirect Medical Education payments to advance teaching in non-hospital ambulatory settings.

Funding should support the resident at various sites of training.

These recommendations are based on several factors, including:

The belief that GME is a "public good," i.e., training a qualified physician workforce is in the best interests of all of our citizens.

GME funding must have stable and predictable sources of support, regardless of the training setting.

International medical graduates

Issues:

The number of international medical graduates (IMGs) in U.S. residency programs more than doubled between 1985 and 1996, with IMGs accounting for one-quarter of the allopathic residency slots in 1996.

IMGs are more likely to train in residency programs located in medically underserved populations, thus playing a “gap-filling” role in the provision of physician services in the U.S. However, they are not as likely as U.S. medical

graduates to settle in underserved areas.

More than one-third of IMGs are on exchange visitor visas, which require physicians to return to their home country for at least 2 years following their training before applying to reenter the U.S. The number of waivers to this requirement has increased, most based on a claim of a “service need” for the physician in a particular location.

COGME Recommendations:

Eliminate the exchange visitor visa waivers for purely service-related reasons.

Increase the return home requirement from two to five years for IMGs participating in U.S. residency training programs on exchange visitor visas.

These recommendations are based on several factors, including:

The original intent of the exchange visitor program was to permit foreign physicians to acquire advanced training skills to take back to their home countries.

The widely held belief that foreign-born IMGs contribute to an overall abundance of physicians in the U.S. and to the

financial burden on the health care system of training a surplus of physicians.

Gaps in the availability of physician care should be addressed through efforts to promote more U.S. medical graduates to practice in underserved areas.

Women in medicine

Issues:

A number of chronic diseases affecting both sexes are more prevalent in women, and there is a range of medical issues unique to women.

Women's participation in the medical profession has increased dramatically in

the last 30 years. In 1970, women represented 7.7 percent of the physician workforce. Today, representing more than 20 percent of the U.S. physician workforce, women physicians are expected to constitute 30 percent by 2010.

COGME Recommendations:

Address gaps in knowledge of women's health issues through greater funding of medical research targeting these areas.

Support medical accreditation bodies in their efforts to assure that a greater understanding of women's health issues is incorporated into physician training at all levels.

Develop among physicians an increased understanding of cultural issues that affect the provision of health care to women from racial and ethnic minority groups.

Encourage medical schools, academic health centers, and professional societies for physicians to develop explicit programs of leadership development for women physicians.

Encourage medical institutions and societies to develop policies that accommodate the competing demands, especially family responsibilities, placed on women physicians.

These recommendations are based on several factors, including: _____

Women have been underrepresented as subjects of medical research, resulting in inadequate information on women's health issues and on how disease processes differ in men and women.

Although bolstering the number of generalist physicians, the concentration of women in these areas may be due to barriers that limit subspecialty opportunities for them.

About 60 percent of women physicians practice in five areas of medicine: family practice, internal medicine, obstetrics-gynecology, pediatrics, and psychiatry

Women remain underrepresented in higher academic ranks and leadership positions.

Minorities in medicine

Issues:

Minority populations are the fastest growing segments of the U.S. population and will make up 32 percent of the population by 2010 and nearly half the population by 2050.

In 1997, minorities represented approximately 24 percent of the U.S. popula-

tion, but only 12 percent of students enrolled in allopathic medical schools.

According to a number of indicators, minority populations suffer from poorer health status than does the white population.

COGME Recommendations:

Support efforts to incorporate into physician training increased understanding of cultural differences in health needs and approaches to health care among minority populations.

Sponsor collaborative efforts to increase the number of academically prepared minority students, and expose them to science and health career opportunities.

Support Federal programs and initiatives of relevant organizations to increase minority representation in medicine.

Support research to identify and eliminate barriers to the entry of underrepresented minorities into medical and surgical specialties, as well as positions in academic medicine.

Support efforts to enhance minority representation in leadership roles in academic medicine and managed care organizations.

Use Federal funding to foster minority entry into medicine.

These recommendations are based on several factors, including: _____

Shortages of health professionals in minority communities are a factor contributing to the disparity in health status.

Minority physicians are far more likely than white physicians to practice in minority communities and among the underinsured and uninsured.

Despite efforts to increase the minority physician population, white physicians will continue to be the major providers of care to minority populations for the foreseeable future and must be better trained to understand cultural differences within the nation's diverse population.

Educating physicians for future needs

Issues:

The increased delivery of health care in managed care organizations and ambulatory settings demands new skills from physicians.

Health information directed to lay audiences has increased markedly, and patients are becoming increasingly

sophisticated consumers of health care services.

Physicians need to be trained appropriately for medical practice occurring in today's fast-changing health care environment.

COGME Recommendations:

Include in undergraduate and graduate medical education curricula:

Basic principles of health care financing and the characteristics of typical health insurance plans.

Interactive and group process skills that enable physicians to participate effectively in health care teams that include other physicians and non-physician clinicians and administrators.

Skills needed for improved communication with patients who have an increased interest in health issues and in discussing in greater depth issues pertaining to their own health care options.

Disciplines and skills that are basic to contemporary medical practice, such as epidemiology, population-based care, health care policy and systems, disease prevention and health promotion, and computer information skills.

Augment clinical training in teaching hospitals with experience in practice sites representative of the environments in which physicians will eventually practice.

Recruit clinician-teachers from the community practice sites, and more fully integrate them into the design and operation of medical educational programs.

These recommendations are based on several factors, including: _____

Health care is being delivered in increasingly complex systems.

sions related to their health care is increasing.

The role for both non-physician clinicians and team approaches to health care delivery is expanding.

The pace of scientific and clinical advances is rapid, and the role of prevention and health promotion in medicine is expanding.

The number of patients who wish to participate more fully as a partner in deci-

Future Steps

In recent years, Congress has established other advisory bodies which have also been mandated to assess health workforce needs. These include the Medicare Payment Advisory Commission (MedPAC), the National Bipartisan Commission on the Future of Medicare, and other advisory committees in the Public Health Service. Consequently, COGME collaborates with these entities in order to avoid duplication of effort and avoid conflicting recommendations.

Furthermore, although changes in health insurance coverage and legislation may alter results of any of its workforce analyses, COGME has chosen to focus its future activities on the following:

COGME will undertake a more detailed review of changes in the need for physicians generally and of the appropriate mix of generalists and specialists.

COGME will continue to examine the potential impact of such factors as the increase in the supply of non-physician clinicians on physician workforce needs or trends.

COGME will study and report on the financing of GME with an emphasis on strategies for financing training in ambulatory settings.

COGME will assess the impact of the Balanced Budget Act of 1997 on GME.

COGME will examine the reduction in Federal support to specialty GME programs to determine if the reduction adversely affects the participation of under-represented minorities in medical and surgical specialties.

COGME REPORTS

First Report of the Council

Volume I and Volume II (1988)

Second Report

The Financial Status of Teaching Hospitals and the Underrepresentation of Minorities in Medicine (1990)

Third Report

Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century (1992)

Fourth Report

Recommendations to Improve Access to Health Care Through Physician Workforce Reform (1994)

Fifth Report

Women and Medicine (1995)

Sixth Report

Managed Health Care: Implications for the Physician Workforce and Medical Education (1995)

Seventh Report

Physician Workforce Funding Recommendations for Department of Health and Human Services' Programs (1995)

Eighth Report

Patient Care Physician Supply and Requirements: Testing COGME Recommendations (1996)

Ninth Report

Graduate Medical Education Consortia: Changing the Governance of Graduate Medical Education to Achieve Physician Workforce Objectives (June 1997)

Tenth Report

Physician Distribution and Health Care: Challenges in Rural and Inner-City Areas (February 1998)

Eleventh Report

International Medical Graduates, the Physician Workforce and GME Payment Reform (March 1998)

Twelfth Report

Minorities in Medicine (May 1998)

Thirteenth Report

Physician Education for A Changing Health Care Environment (March 1999)

Fourteenth Report

COGME Physician Workforce Policies: Recent Developments and Remaining Challenges in Meeting National Goals (March 1999)

Scholar in Residence Report

Reform in Medical Education and Medical Education in the Ambulatory Setting (1991)

Report to Congress

Process by which International Medical Graduates are Licensed to Practice in the United States (September 1995)

Resource Paper

International Medical Graduates: Immigration Law and Policy and the U.S. Physician Workforce (1998)

Resource Paper

Preparing Learners for Practice in a Managed Care Environment (September 1997)