Graduate Medical Education: The Federal Government's Opportunity to Shape the Nation's Physician Workforce

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Katherine Huang, Graduate Medical Education: The Federal Government's Opportunity to Shape the Nation's Physician Workforce, 16 Yale J. on Reg. (1999).
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Note

Graduate Medical Education: The Federal Government’s Opportunity to Shape the Nation’s Physician Workforce

Katherine Huang†

As a key determinant of health care cost, access, and quality, the physician workforce in the United States has become increasingly scrutinized by policymakers seeking to align workforce supply with health care needs. Graduate Medical Education, a prerequisite for entry into the medical profession, directly shapes the size and distribution of the physician workforce and is also funded largely by federal dollars. By establishing an all-payor trust fund to finance Graduate Medical Education and allocating such funds according to health care demand, the federal government may be able to achieve a physician workforce that can further the nation’s goals of providing access to quality, cost-effective health care.

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Introduction

Since the failure of comprehensive health care reform in 1994, the physician workforce has become the focus of efforts to address the triad of pressing health care issues—cost, access, and quality. Physicians, through the prescription of medical services and technologies, greatly influence the cost of health care. For this reason, the supply of physicians has been closely scrutinized for efficiency. Studies show that a surplus of physicians exists today and that the surplus will grow if the current trend continues. While some policymakers advocate a reduction of the physician workforce in order to contain costs, others believe that decreasing the number of physicians would only exacerbate existing problems of access to quality health care. Rather than curtailing the supply of physicians, they argue that the quality of care would be enhanced by increasing the ratio of primary care physicians to specialists and redistributing physicians to underserved areas.

In a perfect market, physician supply and demand would eventually reach an equilibrium. The U.S. health care system, however, does not operate in a perfect market because of government subsidies and regulations. Thus, the supply of physicians is unlikely to balance the demand without government intervention. Such intervention can occur through controls on a once overlooked aspect of the health care system—Graduate Medical Education.

Graduate Medical Education (GME) is the period of clinical training required of all medical school graduates before they can obtain licensure. Training is provided through residency programs operated by teaching hospitals, academic health centers, and other entities. These residencies serve as the sole entry point into the physician workforce for both domestic and foreign medical school graduates. Even though the primary purpose of residencies is education, residents provide much of the patient care in teaching hospitals and comprise an important group of inexpensive, highly skilled health professionals available to treat vulnerable and poor populations. GME is also the key determinant of the areas of practice into which medical graduates will enter as practitioners.

The federal government is the largest explicit financier of GME, contributing $6.8 billion through Medicare, plus additional sums through

1 See infra notes 6-11 and accompanying text.
2 See infra Section II(C).
the Departments of Defense and Veteran Affairs. Prior to the passage of the Balanced Budget Act of 1997, the federal government did not regulate the training programs it financed. Decades of open-ended subsidies led to unrestrained growth in the number of residencies, with no checks on the types or locations of such programs. Today, increasing scrutiny of the federal budget and the Medicare trust fund has led to demands for withdrawing public support for a process that apparently produces too many physicians, too few generalists, and no solutions to the geographic maldistribution of health care providers. At the same time, private health care payors have become increasingly unwilling to pay the higher fees charged by teaching hospitals to cover their educational expenses. These fiscal pressures have forced Congress, the professional organizations, and the public to take notice of the central role of GME in the health care system.

The education of physicians is a public good for which all users of medical services should be responsible. Such broad-based financial support, however, will be neither justified nor forthcoming if GME and the workforce it produces are not responsive to societal needs. Conversely, GME will not become accountable to the public unless the appropriate financial incentives are established. This Note will address how these two pressures inevitably spiral toward a single solution: an all-payor trust fund to finance GME, accompanied by a publicly accountable allocation mechanism for distributing funded residency positions. An integrated, planned system of GME is a powerful potential solution to the nation's health care problems.

Part I of this Note describes the size and distribution of the physician workforce from the 1960s to the present, and contrasts current workforce supply with demand. Part II discusses the role of GME in the medical profession and the sources of funding for GME. It then describes the current state of GME given fiscal pressures from both the private and public sectors and argues that government funding must be maintained if the nation is to continue training physicians. Part III argues that although the Balanced Budget Act of 1997 was a step in the right direction, further reforms are imperative if GME and its financing sources are to produce an adequate and well-distributed supply of physicians. It then proposes that the best way to achieve this result is through an all-payor trust fund, combined with a centralized mechanism for allocating funded residency

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5 See infra Section II(A).
6 See infra Section II(C).
positions to certain types of programs in targeted geographic areas. Part III cautions, however, that the issue of how to treat resident physicians who graduated from foreign medical schools—the group largely responsible for the growth in the number of physician trainees—must be resolved before such a system can be implemented. Part IV concludes by acknowledging the complexities inherent in the establishment of an all-payor trust fund, but emphasizes the urgent current need to reshape the physician workforce.

I. The Physician Workforce from the 1960s to the Present

The supply of physicians has grown steadily since the 1960s as a result both of direct efforts to increase the number of physicians and the increased capability of the population to pay for health care services. The growth, however, has led to a geographical maldistribution of physicians and to an imbalance between specialists and general practitioners. With current public and private market forces demanding cost containment, emphasizing primary care, and focusing on access to services, policymakers are recognizing that the unrestrained growth of the medical profession has resulted in a workforce that is misaligned with current and forecasted needs.

A. Workforce Supply

In the 1960s and 1970s, the U.S. government and other players in the health care arena responded to a forecasted shortage of physicians by implementing affirmative policies to increase the supply of physicians in the country.7 Increased service demands arising from a robust private health insurance market and the implementation of the Medicare and Medicaid programs8 fueled the concern that the nation’s medical

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8 Medicare (health insurance program for aged persons) and Medicaid (funds for the medical care of certain low-income persons) were established by Titles XVIII and XIX, respectively,
workforce would be inadequate.\footnote{See *Association of Am. Med. Colleges, U.S. Physician Workforce* 2 (1996) [hereinafter AAMC, U.S. Physician Workforce].} Persuaded that a larger number of physicians would directly correlate with increased access to health care, the federal government helped double the number of medical students by expanding both the number of medical schools and their class sizes.\footnote{See *Council on Graduate Med. Educ., U.S. Dep't of Health & Human Servs., Eighth Report, Patient Care, Physician Supply and Requirements: Testing COGME Recommendations* 1 (1996) [hereinafter COGME Eighth Report].} Simultaneously, in order to alleviate the perceived physician shortage as well as to equip foreign physicians with skills to benefit their countries upon their return, the government amended immigration laws to permit graduates of foreign medical schools to train and practice in the United States.\footnote{See AAMC, U.S. Physician Workforce, supra note 9, at 2.}

Efforts to enlarge output from domestic medical schools ceased by 1980, and the number of U.S. medical school graduates has since stabilized at approximately 16,000 per year.\footnote{See id.} The steady stream of international medical graduates entering residencies in the United States, however, has continued unabated, swelling the total number of first-year residents from 18,700 in 1980 to more than 23,400 in 1994.\footnote{See id.}

The federal government’s policies to increase the supply of physicians proved very successful. From 1970 to 1990, the U.S. physician workforce grew at 1.5 times the rate of growth of the general population.\footnote{See COGME Eighth Report, supra note 10, at 1. Patient care physicians are only one subset of active physicians. Active physicians, defined as those who devote 20 or more hours weekly to professional activities, are comprised of patient care physicians (74%); physicians involved in teaching, research, and administration (6%); resident physicians and fellows (16%); and others (4%). See id. at 6. In 1995, the nation had 646,022 active physicians. See *Council on Graduate Med. Educ., U.S. Dep't of Health & Human Servs., Eleventh Report, International Medical Graduates, The Physician Workforce, and GME Payment Reform* 5 (1998) [hereinafter COGME Eleventh Report].} The ratio of patient care physicians to population increased by 65% between 1965 and 1992, from 115 to 190 physicians per 100,000 people.\footnote{See *Institute of Med., The Nation's Physician Workforce: Options for Balancing Supply and Requirements* 2 (Kathleen N. Lohr et al. eds., 1996) [hereinafter The Nation's Physician Workforce].} The implemented programs, however, did not have a similar impact on all segments of the physician workforce. During this period of rapid growth, the imbalance between specialists and general practitioners sharpened due to a variety of incentives that favored specialization.\footnote{See, e.g., Steven A. Schroeder, *Training an Appropriate Mix of Physicians to Meet the Nation's Needs* 68 Acad. Med. 118, 118-19 (1993) (noting that “less than 15% of the graduating classes of 1991 and 1992 . . . intended to pursue generalist careers”). See also infra notes 20-21 and accompanying text.} Before the advent of
managed care, fee-for-service payment systems compensated specialists, who utilized high-tech services and procedures, at a higher rate than generalists, who tended to use less expensive services.\textsuperscript{17} Medical students were also inclined toward specialization because of the type of training received in medical school and the prestige traditionally accorded to specialists.\textsuperscript{18} Additionally, students turned away from generalist practice because it involves more chronically-ill patients and a subsequent high volume of referrals and paperwork.\textsuperscript{19} As a result of these influences, the specialist-to-population ratio increased 121\% between 1965 and 1992, from 56 to 123 specialists per 100,000 people, while the generalist-to-population ratio increased only 65\%, from 59 to 67 generalists per 100,000 people.\textsuperscript{20} This disparate expansion dramatically decreased the proportion of physicians practicing as generalists from 51\% in 1965 to 35\% in 1992.\textsuperscript{21}

It is projected that if the current trends persist, the proportion of physicians in patient care will increase an additional 15\% between 1992 and 2010, from 190 to 219 physicians per 100,000 people.\textsuperscript{22} Assuming that 70\% of medical students in residency training enter specialty practice, as they are doing now, the specialist-to-population ratio will increase another 23\%, from 123 to 152 specialists per 100,000 people, while the number of generalists will remain constant at 67 per 100,000 people.\textsuperscript{23}

Paradoxically, the surfeit of physicians has not equalized the geographic distribution of health care providers. Currently, almost forty-seven million Americans, or one in six people, live in designated Health Professional Shortage Areas (HPSAs), defined as areas with a ratio of 3,500 people to one full-time equivalent primary care physician.\textsuperscript{24} In 1995, 62.7\% of the rural counties in the nation were designated as HPSAs.\textsuperscript{25}

\begin{footnotesize}
\begin{enumerate}
    \item[17] See id.
    \item[18] See id.
    \item[19] See id.
    \item[20] See COGME EIGHTH REPORT, supra note 10, at 1.
    \item[21] See COGME EIGHTH REPORT, supra note 10, at 1.
    \item[22] See id.
    \item[23] See id.
    \item[24] See COUNCIL ON GRADUATE MED. EDUC., U.S. DEP'T OF HEALTH & HUMAN SERVS., TENTH REPORT, PHYSICIAN DISTRIBUTION AND HEALTH CARE CHALLENGES IN RURAL AND INNER-CITY AREAS 2, 6 (1998) [hereinafter COGME TENTH REPORT]. The number of full-time equivalent physicians is determined by weighting the number of physicians according to each physician’s level of productivity, as measured by the standard criteria established by the American Medical Association. Thus, for example, a resident physician is assumed to be less productive than a practicing physician, and is therefore counted as a fraction of a full-time equivalent physician. See COGME, EIGHTH REPORT, supra note 10, at 6-7.
    \item[25] See id. at 2. While 20\% of the population live in rural areas, only 9\% of the nation’s physicians practice in rural areas. See id. at 11. Although physician supply in rural areas has grown rapidly over the last twenty years, rural physician supply remains very low when compared to urban supply. See id. at 11-12. The urban supply, however, is in great excess of service needs. This means that some rural areas, usually the most populated ones, may have near-optimal physician-to-population
\end{enumerate}
\end{footnotesize}
With an additional 893 urban HPSAs,²⁶ 3,000 new practitioners would be needed to satisfy the primary care physician demand in shortage areas.²⁷ The geographic imbalance of physicians is exacerbated by the overwhelming number of specialists, since specialists are often unavailable to, or incongruous with, the medical needs of underserved populations.²⁸

The rapid rate of expansion of the total physician workforce and the disproportionate increase in the supply of specialists alarmed the public and private sectors as they realized the negative implications of these trends. Evidence suggests that an oversupply of physicians makes the system more expensive and thus inhibits efforts at cost containment.²⁹ An excessive number of specialists, in particular, inflates health care costs since specialists use more technologically advanced equipment, conduct more expensive procedures,³⁰ and have larger incomes than generalist physicians.³¹ An imbalance between primary care physicians and specialists also has adverse effects on the quality of patient care. An inadequate supply of primary care physicians can lead to poor coordination of care, leaving patients to be treated as a collection of disjointed ailments instead of as a whole. Finally, an oversupply of physicians can substantially reduce the employment opportunities of many well-trained practitioners and force them to practice outside their areas of competence.³² This waste of human capital negatively impacts the physicians themselves, as well as the taxpayers who help finance their education.³³
After decades of permitting and encouraging growth in the physician supply, the government and private sectors were faced with the impacts of the physician surplus that had resulted. The size, specialization, and geographic distribution of the physician workforce were no longer congruous with the nation's medical service needs.

B. Workforce Demand

In 1986, Congress established the Council on Graduate Medical Education (COGME) to examine workforce demands in the current and future health care environments.\(^{34}\) COGME predicts that in the year 2000—assuming a health care system dominated by managed care, capitated financing, utilization controls, and emphasis on primary care—the generalist physician demand will lie within a range of sixty to eighty generalists per 100,000 people.\(^{35}\) COGME also predicts that 85 to 105 specialists per 100,000 people will be required for efficient patient care.\(^{36}\) These figures translate into a workforce of 165 patient care physicians per 100,000 people, composed of approximately 42% generalists and 58% specialists.\(^{37}\) In comparison to the forecasted need, COGME projects that current trends will result in 203 patient care physicians per 100,000 people, with a mix of 31% generalists and 69% specialists.\(^{38}\) In summary, comparing forecasted need with the available supply suggests that the nation has "a moderate need for more generalists and a substantial surplus of specialists."\(^{39}\)

The disjunction between requirements and existing supply was fueled by the infusion of federal dollars into GME, which provided financial incentives for expanding physician training without regard for the numbers, types, and locations of health professionals being produced.

\(^{34}\) See COGME EIGHTH REPORT, supra note 10, at v.

\(^{35}\) See id. at 2.

\(^{36}\) See id. These numbers were derived from a landmark study conducted by the Graduate Medical Education National Advisory Committee (GMENAC), which defines physician need according to the prevalence of disease and necessary medical services. The numbers are also derived from four other demand-based studies. The four demand-based studies project future physician demand based on current utilization rates, projected population increases, and specific assumptions about the health care delivery system. These four studies incorporate different measures and are based on assumptions about varying degrees of managed care penetration in the future health care system. For a detailed analysis of each of the above studies, see id. at 8-11.

\(^{37}\) See id. at 2.

\(^{38}\) See id.

\(^{39}\) Rivo & Kindig, supra note 21, at 895; see also Marc L. Rivo et al., Managed Health Care: Implications for the Physician Workforce and Medical Education, 274 JAMA 712, 714 (1995) (emphasizing that in light of the growth of managed care, the proportion of generalists should be increased).
II. Graduate Medical Education

GME is the period of on-the-job training that is required of all medical school graduates before they can obtain licensure. GME takes place through residency programs run by teaching hospitals, academic health centers, or other health care facilities. Because GME is the sole entry point into the medical profession, the numbers of residency programs and residents they train are directly correlated to the supply of physicians in the nation. The number of residents produced by the system of GME has grown steadily due to several factors. Residents serve as inexpensive providers of health care, giving hospitals an incentive to expand their residency programs. Simultaneously, because the mechanism for financing GME was not regulated, there were no restrictions on the numbers and types of residents being trained. As a result, hospitals were free to expand their training programs. Funds from Medicare, the largest single supporter of GME, also exceeded the actual costs of GME, thus providing the hospitals a strong financial incentive to expand their residency programs. The confluence of these forces produced an explosion in the number of residents being trained and the consequent oversupply and imbalance of the physician workforce. Recently, however, public and private payors of health care have refused to support a system of GME that produces a physician workforce unable to meet the need for generalists across the nation and providers in underserved communities. Nevertheless, the government has recognized that it could not completely withdraw all support for GME and leave GME to the free market because of the continued need to ensure financing of physician training. Instead, the government, through the Balanced Budget Act of 1997, has implemented changes and restrictions in its financing of residency programs, thereby marking its first attempt to align physician supply with demand.

A. Growth in GME

GME residency programs have experienced steady growth as a result of the aforementioned efforts to increase physician supply. The number of physicians in training has increased continuously by approximately 4%
per year since 1988.46 In the 1995-1996 academic year, the total number of residents in allopathic programs was 104,612,47 reflecting a 26.4% increase from the 1988-1989 academic year.48

Most of the growth in residency programs is attributable to the influx of graduates of foreign medical schools into U.S. residency programs. Such an influx is aided in part by immigration laws which permit foreigners to enter the United States on exchange visas and to obtain waivers to remain for permanent residence in certain underserved areas.49 The J-1 visa is issued to exchange visitors to provide them with professional or technical training in order to expand knowledge and improve skills in their home countries.50 While the proportion of allopathic residents who are U.S. medical school graduates (USMGs) decreased from 86% in 1989 to 74% in 1996, the share of international medical school graduates (IMGs) increased from 14% to 26%.51 The number of first-year residency positions filled by IMGs has increased to 140% of the number of USMGs.52 However, less than 40% of IMGs are in the country on J-1 exchange visas.53 Thirty percent of IMGs are permanent residents, 9% are

46 See THE NATION'S PHYSICIAN WORKFORCE, supra note 14, at 3.
47 Osteopathic programs contribute an additional 5,700 residents. See Rivo & Kindig, supra note 21, at 892. For a general comparison of allopathic physicians and osteopathic physicians, see 1998-99 OCCUPATIONAL HANDBOOK, supra note 40. Allopathic physicians (those with M.D. degrees) and osteopathic physicians (those with D.O. degrees) attend separate schools, but both groups may use diagnostic tools and employ treatments, including surgery. The difference between the two is that while allopathic physicians emphasize treatment by producing a condition antagonistic to the illness, osteopathic physicians emphasize treatment by focusing on normal body mechanics and structures. See DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1202 (28th ed. 1994). Osteopathy focuses particularly on the musculoskeletal system, preventive medicine, and holistic patient care. See 1998-99 OCCUPATIONAL HANDBOOK, supra. Allopathic and osteopathic physicians may train in the same residency programs. Osteopathic residents comprised only 3.1% of all first-year residents in 1998, with allopathic residents comprising the large remainder, 96.9%. See Marvin R. Dunn et al., Graduate Medical Education, 1997-1998, 280 JAMA 809, 811 (1998).
48 See COGME ELEVENTH REPORT, supra note 15, at ix.
49 See 22 C.F.R. § 514.27 (1998). Exchange visitors are required to return to their countries of origin after training and may not reenter the United States permanently for at least two years. See id. This requirement can be waived if a federal agency requests the waiver. See id. In 1992, the U.S. Information Agency approved all 486 waiver applications it received. See John K. Iglehart, The Quandary Over Graduates of Foreign Medical Schools in the United States, 334 NEW ENG. J. MED. 1679, 1681 (1996). In 1995, 1,580 applications were approved while seventeen were denied. See id. The U.S. Information Agency estimates that at least 95% of waiver applications were filed on behalf of foreign physicians. See id. The U.S. Department of Agriculture submitted 41% of the applications in 1995, mostly on behalf of rural communities and hospitals trying to attract foreign physicians. See id. Although the law explicitly states that exchange visitors are to serve as vehicles for cultural exchange only and not as physicians to fill hospitals' staffing needs, see 22 C.F.R. § 514.27, hospitals have indicated that the "willingness of foreign students to come to the United States for advanced study was an unexpected but happy conjunction with their need for physician personnel." COGME ELEVENTH REPORT, supra note 15, at 12.
50 See 22 C.F.R. § 514.27 (1998).
51 See COGME ELEVENTH REPORT, supra note 15, at ix.
52 See COGME EIGHTH REPORT, supra note 10, at 1.
53 See INTERNATIONAL MED. GRADUATES SECTION GOVERNING COUNCIL, AM. MED. ASS'N., PROMOTING DIVERSITY IN MEDICINE (visited Nov. 22, 1998) <http://www.ama-assn.org/mem-
U.S. citizens by birth, and another 9% are naturalized citizens. Studies show that 70-75% of all IMGs ultimately remain in the United States to practice. In 1995, 23.8% of the total active physician workforce were IMGs.

Residency training is provided by approximately 7,600 programs accredited by the Accreditation Council on Graduate Medical Education (ACGME). These programs are located at more than 1,300 teaching hospitals and a wide variety of nonhospital institutions. GME is concentrated in hospitals located in urban metropolitan areas, most of which have close relationships with medical schools. Approximately half of the institutions engaged in residency programs are nonprofit teaching hospitals; the other half are owned by state, county, or municipal governments, with varying degrees of affiliations with medical schools.

The demands resulting from growing numbers of uninsured patients, combined with pressures to reduce costs from the competitive health care marketplace, have driven teaching hospitals to rely upon resident physicians as relatively inexpensive providers of high-quality service. Today, some teaching hospitals would arguably be unable to continue caring for vulnerable populations, particularly in rural and inner-city areas, without their residents. The continued financing of GME is thus essential to both the future quality and size of the physician workforce and the satisfaction of the health care needs of disadvantaged populations.

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54 See id. The remaining IMGs are in the country as temporary visitors, students, temporary workers, refugees, or other types of non-immigrant persons. See Dunn et al., supra note 47, at app. 2, tbl.6. Applications from U.S.-citizen IMGs rose from 735 in 1995 to 1,467 in 1997, but the acceptance rate fell from 49.8% to 43.5%. For noncitizen IMGs, applications rose from 5,675 in 1995 to 8,090 in 1997, but the match rate plunged from 50.5% to 34.5%. See Mike Mitka, Match Continues Move Toward Primary Care, AM. MED. NEWS, Apr. 14, 1997, at 1.


56 See COGME ELEVENTH REPORT, supra note 15, at 5.

57 See Dunn et al., supra note 47, at app. 2, tbl.1. A total of 240 of these programs offer combined specialties. See id. These numbers represent programs in operation as of August 1, 1997.


59 See Linda E. Fishman, What Types of Hospitals Form the Safety Net?, 16 HEALTH AFF. 215, 219-20 (1997). Approximately 202 hospitals trained 54% of all residents in 1994. More than 60% of teaching hospitals are in the Northeast, Middle Atlantic, and Great Lakes regions, and 12% of all residents are trained in New York City. See id.

60 See id. at 220.

61 See id. at 220-21.

62 See AAMC, U.S. PHYSICIAN WORKFORCE, supra note 9, at 2-3.

63 See id.
B. GME Financing

The most important factor in the explosion of residency positions has been the method by which GME is financed to meet the average annual per-resident cost of $73,000. The Department of Defense and the Veterans Administration contribute $1 billion, or 13%, of the direct funding for GME. The remaining funds are derived from patient service revenues generated from private payors and Medicaid combined (57%), Medicare (34%), and other sources (9%). Although private insurers do not explicitly pay for the costs of GME, they do pay the teaching hospitals’ higher fees, which arise due to the additional expense of operating educational programs. Medicaid funds are used to fund GME on a state by state basis, with states retaining discretion over the use of the funds. The federal government then, through Medicare, is the single largest explicit supporter of GME.

Prior to 1983, Medicare implicitly subsidized GME by paying the teaching hospitals’ higher service fees. When Medicare shifted from fee-for-service to the prospective payment method in 1983, Medicare implemented payments specifically designed to fund the costs of operating training programs which also cared for patients. Medicare’s direct medical education (DME) payments cover residents’ stipends and fringe benefits, a portion of teaching faculty salaries, administrative expenses, costs of sleeping rooms and supplies, and other overhead costs attributed to residency programs. The indirect medical education (IME) payments reflect the extra costs of patient care in teaching hospitals due to the fact that teaching hospitals care for severely ill patients, experience lower staff productivity, and order additional diagnostic tests as part of the residents’

64 See Braddom, supra note 41, at 340.
65 See id.
66 See id.
67 See, e.g., PHYSICIAN PAYMENT REVIEW COMM’N, 1997 ANNUAL REPORT TO CONGRESS 387 (1997). Adjusting for differences in case mix, labor costs, and location, the costs of teaching hospitals are approximately 25% higher than those of nonteaching hospitals. See Kenneth E. Thorpe, The Health System in Transition: Care, Cost, and Coverage, 22 J. HEALTH POL. POL’Y & L. 339, 353 (1997). The approximate annual cost of teaching, research, and clinical innovation at academic health centers and teaching hospitals is $18.1 billion and accounts for 28% of their total costs. See Samuel Thier & Nannerl Keohane, How Can We Assure the Survival of Academic Health Centers?, CHRON. OF HIGHER EDUC., Mar. 13, 1998, at A64; see also JAMES REUTER, THE FINANCING OF ACADEMIC HEALTH CENTERS 12 (1997) (noting that in comparison to large urban nonteaching hospitals, the indirect costs of teaching add about $2,681 per case, or 27.7% of total cost per patient, in academic health centers and $706 per case, or 10.6% of total cost, in all other teaching hospitals); James Reuter & Darrell Gaskin, Academic Health Centers in Competitive Markets, 16 HEALTH AFF. 242, 247 (1997) (finding that academic health centers are approximately 30% more expensive than their nonteaching competitors, even after the patient case-mix differential has been removed).
68 See Braddom, supra note 41, at 340.
69 See REUTER, supra note 3, at 1.
70 See id. at 1-2.
71 See Braddom, supra note 41, at 340.
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learning process.\textsuperscript{72}

DME payments for each hospital are based on inflation-updated resident costs in 1984, multiplied by the number of residents in the hospital’s programs.\textsuperscript{73} Medicare then pays a proportion of this sum equal to the number of inpatient days utilized by Medicare beneficiaries.\textsuperscript{74} Medicare’s IME adjustment is based on the ratio of the number of full-time equivalent residents to the number of hospital beds.\textsuperscript{75} Medicare’s direct payments for GME totaled $2.2 billion in 1997—47% more than in 1990, while indirect payments totaled $4.6 billion—84% more than in 1990.\textsuperscript{76}

With essentially no limits, Medicare’s funding mechanisms served as a lucrative financial incentive for hospitals to increase the numbers of residents being trained. As residents provided patient care at low costs to the hospitals, they also drew in federal dollars, which hospitals used to subsidize expenses that were not directly related to educational programs.\textsuperscript{77} Furthermore, teaching hospitals were free to accommodate residents interested in specialization without suffering any loss in funding.\textsuperscript{78} The result was an explosion in the number of residency positions,\textsuperscript{79} particularly in urban areas where the need for providers was great and the ability to attract residents was high.\textsuperscript{80}

\textsuperscript{72} See id. at 340, 342.
\textsuperscript{73} See id. at 341. The formula for calculating DME payments is as follows: (1) The direct costs per resident in fiscal year 1984 is used as the base-year amount per resident; (2) The base-year amount is updated for inflation; (3) The updated per-resident amount is multiplied by the number of residents in the current year; and (4) This amount is then multiplied by the proportion of the hospital’s inpatient days that are used by Medicare beneficiaries. See id. Legislation in 1993 reduced DME payments by half for any residents still in training beyond the minimum number of years required for initial board certification, or five years, whichever comes first. See id. at 340. Since 1987, hospitals have been permitted to count the time residents spend in nonhospital settings, but such time must be part of the educational program and the hospital is obligated to pay the resident’s salary during the time spent outside the hospital. See id. at 341.
\textsuperscript{74} See John K. Iglehart, Medicare and Graduate Medical Education, 338 NEW ENG. J. MED. 402, 403 (1998).
\textsuperscript{75} See id.
\textsuperscript{76} IME payments are calculated from a curvilinear statistical formula that increases payments as the ratio of residents to hospital beds increases. See Braddom, supra note 41, at 342.
\textsuperscript{77} See generally John K. Iglehart, The American Health Care System: Teaching Hospitals, 329 NEW ENG. J. MED. 1052, 1052-53 (1993) (discussing how teaching hospitals use revenues from patient care and GME payments to cross-subsidize their multiple missions, such as patient care, indigent care, research, and physician training).
\textsuperscript{78} See REUTER, supra note 3, at 8.
\textsuperscript{79} See id.
\textsuperscript{80} See Rivo & Kindig, supra note 21, at 892. A highly disproportionate number of residents train in the Northeast. See id. The five states with the largest numbers of residents are Connecticut, Massachusetts, New York, Pennsylvania, and Rhode Island, each training more than 57 residents per 100,000 people. See id. The state of New York alone trains 84 residents per 100,000 people. See id. IMGs are also unevenly distributed. See id. In 1993, 56% of IMGs began their training in one of five states (Illinois, Michigan, New York, New Jersey, or Pennsylvania), thereby accounting for 45% of all first-year residents in those states. In all other states, IMGs represent only 19% of all first-year residents. See id.
C. Increasing Fiscal Pressures and Calls for Reform

The unbridled expansion of residency programs led directly to the existing physician surplus, specialty imbalance, and geographic maldistribution of practitioners. These conditions sparked strong criticism calling for reform in the financing of GME. A brief discussion of the different concerns and recommendations follows.

In light of the increasingly competitive health care market, managed care organizations and other payors began refusing to pay the higher fees required by teaching hospitals to cover the expenses of their residency programs. These payors began withdrawing their patients from such hospitals and bargaining for prices comparable to hospitals without residents, thereby threatening to deprive teaching hospitals of the patient base and the revenues needed to operate as educational institutions. Concurrently, the managed care industry complained that residents were not receiving adequate instruction in nonhospital institutions and, with its emphasis on primary care and ambulatory settings, refused to continue

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81 Residency programs have a direct correlation to physician supply because physicians may obtain licensure only after completing a residency program. Similarly, residency programs are directly correlated to specialty imbalance because physicians may obtain board certification in a specialty only after completing a residency program in that specialty. See 1998-99 OCCUPATIONAL HANDBOOK, supra note 40. The relationship between geographic maldistribution of physicians and the uneven distribution of residency positions is not as clear, but studies show that 51% of physicians practice in the state in which they completed their residency training. See Sarena D. Seifer et al., Graduate Medical Education and Physician Practice Location: Implications for Physician Workforce Policy, 274 JAMA 685, 687 (1995). Moreover, training in a state with many residents does not correlate with an increase in exportation of physicians out of that state; states that train more residents subsequently retain more physicians. See id. at 689. In addition, generalists are somewhat more likely than specialists to remain in the state in which they obtained their GME. See id. at 688. Greater exposure to underserved populations during residency training is also likely to result in continued interest in practicing in shortage areas. See COGME TENTH REPORT, supra note 24, at 37-38. Thus, there is a correlation between the location of residency programs and physician distribution.

82 See, e.g., Reuter & Gaskin, supra note 67, at 242. Managed care entities had some success in driving down fees by forcing teaching hospitals to aggressively cut their costs. For example, from 1990 to 1993, GME spending grew by 21% in areas with high HMO penetration, compared to 36% in areas with less competition from HMOs. See REUTER, supra note 3, at 6; see also Reuter & Gaskin, supra at 250-51.

83 See, e.g., Reuter & Gaskin, supra note 67, at 249. However, preliminary data suggests that loss of market share does not have a negative effect on the financial status of academic health centers. Notwithstanding lower occupancy levels, academic health centers seem to be maintaining their overall operating margins. Between 1989 and 1994, despite the fact that health maintenance organization enrollees and occupancy declined from 80.5% to 75.9%, average margins increased from 2.0% to 3.7%. See id. at 250. Academic health centers have been able to maintain favorable operating margins because of their ability to slow the rate of growth in their costs; rising Medicaid disproportionate-share payments from states; and Medicare's IME payments, which have generally exceeded the costs of treating Medicare beneficiaries. See id. at 249-51.

84 Ambulatory care sites deliver outpatient care and include community health centers, private doctors' offices, rural health clinics, ambulatory care sites of managed care organizations, hospital-based faculty practices, and free-standing outpatient care centers. See Jerome P. Kassirer, Redesigning Graduate Medical Education—Location and Content, 335 NEW ENG. J. MED. 507, 507 (1996).
supporting a process which produced physicians ill-suited to its needs.\(^8^5\)

As private support eroded, public sources of funding for GME became the target of criticism. Medicare’s funding of GME was blamed for causing, at an annual price of $7 billion, an oversupplied, unevenly distributed workforce composed of too many specialists.\(^8^6\) Policymakers noted that Medicare margins were higher for teaching hospitals than for other hospitals and that, in particular, the formula for determining IME payments was compensating teaching hospitals in excess of the actual indirect costs of treating Medicare patients.\(^8^7\) Like the managed care organizations, critics argued that Medicare’s support of excess training enabled teaching hospitals to depend on residents for patient care, thereby impeding efforts to separate and independently fund uncompensated care.\(^8^8\) In addition, supporters of reform indicated that the exclusion of the time residents spent in nonhospital settings from the calculation of IME payments created a significant disincentive for hospitals to provide the ambulatory care training integral to physicians practicing in today’s health care environment.\(^8^9\)

The sharp criticism of GME, together with teaching hospitals’ protest of their financial difficulties, led the Council on Graduate Medical Education (COGME), legislatively mandated to advise Congress and the Secretary of Health and Human Services,\(^9^0\) to promulgate a series of recommendations.\(^9^1\) The main goals of the COGME recommendations were to reduce the number of residency positions to 110% of the number of USMGs and to produce a workforce of 50% generalists and 50% specialists.\(^9^2\) These goals were to be achieved by eliminating Medicare.

\(^8^5\) See Iglehart, supra note 77, at 1052-1054. See also Marsha R. Gold, Effects of the Growth of Managed Care on Academic Medical Centers and Graduate Medical Education, 71 ACAD. MED. 828, 835-36 (1996) (discussing managed care plans’ perceptions that teaching hospitals are training the wrong types of physicians with the wrong skills).

\(^8^6\) See Hearing on Graduate Medical Education Before the Senate Comm. on Finance, 105th Cong. (May 12, 1997), available at <http://www.hcfa.gov/testimony/gme3l2/htm> (statement of Bruce C. Vladeck, Adm’r, Health Care Fin. Admin.).

\(^8^7\) See id.

\(^8^8\) See AAMC, U.S. PHYSICIAN WORKFORCE, supra note 9, at 3; John K. Iglehart, supra note 49, at 1679.

\(^8^9\) See Kassirer, supra note 84, at 508.

\(^9^0\) See COGME ELEVENTH REPORT, supra note 15, at v.

\(^9^1\) See generally COUNCIL ON GRADUATE MED. EDUC., U.S. DEP’T OF HEALTH & HUMAN SERVS., FOURTH REPORT, RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE THROUGH PHYSICIAN WORKFORCE REFORM (1994); COUNCIL ON GRADUATE MED. EDUC., U.S. DEP’T OF HEALTH & HUMAN SERVS., COGME’S 1997 RECOMMENDATIONS TO THE CONGRESS AND THE SECRETARY OF HEALTH AND HUMAN SERVICES ON GRADUATE MEDICAL EDUCATION PAYMENT REFORM (1997) (hereinafter COGME 1997 RECOMMENDATIONS); see also Rivo & Kindig, supra note 21, at 89 (assessing the nation’s progress towards achieving COGME’s goals). However, COGME notes that even if its goals of reducing residency positions and raising the proportion of generalists are met, the nation will still have approximately 87,000 specialists in excess of demand and 8,000 generalists below demand. See COGME EIGHTH REPORT, supra note 10, at 3.

\(^9^2\) See id.
funding for new IMGs entering the country on exchange visas, revising the temporary visa programs to reduce the number of IMGs remaining in the United States, capping the number of funded residencies, providing funding for ambulatory care training, and supporting education programs in shortage areas.\textsuperscript{93}

Also recognizing that the era of unrestrained, free-for-all explosion of GME had come to an end, six national professional organizations united to issue a Consensus Statement on the Physician Workforce.\textsuperscript{94} Together, they asserted that:

To decrease the rate of physician supply, limits must be placed on the number of medical school graduates entering GME. Since the federal government currently plays a major role in financing GME and is responsible for establishing immigration laws that affect IMG participation in GME in this country, it is imperative that the federal government partner with the medical education community to achieve this goal.\textsuperscript{95}

The significance of the Consensus Statement lies in the fact that medical organizations, historically powerful and distinctively autonomous groups,\textsuperscript{96} requested government intervention in their activities.\textsuperscript{97} With the goal of decreasing physician supply by constraining GME, the Consensus Statement recommended limiting federal funding to the number of GME

\textsuperscript{93} See generally COGME 1997 RECOMMENDATIONS, supra note 91.
\textsuperscript{94} AMERICAN ASS'N OF COLLEGES OF OSTEOPATHIC MED. ET AL., CONSENSUS STATEMENT ON THE PHYSICIAN WORKFORCE (1997) [hereinafter, CONSENSUS STATEMENT].
\textsuperscript{95} Id. at 1.
\textsuperscript{96} See generally PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (describing how the medical profession rose to its state of insular dominance and independence in American society).
\textsuperscript{97} While the medical profession in general agrees that a surplus of physicians is not beneficial to society, its call for regulation may be motivated in part by the view that residents are future competitors for a limited market share. Already, employment opportunities appear to be decreasing. See Itzhak Jacoby & Gregg S. Meyer, Creating an Effective Physician Workforce Marketplace, 280 JAMA 822, 823 (1998). The authors refer to studies which have found that, in some specialties, up to 10\% of residents completing training in 1995 could not secure a full-time position in their specialty. See id. In 1996, up to 7.1\% of surveyed residents were not able to find employment and 22.4\% of residents reported "significant difficulty" in securing a position. This data led the authors to conclude that "we are beginning to see the emergence of a real surplus, defined as a lack of job opportunities." Id. at 823. This trend is confirmed by the steep decline in recruitment advertisements in professional journals. See Sarena D. Seifer et al., Changes in Marketplace Demand for Physicians: A Study of Medical Journal Recruitment Advertisements, 276 JAMA 695, 696-97 (1996). The study found sharp declines in the number of advertised positions for specialist physicians over the past five years. See id. In 1990, there were four specialist positions for every generalist position advertised. By 1995, this ratio had dropped to 1.8. See id. Nevertheless, family medicine positions continued to grow and in fact doubled from 1990 to 1995. See id. at 697. Another factor pointing to these competitive pressures is the finding that aggregate physician incomes declined in 1994 for the first time since income statistics began to be collected in 1982. See Carol J. Simon & Patricia H. Born, Physician Earnings in a Changing Managed Care Environment, 15 HEALTH AFF. 124, 124 (1996).
positions sufficient to accommodate all USMGs; allowing IMGs to train in the United States without paying for IMGs’ residency positions from Medicare or other GME funds; ensuring that IMGs return to their countries of origin after training; implementing federal incentives to encourage students to pursue careers as generalists, particularly in rural and inner-city communities; establishing a national all-payor fund as a stable source of GME funding; directly paying the entities that incur the costs of GME, even if they are not hospital-based; providing transitional funds to hospitals that lose residency positions; and commissioning a national physician workforce advisory body, legislatively mandated but staffed independently of government agencies, to monitor the workforce size and composition.98

With the professional organizations’ Consensus Statement, it became clear that GME can no longer be ignored but rather is an integral part of the problem of physician supply. Both public and private payors of health care are no longer willing to fund the training of physicians without some reassurance that these physicians will be able to meet their service needs. The question is not whether GME should be reformed, but how such reforms should be implemented.

D. The Case Against the Free Market Approach

While the professional organizations advocate more government involvement in GME in order to solve the surplus and maldistribution problems of the physician workforce, some policymakers argue that a free market without any government intervention—or funding—will resolve these problems. They contend that, as with any other free market, the health care system will eventually adjust physician supply to correlate with demand.99 This argument is flawed, however, because it rests on the false premise that the health care system operates in a free market. The argument also ignores the public-good character of GME and the effects that the lack of subsidies would have on the educational and social mission of GME.

Proponents of the market approach argue that the health care system has become market driven, with capitation as the increasingly predominant financing mechanism. Thus, the costs of physician oversupply and of artificial-expense inflation through overutilization of services will be borne by the physicians themselves, and no longer by the payors.100 They garner

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98 See CONSENSUS STATEMENT, supra note 94.
99 See generally Spencer Foreman, Managing the Physician Workforce: Hands Off, the Market is Working, 15 HEALTH AFF. 243 (1996); Uwe E. Reinhardt, Planning the Nation’s Health Workforce: Let the Market In, 31 INQUIRY 250 (1994).
100 See, e.g., Foreman, supra note 99, at 244-45; Uwe E. Reinhardt, The Economic and
support for their position from studies indicating that residents are currently responding to supply and demand forces in the absence of government intervention.\footnote{101}

Some evidence suggests that perceptions of an oversupply of specialists have led medical students to gravitate toward primary care residencies. According to an Association of American Medical Colleges (AAMC) Graduation Questionnaire, student interest in generalist careers increased from 14.6% in 1992 to 27.6% in 1995.\footnote{102} Results from the National Residency Matching Program further support this finding, indicating that in 1997, 56% of U.S. medical students matched to a first-year residency position in internal medicine, family practice, or pediatrics.\footnote{103} The percentage of filled residency positions also showed that USMGs were favoring primary care residencies.\footnote{104} Although the increased interest in primary care can be attributed to students' interpretation of signals from the marketplace, it can also be the result of students' personal preferences with respect to lifestyle, the influence of medical schools' growing emphasis on primary care, and the expansion of financial incentives in primary care.\footnote{105} Furthermore, the figures on USMGs do not correlate directly with the number of physicians who will enter the workforce as general practitioners, as many first-year residents eventually move into specialties and IMGs occupy the residency positions left open by USMGs.\footnote{106}

Other studies relied upon by the followers of the market approach show that an increased number of residents are having difficulty obtaining suitable practice positions within their state of residency and that many are moving to states with greater opportunities.\footnote{107} One study indicates that reductions in entry-level residency positions in most individual specialties and subspecialties were occurring before any legislative or fiscal curtailment of GME growth had been implemented.\footnote{108} However, the authors of the study were unable to identify concrete reasons for these reductions, and they further noted that program downsizing was not clearly correlated with difficulty in finding practice opportunities for program graduates.\footnote{109} Such reductions were also masked by the creation of


\footnote{101 See Foreman, supra note 99, at 245.}
\footnote{102 See COGME Eighth Report, supra note 10, at 2.}
\footnote{103 See Mitka, supra note 54, at 1.}
\footnote{104 See id.}
\footnote{105 See id.}
\footnote{106 See id.}
\footnote{108 See id. at 752.}
\footnote{109 See id. at 754.}
residency programs in newly established specialties and by the enrollment of more IMGs in upper-level residency positions.\textsuperscript{110} Thus, while the National Residency Matching Program reported that the number of residency positions offered in 1997 declined for the third straight year, the percentage of positions filled was higher than in previous years.\textsuperscript{111} The total number of applicants was also higher in 1997 than in any other year, mostly due to an increase in IMG applicants.\textsuperscript{112} Thus, evidence used to justify a free market solution to the workforce problem is at best inconclusive.

Although the "invisible hand" is an appealing theory, GME does not exist in a free market, but rather in a system subsidized heavily by public funds\textsuperscript{113} that interfere with signals from the marketplace, creating artificial incentives for offering more residency positions.\textsuperscript{114} Moreover, residency positions are determined by the desires of training program directors, who are generally unaware or unaffected by practice opportunities and are able to pass on educational expenses to third-party payors.\textsuperscript{115} Also, the training pipeline for physicians spans a minimum of seven years so that physician supply may not be able to adjust to market demands rapidly enough to decrease the number of new entrants into the medical education system.\textsuperscript{116} Furthermore, students choosing their residencies are often ill-informed about market demand, and most do not take into account employment prospects so far in the future.\textsuperscript{117} Thus, despite suggestions that teaching hospitals are downsizing their residency programs without any legislative mandates, the overall supply of physicians is not being streamlined by market forces alone.

The most salient reason for not leaving GME to the market is that without subsidies, GME cannot accomplish its dual mission of training

\textsuperscript{110} See id.
\textsuperscript{111} See Mitka, supra note 54, at 1. According to the National Residency Matching Program, 20,209 first-year residency positions were offered in 1997, compared to 20,563 in 1996 and 20,751 in 1995. See id. However, although the number of positions offered has decreased, the percentage of positions filled has increased: 89.9% of positions were filled in 1997, whereas only 87.6% of positions were filled in 1996 and 86.1% were filled in 1995. See id.
\textsuperscript{112} See id. An all-time high of 25,323 students applied in 1997, and 69% were accepted. See id. Of the graduates of U.S. medical schools applying for residencies in 1997, 13,554 (92.7%) matched. See id.
\textsuperscript{113} See Mullan, supra note 33, at 916.
\textsuperscript{114} See Rivo & Kindig, supra note 21, at 894.
\textsuperscript{115} See Robert G. Petersdorf, Future Directions in Graduate Medical Education, in HEALTH POLICY ISSUES AFFECTING GRADUATE MEDICAL EDUCATION 159, 164 (Donald G. Lansley et al. eds., 1992).
\textsuperscript{116} See Jacoby & Meyer, supra note 97, at 824 (noting that medical students lack the timely and reliable information about markets necessary to make informed choices about their future employment); Gregory W. Ruhnke, Residencies and Employment Under Managed Care: A Medical Student's View, 15 HEALTH AFF. 113, 115 (1996) (arguing that length of training prevents medical students from accurately considering market demands when choosing specialties).
\textsuperscript{117} See Ruhnke, supra note 116, at 115.
future physicians and providing skilled labor to care for vulnerable populations. Residency programs inevitably drive up the costs of teaching hospitals, placing these hospitals at a competitive disadvantage in the marketplace.\textsuperscript{118} Some policymakers argue that no other professional students receive subsidies for their educations;\textsuperscript{119} however, medical education is unique in that trainees are not only students, but are also principal health care providers at their residency institutions. Because in teaching hospitals the costs of education cannot be completely dissociated from the costs of caring for patients, a lack of GME subsidies will result in higher charges to patients.\textsuperscript{120} This effect may reduce a teaching facility's patient base, causing loss of revenue as well as loss of accreditation for the residency program due to the absence of learning experiences for its students. Evidence also suggests that teaching hospitals would not be financially viable if driven solely by market forces because the hospitals themselves provide a large amount of uncompensated care and must rely in part on Medicare GME payments to remain solvent.\textsuperscript{121} In addition to failing its educational mission, unsubsidized teaching hospitals would be unable to address the needs of poor patients. Teaching hospitals are not only state-of-the-art tertiary care facilities, but they are also important safety-net providers.\textsuperscript{122} More than 60\% of the major teaching hospitals are located in urban areas and one-third of them serve inner-city areas with high numbers of uninsured patients.\textsuperscript{123} Major public teaching hospitals provide triple the amount of uncompensated care relative to their share of the overall hospital market; in 1994, they devoted nearly 20\% of their expenses to uncompensated care.\textsuperscript{124} Without government subsidies, teaching hospitals would not be able to continue their educational and social mission. Thus, while there is merit to the argument that government financing is the cause of market failure in the first place, it does not follow that removing public financing will permit the market to function usefully. The education of physicians is a public good from which the nation as a whole benefits and is therefore obligated to support.\textsuperscript{125}

\textsuperscript{118} See, e.g., Reuter & Gaskin, supra note 67, at 247.
\textsuperscript{119} See Reinhardt, supra note 100, at 253-54.
\textsuperscript{120} See Ruth S. Hanft, Measuring the Costs of Primary Care Medical Education, in The U.S. Health Workforce: Power, Politics, and Policy 253 (Marian Osterweis et al. eds., 1996).
\textsuperscript{121} See, e.g., Fishman, supra note 59, at 219-21 (pointing out that teaching hospitals are able to remain in a fiscally stable condition only because of Medicare's GME payments, without which the hospitals would encounter severe financial difficulties similar to those experienced by other safety-net providers).
\textsuperscript{122} See id. at 219.
\textsuperscript{123} See Iglehart, supra note 77, at 1053.
\textsuperscript{124} See Joyce M. Mann et al., A Profile of Uncompensated Hospital Care, 1983-1995, 16 Health Aff. 223, 227 (1997).
\textsuperscript{125} See generally American College of Physicians, The Case for Graduate Medical Education as a Public Good (visited Nov. 6, 1998)

Public financial support for GME is absolutely necessary if the socially beneficial objectives of medical education are to be sustained.\(^\text{126}\) In 1997, Congress recognized the need to continue financing medical education and acknowledged GME as a potential source of solutions to the nation’s specialty imbalance, geographic maldistribution, and surplus problems.\(^\text{127}\) Consequently, it implemented efforts through the Balanced Budget Act of 1997 to shape GME into a publicly accountable process.\(^\text{128}\)

To achieve this goal, the Balanced Budget Act reduced Medicare payments to teaching hospitals while extending some funds to nonhospital residency programs, limited the number of residents eligible for subsidies, redirected certain funds from managed care organizations to teaching hospitals, and established a voluntary residency-downsizing program.\(^\text{129}\)

The passage of the Balanced Budget Act of 1997 represented the first significant attempt to use Medicare payments to shape the physician workforce.\(^\text{130}\) Although Medicare as a whole was significantly downsized by the Act, medical education payments were specifically targeted for reduction.\(^\text{131}\) The reduction in Medicare’s DME payments will save a total of $700 million over five years.\(^\text{132}\) The savings in IME, effected through changes in the payment formula, will equal $5.6 billion.\(^\text{133}\)

Although the total amount of DME payments was reduced, DME coverage was extended to new institutions. Recognizing that the hospital-centered reimbursement formula was hampering the development of residencies in ambulatory care centers and thereby constricting growth in primary care,\(^\text{134}\) the Balanced Budget Act extended DME payments to cover direct costs of residency programs operated by selected nonhospital providers, including federally qualified health centers, rural health clinics, and other ambulatory care centers.\(^\text{126}\) See generally Michael Hash, Financing Academic Medical Centers: A Shared Responsibility, 71 ACAD. MED. 58 (1996); Thier & Keohane, supra note 67. But see Reinhardt, supra note 100, at 254 (questioning the legitimacy of government intervention).

\(^{127}\) See REUTER, supra note 3, at 14-15.


\(^{130}\) See REUTER, supra note 3, at 14.

\(^{131}\) See Iglehart, supra note 74, at 402. Medicare constitutes only 13.1% of the federal budget, but it will bear 56.5% of the budget reductions, amounting to $116.3 billion. See id.

\(^{132}\) See id. at 403.

\(^{133}\) See id. Previously, IME payments amounted to an additional 7.7% for every 10% increment in a hospital’s resident-to-bed ratio. The Balanced Budget Act will reduce the adjustment to 5.5% by the year 2001. See id.

\(^{134}\) See Hanft, supra note 120, at 256.

managed care plans with Medicare beneficiaries, and others deemed appropriate by the U.S. Department of Health and Human Services.\footnote{See Iglehart, supra note 74, at 403.}

In its reorganization of GME financing, Congress also took the controversial step of imposing a cap on the total number of residents eligible for DME funds.\footnote{See id.} In order to mitigate the financial consequences of eliminating training positions, the cap will be lowered gradually by recomputing it based on a three-year rolling average of the number of residents.\footnote{See 42 U.S.C.A. § 1395ww(h)(4)(G)(i) (West Supp. 1998).} The Secretary of Health and Human Services has discretion to make exceptions to the cap for certain programs, but any such increases must be accompanied by a decrease elsewhere in order to maintain the global limit on the number of residents.\footnote{See 42 U.S.C.A. §§ 1395ww(h)(4)(F)-(H) (West Supp. 1998).}

These payment cuts will be partially offset by returning to teaching hospitals a portion of the premiums that Medicare pays to managed care organizations. Prior to the passage of the Balanced Budget Act, Medicare paid managed care organizations on behalf of Medicare beneficiaries enrolled in managed care plans.\footnote{See Iglehart, supra note 74, at 403.} These payments included the additional funds for GME that Medicare incorporates when it pays hospitals for beneficiaries who are not enrolled in managed care plans.\footnote{See id.} The managed care organizations, however, were free to negotiate fees with the hospitals so that when Medicare managed care enrollees were admitted to teaching hospitals, the managed care entities often failed to transmit the extra funds to teaching hospitals to cover the added costs of GME.\footnote{See REUTER, supra note 3, at 7-8.} This caused teaching hospitals to be at a competitive disadvantage when bidding for risk contracts.\footnote{See 42 U.S.C.A. § 1395ww(h)(3)(D) (West Supp. 1998).} After academic medicine and the managed care industry lobbied heavily to gain control of these funds, Congress decided to carve out educational subsidies from managed care premiums and give them directly to teaching hospitals.\footnote{See Iglehart, supra note 74, at 403.} A total of $4 billion will be returned to teaching hospitals in annual installments of 20% over a five-year period.\footnote{See id.} This policy is likely to have significant financial implications, as 11% of Medicare beneficiaries were enrolled in health maintenance organizations in 1996 and the number is expected to double by 2003.\footnote{See REUTER, supra note 3, at 7.} In addition, by separating teaching costs from patient care revenues, teaching hospitals will no longer be forced to pass on education costs to payors of health care.
care. As a result, the teaching hospitals will be better able to compete with nonteaching hospitals.

The Act further offers teaching hospitals across the nation the opportunity to participate in a residency-downsizing program modeled after a current demonstration program in New York. The optional program would offer financial incentives to reduce the number of residents being trained by 20-25% over a five-year period. In return for eliminating positions, participating hospitals would be paid a diminishing proportion of the medical education payments they would have received for those positions. At the end of the transition period, the hospitals would receive no more funds for the positions eliminated at the start of the transition period. Any hospital that failed to eliminate positions it had pledged to cancel would receive no payment. Additionally, reinstating terminated training positions at the end of the transition period would require hospitals to return all payments to Medicare. Regulations to implement the demonstration are still being drafted and there is as yet no data on how many hospitals will apply to participate. A second

146 See id. at 8.
147 See id. Teaching hospitals may still be at a disadvantage in the competitive marketplace because disproportionate-share payments from Medicare, used to compensate hospitals for higher operating costs due to high levels of uncompensated care, were not carved out of payments to managed care companies. In 1997, teaching hospitals received approximately $3 billion in disproportionate-share funds. See Iglehart, supra note 74, at 403. Congress also failed to resolve the extreme variation in Medicare payments among hospitals. In 1995, 10% of teaching hospitals had per-resident payments of more than $98,800, whereas the average payment for the lowest 10% was below $37,400; the national mean was $62,700. See id. at 406. Failing to agree on a solution, Congress directed the Department of Health and Human Services to examine the reasons for variation in the per-resident payments and to recommend means to equalize payments. See id.

148 See 42 U.S.C.A. § 1395ww(h)(6) (West Supp. 1998). Under the demonstration project, designed by the Greater New York Hospital Association, 41 hospitals will, over a five-year period, reduce their programs by 2,000 positions and increase the proportion of students in primary care residencies. See Mike Mitka, Federal Project Pays N.Y. Med Schools to Cut Residency Slots, AM. MED. NEWS, Mar. 10, 1997, at 1. In return, participating hospitals will receive a lump-sum cash payment equal to a decreasing fraction of the funds they would have received from Medicare had the positions not been eliminated. See id. The plan is expected to cost a total of $400 million, but should save the federal government $300 million per year if successful. See id. Criticism of the New York demonstration program was particularly severe before the enactment of the Balanced Budget Act, in large part because the financial incentives were being offered to hospitals in only one state whose two senators were active in the Senate Finance Committee. See Elizabeth Rosenthal, U.S. to Pay New York Hospitals Not to Train Doctors, Easing Glut, N.Y. TIMES, Feb. 18, 1997, at A1. Critics also argue that the program creates a new entitlement, see Iglehart, supra note 74, at 405; does not address the issue of underserved areas, see id.; ration health care by limiting supply, see Paying to Have Fewer Doctors, INVESTOR’S BUS. DAILY, Feb. 20, 1997, at A32; and does not guarantee that USMGs will have priority over IMGs for the residency positions, see Mitka, supra, at 1.

149 See Mitka, supra note 148.
150 See id.
151 See id.
152 See id.
153 See, e.g., Iglehart, supra note 74, at 404.
154 See Iglehart, supra note 74, at 404. See also 42 U.S.C.A. § 1395ww(h)(6)(D)(iii) (West Supp. 1998). The Congressional Budget Office estimates that the combined effect of the cap and the
demonstration project under consideration would permit GME payments to be made to consortia rather than to hospitals directly. As a final step in making GME more accountable, the Act charged the Medicare Payment Advisory Commission (MedPAC) with developing recommendations on federal policies regarding GME payments, IMGs, and physician workforce requirements.

Responding to pressure from the public and private sectors, the Balanced Budget Act of 1997 represents a significant and historic step towards aligning GME with physician workforce requirements. Its provisions recognize that by leveraging Medicare funds for GME, the federal government has a powerful tool for shaping the physician workforce across the nation. However, the Balanced Budget Act confined its changes to restructuring financial incentives for residency programs, and failed to ensure a continuous source of funds for supporting residency training. In addition, the Act did not explicitly address the questions of geographic and specialty maldistribution.

III. The Urgent Need for Additional Reform

The Balanced Budget Act directly acknowledged the relevance and influence of GME, thus representing a significant advancement toward solving the physician workforce problem. However, the Act did not address the issue of fashioning a stable funding source, nor did it provide for the establishment of a permanent scheme of monitoring GME and the workforce it produces.

The policy changes in the Balanced Budget Act will reduce Medicare’s GME payments by an estimated $5.6 billion in indirect medical education payments and $700 million in direct medical education payments over five years. Combined with Medicare’s $44 billion reduction in patient care payments to all hospitals over a five-year period and the financial pressures imposed by managed care organizations unwilling to assume education costs, teaching hospitals must cope with escalating burdens by aggressively containing their expenses and further eliminating excess bed capacity. Despite arguments that teaching hospitals can continue to maintain positive operating margins and

incentive program will reduce the total number of residents by 3%. See REUTER, supra note 3, at 12.

155 See REUTER, supra note 3, at 12.
157 See Iglehart, supra note 74, at 403.
158 See id. at 404.
159 Analysts estimate that teaching hospitals can maintain their positive Medicare margins (the difference between Medicare payments and the costs of treating Medicare patients) at 1997 levels if they continue restraining growth in costs. See Stuart Guterman, The Balanced Budget Act of 1997: Will Hospitals Take a Hit on Their PPS Margins?, 17 HEALTH AFF. 159, 164-65 (1998). Increases in prospective payments under the Balanced Budget Act will continue to be in excess of the costs of
become aggressive competitors for Medicare managed care enrollees,\footnote{160} adequate and stable funding for GME will remain a problem because of Medicare’s fiscal uncertainty. The Balanced Budget Act failed to explore alternative sources of financing, leaving open the debate on whether Medicare—a program itself facing financial disaster—should continue to be the primary program to support medical education. Furthermore, although the Act recognized that the means to correct maldistribution and specialty imbalances are most likely intertwined with GME financing, it failed to address the pressing problem of geographic maldistribution of residency positions and had only an incidental effect on the specialty mix of residents.\footnote{161}

Given the baseline assumption that GME cannot exist without public subsidies and that the training of physicians must continue, an all-payor fund must be established. This system will not be accepted by the public unless the fiscal imposition is accompanied by some centralized allocation mechanism that can produce a physician workforce suited to societal needs. Conversely, the professional organizations representing hospitals will not embrace a centralized allocation mechanism to equalize physician distribution across the nation, unless their loss of autonomy is compensated by financial support. Together, these viewpoints suggest only one solution: a shared-responsibility fund to finance GME, plus a publicly accountable mechanism for allocating funded residency positions.

A. \textit{An All-Payor Trust Fund}

Medical education has many of the attributes of a classic public good in that it benefits the community as a whole and, as with any public good, it would be undersupplied in the absence of subsidy. \ldots \ [J]ust because the government has an obligation to help meet society’s need for medical education does not mean that Medicare has the obligation to pay for the entire subsidy. \ldots \ If a public good benefits all of society, then it makes eminent sense that all society should contribute appropriately to paying for it. But since we do not want to use the T-word, we resort instead to increasingly complicated contributional schemes.\footnote{162}

\footnote{160} Even after reductions in IME payments are imposed by the Balanced Budget Act, a major teaching hospital can offer fees to managed care organizations that are much lower than what the hospital would receive for a Medicare beneficiary in a traditional plan. See \textsc{Reuter}, supra note 3, at 14. For example, a hospital with four residents for every 10 hospital beds theoretically can provide services to Medicare managed care patients at a 20\% discount from what traditional Medicare would pay. See id.

\footnote{161} See Seifer et al., supra note 81, at 687.


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The commonly cited rationales for supporting GME with Medicare dollars are to ensure that Medicare beneficiaries can receive care at state-of-the-art facilities (most of which are teaching hospitals), to ensure the financial durability of teaching hospitals, and to support the training of physicians to meet beneficiary needs.\textsuperscript{163} While these justifications remain valid, the health care system today provides a framework in which broad-based support for GME is more reasonable than putting most of the burden of educational costs on Medicare alone. Since Medicare payments are made only to institutions that serve Medicare patients, some hospitals are not eligible for GME subsidies despite the fact that they train residents who serve public needs. Furthermore, teaching hospitals and their residents serve as safety-net providers for the uninsured and the seriously ill, regardless of whether the patients are Medicare beneficiaries.\textsuperscript{164} Thus, while the original intent of Medicare funding was to provide access for the elderly, Medicare dollars are now being used primarily to support residents who treat the poor.\textsuperscript{165} Shifting federal funding to general revenues, instead of tying GME payments to Medicare, would permit Congress to use more effectively these subsidies to ensure access to care for the whole population or to target support to critical institutions that need financial assistance.

A general consensus exists among the professional organizations and many members of Congress that an all-payor fund is the most viable and reasonable method for ensuring adequate financing for GME.\textsuperscript{166} Proposals for establishing trust funds have generally included financing through assessments on health insurance premiums. For example, the proposed Medical Education Trust Fund Act of 1997\textsuperscript{167} would have derived revenues from a 1.5% tax on health insurance premiums, Medicare, and Medicaid. The contribution from each of these sources would have been proportional to the medical education costs incurred by their respective

\textsuperscript{163} See PHYSICIAN PAYMENT REVIEW COMM'N, supra note 67, at 383-86.

\textsuperscript{164} See Mann et al., supra note 124, at 227.

\textsuperscript{165} See, e.g., PHYSICIAN PAYMENT REVIEW COMM'N, supra note 67, at S365; Fishman, supra note 59, at 221. This fact is highlighted by a comparison of teaching hospitals' Medicare margins and overall operating margins with those of nonteaching hospitals. While teaching hospitals' Medicare margins far exceeded those of nonteaching hospitals, their total operating margins lagged far behind those of facilities without residency programs, indicating that Medicare is paying too much while other payors do not contribute enough to GME. See PHYSICIAN PAYMENT REVIEW COMM'N, supra, at 387.


\textsuperscript{167} S. 21, 105th Cong. (1997). Congress first considered the establishment of an all-payor fund when the Senate Finance Committee included a Graduate Medical Education and Academic Health Centers Trust Fund in its version of President Clinton's Health Security Act of 1994. This trust fund would have increased federal funding for academic medicine by 80% through a 1.75% assessment on health insurance premiums. See 143 CONG. REC., supra note 166, at S361-62.
beneficiaries. The fund would have disbursed $17 billion per year to support GME and other mission activities. These funds would have come from yearly inputs of $4 billion from the private sector, $9 billion from current Medicare GME payments, and $4 billion from federal Medicaid funds. Although the bill was defeated, members of Congress and most of the professional organizations continue to advocate a shared-responsibility financing mechanism overseen by the federal government.

There are many potential sources of financing for a GME trust fund. For example, funding could come from income or payroll taxes, the broadest forms of support. However, federal policymakers are currently seeking to reduce taxes and the trust funds already financed by payroll assessments are themselves fiscally unstable. Another source of funding could be targeted taxes such as alcohol and tobacco taxes. These would be health-related, but the burdens would tend to fall on low-income families who spend a larger proportion of their income on such products. A provider tax also would be health-related, but the burden would be passed on to the sick, and a new collection machinery would have to be established after determining which providers and revenues should be taxed. Another option is to require residents themselves to pay the equivalent of tuition, but this cost, added to debts from undergraduate and medical education, may be prohibitively high.

The most feasible alternative for financing a public GME fund is to impose a tax on health insurance premiums. Limited forms of such a tax

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168 See id. at 365.
169 See id.
170 See id.
171 Cf. Hearing on Future Financing of Graduate Medical Education Before the Senate Comm. on Fin., 105th Cong. (1997) (hereinafter Hearing on Future Financing) (statement of Ralph W. Muller, Pres., Univ. Chicago Hosps. & Health Sys. and Chair-elect, Council of Teaching Hosps. & Health Sys.) (“The federal government alone is in a position to make formal and explicit what has always been informal and implicit by facilitating financial support for medical school academic programs and teaching hospitals through contributions to a trust fund.”).
172 Income taxes could be raised by increasing marginal tax rates, changing tax rates, or permitting a smaller portion of employer-paid health benefits to be tax-exempt. The large tax base would produce more than sufficient funds for GME, but the current political atmosphere would most likely preclude this option. See Henry R. Desmarais & Michael M. Hash, Financing Graduate Medical Education: The Search for New Sources of Support, 16 HEALTH AFF. 48, 52, 55 (1997). A 1% increase in payroll taxes would yield $46.9 billion annually in the year 2002, see id. at 55, but payroll taxes are considered less equitable and are already in great demand. See id. at 52. Furthermore, the financing of medical education would not be as direct and tangible as unemployment and Social Security benefits supported by payroll taxes. See id.
173 Increasing federal cigarette tax to $.99 per pack would yield $9.3 billion annually in 2002, and increasing the federal liquor tax by $2.50 per proof gallon would yield $4.6 billion. See id. at 55.
174 See id. at 52.
175 See id. at 53. A 1% federal provider tax on all health services and supplies would yield $14.5 billion annually in 2002. See id. at 55.
176 See Desmarais & Hash, supra note 172, at 54. “Tuition” of $15,000 per year would yield $1.8 billion annually in 2002. See id. at 55.
are already being collected in forty-nine states. Health plan taxes would be supported by a broad base and a 1% tax on premiums would yield $6 billion per year by 2002. Depositing contributions into one or more accounts designed specifically to support medical education would insulate such funds from Medicare cuts. This alternative, of course, is not perfect. As with other general revenues, the scheme would be subject to both fluctuations in the appropriations process and competition among stakeholders. Additionally, assessments on health plans may cause employers to cease providing benefits, to limit coverage, or to reduce wages. Nevertheless, taxing insurance premiums remains the most efficient way of financing an all-payer trust.

The creation of an all-payer fund would provide an opportunity to correct many of the problems caused by the current state of the physician workforce. For example, it would alleviate obstacles to affordable, quality health care. However, a broad-based system for financing GME, without more, would not guarantee solutions to specialty and geographic imbalances. In order to address these problems, it is necessary to devise a mechanism for producing a physician workforce that meets societal needs. A system of allocation of residency positions through targeted financial incentives would produce the desired result.

B. Allocation of Funded Residency Positions

Past proposals for establishing medical education trust funds have included national workforce commissions, vested with varying degrees of authority, to enforce policy goals. For example, President Clinton’s Health Security Plan of 1994 would have authorized a National Council on GME to do the following: ensure that 55% of new residents entered primary care programs, cap the total number of residents, allocate positions among institutions and medical specialties, and distribute payments from the trust fund. Significantly, however, a major reason for the defeat of Clinton’s plan was its substitution of government regulations

177 See id. at 53. Utah is the only state that does not impose a tax on health insurance premiums. See id.

178 See id. at 55.

179 See PHYSICIAN PAYMENT REVIEW COMM’N, supra note 67, at 393.

180 See id. at 53. Other obstacles to overcome before a premium tax can be imposed include amending ERISA to permit federal intervention, deciding how to obtain contributions from businesses that do not offer health benefits, and resolving questions of how to treat a wide variety of insurance products. See Hash, supra note 126, at 59.

181 The Clinton health plan was never introduced in either the House or the Senate. However, several committees considered bills that were modifications of Clinton’s proposal, including H.R. 3600, 103d Cong. (1993) and S.1757, 103d Cong. (1993).

Any centralized mechanism for dictating the types and locations of residency programs will undoubtedly encounter the same resistance, as teaching hospitals and academic health centers with large financial stakes would oppose regulations accompanied by a deprivation of government funding. Nevertheless, their need for an all-payor trust fund may require them to concede some impairment of autonomy, or otherwise risk loss of public funding. Even if professional resistance to an allocation mechanism is overcome, the inherent discretion in the decisional process will give rise to concerns that "an explicit, highly visible, political algorithm to allocate residency positions among specialties, geographic regions, and teaching hospitals within regions is bound to unleash an unseemly scramble for the funds and the cheap, highly skilled labor that comes with these allocations." Conflicts among stakeholders and the fear of unfairness can be minimized, however, by an allocation mechanism that vests the decisionmaking power in a government entity subject to due process requirements and that distributes funds to states instead of to individual institutions.

1. Allocation of Residency Positions by a National Government Entity

The best way to implement a coordinated distribution scheme is to delegate the allocation of residency positions to a federal body. This can be achieved by creating a new governmental entity or by vesting enforcement capabilities in already-existing entities. The group currently vested with authority to accredit residency programs, the Accreditation Council on Graduate Medical Education (ACGME), is dominated by professional interests.

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183 See generally Theda Skocpol, Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics 133-72 (1996) (describing the failure of the Clinton plan as resulting from its attempt to regulate health care without providing subsidies, resulting in the mobilization of antigovernment sentiments to defeat any sort of intervention).

184 See Hearing on Future Financing, supra note 171, at 15. The American Association of Medical Colleges forcefully opposed a cap on the number of funded residencies. See id. at 13. Instead, they advocated first reducing funding for IMGs. See id.

185 Reinhardt, supra note 100, at 252.; see also Daniel M. Fox, From Piety to Platitude: The Changing Politics of Health Workforce Policy, 21 J. Health Pol'y, Pol'y & L. 825, 839-40 (1996) (arguing that workforce policy has shifted from being "ideologically driven" to being dominated by distributive concerns).

186 Existing entities have the authority to examine and recommend solutions, but lack enforcement capabilities. Examples include MedPAC, the Council on Graduate Medical Education, and the National Bipartisan Commission on the Future of Medicare.

187 The Accreditation Council for Graduate Medical Education (ACGME) is sponsored by the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. See Accreditation Council on Graduate Med. Educ., Graduate Medical Education
are the basis for many government decisions,\textsuperscript{188} courts have held that it is not a state actor\textsuperscript{189} and is thereby not subject to due process requirements.\textsuperscript{190} Such an entity, though a national organization, is not subject to public scrutiny and would therefore not appropriately be charged with distributing subsidies from an all-payor trust fund. Although restructuring residency accreditation by, for example, shifting the focus from individual departments to the institution as a whole may promote greater sensitivity to larger workforce needs,\textsuperscript{191} the professional organizations would not cede control over accreditation activities, primarily because they possess the most expertise on the standards of accreditation for educational programs. The residency distribution mechanism, then, must be independent of the accreditation system.

\textit{Information Review and Accreditation of Graduate Medical Education} (visited Dec. 1, 1998) \langle http://www.acgme.org/acgme/polprod/sect1.htm \rangle. ACGME consists of four representatives from each sponsoring organization, two representatives of the public selected by the ACGME, a resident representative, a representative of the federal government who has nonvoting capacity, and the chair of the Residency Review Committee Council who also sits as a nonvoting representative. See \textit{id}. Accreditation of a particular residency program is granted by ACGME upon the program's recommendation by the Residency Review Committee (RRC). See \textit{id}. Each RRC is composed of representatives appointed by the American Medical Association, the appropriate specialty board, and, in some cases, a national specialty organization. See \textit{id}.

Accreditation of a residency program is granted only after an application is filed by the program director and ACGME visits the site and subsequently determines that the program complies with the Essentials of Accredited Residencies in Graduate Medical Education. See \textit{id}. With the exception of information on accreditation status, the contents of program files are confidential, as are all other documents regarding a program used by a review committee. See \textit{id}.

ACGME has recently proposed a number of bylaw changes that would result in its incorporation as an independent agency. See American Med. Ass'n, Resident Physician Section, \textit{Prominent Resident Issues} (visited Nov. 22, 1998) \langle http://www.ama-assn.org/mem-data/special/rps/rpsissue/rpsissue.htm \rangle. The AMA opposes several of these revisions because they would remove the ability of the sponsoring organizations to veto action and they would decrease the influence of the American Medical Association. See \textit{id}.

\textsuperscript{188} \textit{See}, e.g., \textit{Michael J. Frank, Safeguarding the Consciences of Hospitals and Health Care Personnel: How the Graduate Medical Education Guidelines Demonstrate a Continued Need for Protective Jurisprudence and Legislation}, \textit{41 St. Louis U. L.J.} 311, 320-25 (1996) (arguing that ACGME's "status as a private institution is somewhat attenuated by the fact that federal and state governments rely on ACGME's evaluation of residency programs to determine whether a hospital merits public funding").


\textsuperscript{190} For an argument on why accrediting agencies should be subject to constitutional due process, see generally Michael W. Prairie & Lori A. Chamberlain, \textit{Due Process in the Accreditation Context}, \textit{21 J.C. & U.L.} 61 (1994). These authors propose that the increasing interrelationship between government and accrediting agencies may result in the imposition of due process requirements in certain situations, particularly as the decisions of accreditation bodies often determine government funding and substitute for state licensing requirements. See \textit{id} at 62.

\textsuperscript{191} \textit{See generally} August G. Swanson, \textit{Institutional Accreditation, in Health Policy Issues Affecting Graduate Medical Education} 3 (Donald G. Lansley et al. eds., 1992); Alexander H. Williams III, \textit{Institutional Accreditation, in Health Policy Issues Affecting Graduate Medical Education} 9 (Donald G. Lansley et al. eds., 1992) (presenting arguments on the broader benefits of institutional accreditation when compared to separate accreditation for individual residency programs in the same teaching hospital).
Graduate Medical Education

The national character of the entity established to handle the all-payor trust fund is an essential element for aligning GME with societal requirements. A federal body can better assess the total number of residents needed by the nation as a whole. Additionally, due to interstate variation, only policymaking at the national level can address the geographic maldistribution of physicians across the country and minimize potential inequities. If states are permitted to independently implement policies of different degrees of restrictiveness and financial hardship, students and health care institutions will relocate to jurisdictions offering more attractive benefits, thereby forcing states to match the benefits of other states despite their own fiscal constraints. More importantly, the decision as to which residency positions should be funded must be subject to public scrutiny and due process constraints so that uneasy stakeholders can obtain appellate review, in either a judicial forum or some other context, when they are denied funding. Such review will be necessary to permit a centralized body to control access to the trust fund, since its decisions will be upheld so long as they are supported by concrete, verifiable data on workforce supply and demand.

2. The States as Recipients of Funds

The role of the national allocation entity should be to use reliable data on workforce and population demographics to approximate a target range of medical residents needed to provide a certain level of access to health care in each state. Subsidies for that number of residents should be taken out of the all-payor trust fund and given to the states as lump-sum payments.

Individual states have a greater capacity for implementing the controls on workforce production designed by the national allocation organization. Since regional needs and resources vary due to differences in managed care penetration, population characteristics, health care infrastructure, and other factors, states are the appropriate loci for specifically calculating the location, number, and types of residencies that should be funded.

Additionally, making states the recipients of funds is the preferred alternative because opposition to state intervention will not be as great as that against direct federal intrusion. States are readily seen as laboratories

192 See Sparer, supra note 182, at 811.
that are able to overcome group opposition in order to enact policy innovations.\textsuperscript{195} Many states have already implemented mechanisms to monitor and legislatively shape workforce production. For example, Maryland sets hospital reimbursement rates for all public and private payors and adjusts the rates for GME costs;\textsuperscript{196} Massachusetts includes DME costs in Medicaid patient admissions and weights payments favorably toward primary care residencies;\textsuperscript{197} Minnesota is implementing a Medical Education and Research Trust Fund supplemented by $8.4 million in state funding;\textsuperscript{198} New York is instituting an assessment on insurers and purchasers of care to support an annual $544 million Professional Education Fund;\textsuperscript{199} and Utah is establishing an all-payer financing system accompanied by an entity to distribute funds to teaching hospitals and other programs.\textsuperscript{200} Other states have passed affirmative measures to increase the proportion of primary care residency programs.\textsuperscript{201} These measures include mandates for the creation of family practice residencies,\textsuperscript{202} additional funding to enlarge family practice training programs,\textsuperscript{203} statutory prescriptions on the number of funded residencies,\textsuperscript{204} and admission preferences for students entering primary care practice in underserved areas.\textsuperscript{205}

In addition to being designated as the recipients of GME funds, states should be given the discretion to allocate their lump-sum payments to consortia within their borders.\textsuperscript{206} Each consortium would include one or


\textsuperscript{197} See SALSBERG, supra note 196, at 27.

\textsuperscript{198} See id. at 30-31.

\textsuperscript{199} See id. at 35.

\textsuperscript{200} See id. at 39.

\textsuperscript{201} See generally Kristine Marietti Byrnes, Is There a Primary Care Doctor in the House? The Legislation Needed to Address a National Shortage, 25 RUTGERS L.J. 799, 832-36 (1994) (discussing state programs to increase primary care residencies).

\textsuperscript{202} See HAW. REV. STAT. ANN. § 304-67 (Michie 1996) (mandating a family practice residency program at the University of Hawaii); TENN. CODE ANN. § 49-9-703 (1996) (creating a state family practice residency program).

\textsuperscript{203} See TENN. CODE ANN. § 49-7-401 (1996).

\textsuperscript{204} See NEB. REV. STAT. § 71-5204 (1996) (delineating the number of funded residencies per year and prohibiting the expansion of residency programs that are not family practice programs).

\textsuperscript{205} See W. VA. CODE § 18B-16-4 (1997).

\textsuperscript{206} For a description of the advantages and disadvantages of the consortium approach, see COUNCIL ON GRADUATE MED. EDUC., U.S. DEP'T OF HEALTH & HUMAN SERVS., NINTH REPORT, GRADUATE MEDICAL EDUCATION CONSORTIA: CHANGING THE GOVERNANCE OF GRADUATE MEDICAL EDUCATION TO ACHIEVE PHYSICIAN WORKFORCE OBJECTIVES 27-29 (1997).
more teaching hospitals, a medical school, ambulatory care sites, and managed care organizations involved in medical education. Consortia would have the flexibility to redistribute residency positions among the consortium members in order to ensure adequate ambulatory care training for the students and to provide a sufficient level of service for the health care institutions. Thus, the consortia approach may be a tool to address workforce distribution problems arising from GME, particularly if consortia are granted formal authority to disperse funds and to assign residency positions. Since the members of each consortium would ultimately be responsible for directing payments to specific facilities, dispensing funds from the national trust fund through consortia would further decrease the perceived impact of government regulation. Although states so far have not been successful in persuading voluntarily formed consortia to accept and distribute GME funds, in part because of intra-consortium competition, states could condition the receipt of funding on achievement of policy goals in order to stimulate cooperation.

C. A Key Obstacle to Implementation: IMGs

A key obstacle to the implementation of this all-payor-funded allocative plan is the influx of IMGs into the medical education pipeline. IMGs contribute substantially to the nation’s physician oversupply and, in a system of reduced residency programs, limit the positions available to USMGs. Thus, any plan intended to curb the workforce surplus should directly address the issue of IMGs. Any attempt to limit the number of IMGs, however, should be informed by constitutional constraints on differential treatment and by the special role of IMGs in the provision of services.

Many policymakers and professional associations argue that if residency programs are reduced in size, priority for the positions should be given to USMGs, since a medical school education without GME would not permit the student to practice medicine. However, a complete bar on the entry of IMGs based solely on their status as foreign medical school graduates would probably violate constitutional equal protection principles, particularly as nearly half of all IMGs training in the United

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207 See SALSBERG, supra note 196.
208 See Fitzhugh Mullan et al., Doctors, Dollars, and Determination: Making Physician Workforce Policy, 12 HEALTH AFF. 138, 147 (Supp. 1993).
209 See supra notes 46-51 and accompanying text.
210 See, e.g., Geri Aston, Stakeholders Sound Off As AMA Redefines Stance on GME Funding, AM. MED. NEWS, Dec. 23, 1996, at 1.
211 See COGME ELEVENTH REPORT, supra note 15, at 9-11. Other legal issues concerning restrictions on IMGs include unlawful denial of educational opportunities, potential violation of Medicare beneficiaries’ right to health care, infringement on the right to travel, and discrimination in the workplace. Id. at 10. A skills assessment exam required only of IMGs seeking to enter U.S.
States are either permanent residents or U.S. citizens.\textsuperscript{212} In addition to potential legal challenges, limiting the number of IMGs could have other undesirable consequences. Evidence suggests that underserved areas have higher proportions of IMGs than communities not designated as underserved.\textsuperscript{213} As a result, their removal would leave a gap in the safety net. For example, IMGs appear to be overrepresented in counties with high infant mortality rates, low socioeconomic status scores, large nonwhite populations, and physician-to-population ratios substantially below the national average ratio.\textsuperscript{214} Nevertheless, data shows that after training, foreign medical graduates enter into specialties and distribute across geographic locations in patterns very similar to those of USMGs.\textsuperscript{215}

Another factor to consider when studying the IMG issue is the political nature of the decisions surrounding GME policy. A brief example can illustrate this point. Approximately 50\% of first-year residents in GME programs in New York are IMGs.\textsuperscript{216} With high levels of dependence on IMGs to serve its inner-city populations and with both senators influential on the Senate Finance Committee, New York has so far been successful in blocking any explicit priority to USMGs.\textsuperscript{217}

One solution to the IMG-dilemma would be to avoid it altogether by expanding the number of students graduating from domestic medical schools in order to target the optimal number of residents.\textsuperscript{218} United States citizens and permanent residents would then be more likely to be accepted into domestic medical schools, and would not be forced to study abroad only to face the possibility of being unable to enter residency in the United

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\textsuperscript{212} See Dunn et al., supra, note 47, at 841 app. 2, tbl.6.
\textsuperscript{214} See COGME ELEVENTH REPORT, supra note 15, at 17; see also Mick & Lee, supra note 213, at 144, 147. One study shows that 77 hospitals are considered dependent on IMGs to provide uncompensated care. See Michael E. Whitcomb & Rebecca S. Miller, Participation of International Medical Graduates in Graduate Medical Education and Hospital Care for the Poor, 274 JAMA 696, 698 (1995). There is no obvious reason why IMGs tend to be concentrated in residency programs in underserved areas, as the selection of residents is determined solely by the individual programs. One explanation for the uneven distribution of IMGs is implicit—discriminatory preference for USMGs. Cf. Moran, supra note 211, at I (discussing a new clinical skills assessment test required only of IMGs seeking to enter American residency programs that is expensive and overly laden with logistical difficulties for the IMGs).
\textsuperscript{215} See Mullan et al., supra note 55, at 1521, 1525.
\textsuperscript{217} See id. at 859-61; see also Rosenthal, supra note 148, at A4.
\textsuperscript{218} Policymakers have determined the optimal number to be 110\% of the current number of USMGs. See COGME EIGHTH REPORT, supra note 10, at 17; CONSENSUS STATEMENT, supra note 94.
States. Another approach to address the IMG problem would be to mandate a year of U.S. medical school education before any student can enter GME. This regulation would be similar to the one already in force, requiring all physicians to train in a U.S. residency program before obtaining licensure. This scheme would not be discriminatory and would also ensure that the shortage areas currently being served by IMGs would be satisfied by the additional USMGs.

Conclusion

The role of federal subsidies in health care workforce production no longer represents the "quiet politics of interests." As the physician workforce produced by GME has become visibly distorted and ill-suited to societal needs, government financing of GME is no longer simply accepted as a self-evident truth and must instead be justified to the public. A viable solution to physician supply imbalances lies in centralized controls on GME. Although an explicit allocation mechanism to assign funded residencies by type and location would be able to align physician supply with demands, the influential professional organizations will not concede to such government intervention without being guaranteed continuous financial support. Therefore, a national workforce policy to alleviate geographic inequities and specialty maldistributions must be accompanied by a shared-responsibility trust fund.

Simultaneously, the financial future of academic medicine and GME in particular is becoming increasingly threatened in the competitive health care marketplace, causing stakeholders to clamor for a stable source of funds. With Medicare itself in a fiscal crisis, payments to support GME will have to be derived from an all-payer fund specifically established for the purpose of maintaining the public good that GME represents. Taxpayers will not be willing to contribute to such a fund, however, if the physician workforce they are required to subsidize is not publicly accountable or responsive to their needs. From this perspective, broad-based financial support must be accompanied by a federal workforce initiative, giving rise to the same compromise solution.

Nevertheless, broader workforce goals should not be permitted to obscure the needs of residents and their patients. While there is a glut of

219 CAROL S. WEISSERT & WILLIAM G. WEISSERT, GOVERNING HEALTH: THE POLITICS OF HEALTH POLICY 271 (1996) (arguing that subsidies for the health care industry are often passed by Congress with little debate or public attention, leaving subsidies to continue long after the targeted problem has been solved).

physicians, residents are in short supply at many of the inner-city teaching hospitals, where they work long hours for little compensation. Reducing the overall numbers of residents may also negatively impact the level of uncompensated care they provide, and transitional funding as well as nonphysician replacement providers will most likely be necessary. The legally complex issue of IMGs will also factor into any debate about GME. Interstate migration may also defeat any efforts at correcting geographic maldistribution, but educational programs designed to introduce residents to underserved communities may encourage students to continue serving the shortage areas. Finally, in order for the national policy to succeed through targeted financial controls, the exact cost of training residents must be determined separately from the cost of patient care so that government payments to residency programs can cover the actual costs of GME.\textsuperscript{221}

One critic of government involvement argues that "concentration of so much regulatory (and economic) power in one body . . . also concentrates the potential for serious error which amplifies such errors. On this score, the checkered history of U.S. workforce policy is anything but reassuring."\textsuperscript{222} However, because of the absence of a centralized entity which could adjust quickly to fluctuations in supply and demand, past policies led directly to the physician workforce fiasco today. Whereas a market is prone to errors that cannot easily reverse themselves, an allocation scheme by which one body would determine the number, types, and locations of residency positions to be funded would be flexible enough to correct any miscalculations in workforce demographics. The foundation of the scheme does lie, however, in calculating correctly and gathering accurate information. With numerous variables and uncertain developments in the health care delivery system,\textsuperscript{223} determining the GME characteristics necessary to produce the required workforce several years later will be a difficult task. Furthermore, the allocation scheme will lose not only its efficacy, but also its moral force if it makes any errors in calculation, for the sole justification for imposing both an all-payor trust fund on the public and government intervention on GME is their joint capacity for fulfilling future workforce needs by reshaping present training programs.

\textsuperscript{221} See, e.g., Hanft, \textit{supra} note 120, at 259.
\textsuperscript{222} Reinhardt, \textit{supra} note 100, at 252.
\textsuperscript{223} See Bernard J. Mansheim, \textit{Deploying Primary Care Personnel in Managed Care Plans: More Art than Science, in THE U.S. HEALTH WORKFORCE: POWER, POLITICS, AND POLICY} 153 (Marian Osterweis et al. eds., 1996) (arguing that the recent national health reform debacle, powerful market forces, and a highly disjointed health care system all render predictions about physician workforce a "guesstimate" at best).