Training our future health care workforce

Key Points

- The 1997 cap on residency slots - The Balanced Budget Act of 1997 froze the number of physician residency positions available for Medicare funding at the 1996 level, artificially limiting the number of physicians trained each year. The Association of American Medical Colleges (AAMC) estimates that there will be a deficit of 46,000 to 90,000 physicians by 2025. The Minnesota Hospital Association commissioned a study last year to determine whether there will be a primary care physician and registered nurse shortage in Minnesota. Over the next 10 years, Minnesota will experience a shortfall of almost 850 primary care physicians and the nursing supply should be adequate.

- The Minnesota impact of the cap on residency slots - In October 2013, the University of Minnesota (U of M) announced it has no plans to expand its medical student enrollments because of the lack of residency training positions and funding. In a letter to state legislators, the Dean of the medical school wrote: “a cap on the number of training positions set by the federal government in 1997 and reduced federal and state funding for residency training programs has meant that until these issues are addressed, it makes no sense to increase medical school enrollments. There will be no place to train them.” The U of M prepares 70 percent of Minnesota’s health care professionals and has one of the largest medical school enrollments in the country.

- Renew and increase commitment to medical education - The federal government has long recognized its responsibility for funding its share of the direct and indirect costs for training health care professionals. But despite projected physician shortages, deficit cutting proposals include dramatic recommendations to further reduce GME funding.

Federal action requested

- Re-introduce legislation to lift the 1997 cap on residency slots.

- Reject proposed cuts to Graduate Medical Education (GME), Indirect Medical Education (IME) and Children’s Hospitals Graduate Medical Education (CHGME) programs.
Background

Federal support for training our next generation of health care professionals is critical as the nation prepares for workforce shortages, the effects of an aging population and the influx of newly insured residents. Future health professionals need practical, hands-on, supervised training before treating patients independently. Budget deficits and the growing pressure to reduce health care costs have created a target on medical education spending.

Health care professionals trained in Minnesota are far more likely to stay in Minnesota. Our winters contribute to unique recruiting challenges. In 2011, about half of the medical students that graduated from the University of Minnesota completed residencies outside of Minnesota. However, data show that 72 percent of physicians who completed residencies in Minnesota stayed to practice in our communities. Minnesota’s teaching hospitals need federal support to ensure that we do not remain a net exporter of physicians.

Teaching hospitals are centers for research and innovation, helping to develop new treatments and cures, and they provide highly specialized services such as burn care. IME payments partially compensate hospitals for the higher costs associated with training residents such as “learning by doing,” greater use of emerging technology and patients’ higher severity of illness. Direct GME payments help fund resident and faculty salaries, for example.

As Minnesota hospitals and health systems consider “tomorrow’s” health care workplace — in addition to considering potential workforce shortages — they anticipate significant transformations that will include things like:

- Team-based staffing models;
- Care teams that more closely mirror the increased diversity of our patient population;
- Evolving and emerging technologies that render some manually intensive jobs obsolete, while creating new jobs that do not exist today;
- Ongoing and increasing performance improvement, reliance on evidence-based care protocols and transparency efforts; and
- Changes to the reimbursement system that will continue to move toward paying for the value of care patients receive rather than the volume of tests and services providers deliver.