



MEMORANDUM

Date: November 1, 2013

To: The Honorable Chairman and Members
Pima County Board of Supervisors

From: C.H. Huckelberry
County Administrator 

Re: **Graduate Medical Education and the County Allocation to the Arizona Board of Regents to Support Same**

Attached please find information from Deputy County Administrator Jan Leshner and Dr. Ann Weave Hart, President of The University of Arizona, regarding Graduate Medical Education (GME). This information is self-explanatory; it documents the severe physician shortage the country will have by 2025, with the critical shortage occurring in primary care physicians.

The shortage of physicians in Arizona will be particularly acute, since the GME programs funded at the national level are fiscally constrained by the 1997 Balanced Budget Act, which ties the number of residency positions to the levels of 1996. However, since 1996, Arizona's population has grown by 41 percent.

The County's \$15 million contribution to the Arizona Board of Regents (ABOR) for GME is an economic development multiplier; it returns approximately \$45 million to the ABOR for GME, including that conducted at The University of Arizona Medical Center-South Campus.

Our allocation in the past has been \$15 million annually. I do not see this allocation either increasing or decreasing in the next few County budget years.

CHH/mjk

Attachments

c: Jan Leshner, Deputy County Administrator for Medical and Health Services



MEMORANDUM

Medical and Health Services

Date: October 31, 2013

To: C. H. Huckelberry
County Administrator

From: Jan Leshner 
Deputy County Administrator

Re: **Comments by President Ann Weaver Hart about Graduate Medical Education and the Future of Healthcare for American Families**

Earlier this week President Hart posted comments to her blog about the national shortage of physicians and talked about how the U of A is working to address the heightened demand.

President Hart's column (attached) states that the U.S. will have a shortage of 130,600 physicians by 2025, and the need is even more critical with primary care physicians. She notes that without expansion of Graduate Medical Education (GME) programs, many Americans will be unable to afford high quality healthcare.

The size of GME programs funded at the national level is defined by the 1997 Balanced Budget Act. If there had been no increase in population since that time the GME programs could have kept up with the losses to the medical workforce. However, since the Act was adopted the population of Arizona has grown by about 41% and GME has failed to keep up.

President Hart discussed how the University of Arizona is supporting GME and notes that, "The UA College of Medicine – Tucson has had success with expansion to a primary care setting at its South Campus, which has also built a strong record of retaining graduates in Arizona."

JL/cbc

Attachment



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October 25, 2013

Our nation is facing a crisis in healthcare. As the baby boom generation ages, as more Americans become insured, and as the national population expands, the country will need more doctors to provide the high quality and low cost healthcare that we all deserve. In fact, the Association of American Medical Colleges estimates that the U.S. will have a shortage of 130,600 physicians by 2025, and the need is even more acute with primary care physicians. Without expansion of Graduate Medical Education programs and redistribution of the proportions of specialists and primary care doctors trained in those programs, many Americans will be unable to afford high quality healthcare.

Graduate Medical Education (GME) is the period, after four years of medical school, required for supervised development of the necessary skills, experience, knowledge, and attitude that allows a resident MD to mature into an independent and effective clinician. Programs are most often organized as part of academic medical centers, where teaching hospitals partner with medical colleges.

Academic medical centers are generally better positioned than other hospitals to run GME programs, especially in terms of cost. Teaching hospitals do recover some cost through revenue from clinical services, but it does not offset the cost of GME programs. As such, Medicare is the primary source of GME funding.

The Challenges to GME Expansion

The role of Medicare in funding GME slots creates two critical challenges for the successful expansion and adjustment of the nation's GME system.

First, the size of GME programs funded by Medicare at existing teaching hospitals is defined by the 1997 Balanced Budget Act, which ties the number of residency positions to

1996 levels. Were population levels the same, these existing GME programs might be able to keep pace with losses to the medical workforce, but the nation's population grew by approximately 17 percent from 1996 to 2011, and graduate medical education has failed to keep up. In states like Arizona, where the population grew by around 41 percent during the same years, the problem is even more severe.

Since the institution of the cap, growth in GME programs has been moderate. Some hospitals have added GME positions due to institutional need for the overall clinical activity performed through the training process. However, a great deal of the expansion that has occurred in the past fifteen years has been in medical subspecialties, while the greatest area of need is in primary care training. The hospitals that house these new positions are now above their cap and incurring the entire expense of additional slots.

Hospitals that do not have teaching programs are unlikely to be able to meet the demand on their own. Most GME programs are sponsored by academic medical centers because they have the professional expertise and staffing available to run these programs. Hospitals that are not affiliated with a medical college face the dual challenge of hiring new employees with the experience and knowledge to run GME programs before going through a years-long planning and development process to begin a program. Consequently, startup costs are immense and most independent hospitals often do not have the resources to cover them.

Further, the benefits of training in academic medical centers are sometimes allayed by the fact that primary care physicians most often practice in other environments. Thus, in addition to the difficulty of finding the resources to expand the GME system is the added challenge of knowing where and how to achieve effective growth. Expansion must be targeted so the proportion of primary care, general surgery and subspecialty GME slots is parallel to workforce need and that the geographic distribution of healthcare resources is even.

Innovating a Solution

A means to grow GME programs nationwide does exist, however, if policymakers, higher education leaders, and healthcare experts can partner to leverage the academic health center model with multiple clinical partners in each urban area or region. Academic health centers combine the expertise of physician scientists, clinical excellence and a robust teaching operation found at an academic medical center, and they add professionals from other health science disciplines to broaden opportunities for training, research, and clinical partnership.

In Arizona, the University of Arizona's two medical colleges are working closely with several clinical partners to develop a model whereby an academic health center sponsors GME programs that are distributed throughout a city or region, rather than being housed only at large hospitals with multiple subspecialties. Enabled by the state's support for the transfer of funds from one government agency to another (from the UA or a municipality to the state, for instance), public universities and local governments in Arizona are able to provide resources to Arizona's Medicaid agency which then can access federal dollars that require matching investment at the state level. Through this mechanism, teaching hospitals affiliated with the UA's Arizona Health Sciences Center (AHSC) can provide support for joint research, teaching and patient care missions, which will enable the expansion of GME programs in Arizona.

Together, the University and its partners are working to innovate a statewide solution to Arizona's GME shortage. The state needs roughly 1,000 new residency positions, evenly spread across the first, second and third years of training to create a pipeline of independent practitioners. With further investment from the state and industry stakeholders, and the coordination of administrative and other costs, the UA and its partners will be able to move closer to the vital goal of meeting the state's healthcare requirements in the future. Opening the resources of an academic health center to community-based clinical settings will provide the capacity for expansion and the balance of specialist and primary care training that is necessary.

Furthermore, basing UA-coordinated GME programs in local health centers and hospitals brings high quality clinical care to areas of the state in need. This approach also encourages the reapportionment of training positions to better balance primary care, general surgery, and subspecialties, and provides primary care doctors training in the appropriate environment. The UA College of Medicine-Tucson has had success with expansion to a primary care setting at its South Campus, which has also built a strong record of retaining graduates in Arizona.

Nation-Wide Need, State-Specific Solutions

Arizona is a unique case. Phoenix is the largest city in the United States without an academic health center and is a natural place for this kind of expansion. Along with an accomplished and high quality clinical partner, the College of Medicine-Phoenix must be at the heart of a strong academic health center to meet Arizona's health care needs in the coming decades.

Each state must find solutions that address the specific needs and challenges of its communities. However, the distributed model of GME programming being used by the UA's Arizona Health Sciences Center can be adapted for other cities and regions, where community-based settings will broaden the reach of academic health centers and the intellectual, physical and economic infrastructure that they provide for this vital endeavor. If individual states, industry stakeholders, teaching hospitals and medical colleges can work together to invest in GME and thereby leverage federal funding, this transformation can occur. In every case, the cooperation between clinical institutions and their community partners will be the driving force in creating a viable solution.

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