

# AAMC Physician Workforce Research Conference 2009

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# Profile of HFHS



- **93 y.o. hospital-based health system with:**
  - **7 hospitals - flagship (HFH) in downtown Detroit**
  - **Health Alliance Plan - 500,000 HMO members**
  - **Employed physician practice (HFMG) - 1200 physicians**

# Profile of HFMG

- 2 million outpatient visits
- 650,000 patients (150,000 capitated)
- **700 allopathic GME trainees:**
  - **7<sup>th</sup> largest in U.S.**
- **Nation's largest osteopathic education enterprise**
- \$57 million in research - 4 NIH program projects
- Major affiliation with Wayne State School of Medicine

# Detroit Issues = National Issues

- Systems of Care—Doctors and Hospitals must be aligned with common:
  - Information systems
  - Financial incentives
  - Quality/cost agendas
- Primary Care Morale at Crisis Levels
  - will be melt down w/out redesign
  - chronic care needs system approach
- Technology Proliferation Unchecked

# National Health Care Priorities

- Universal Coverage - enough docs? consider Massachusetts experiment
- Primary Care Crisis - payment reform?
- Reduce Health Care Costs - How?
- Improve Quality/Access – How to organize systems of care ?

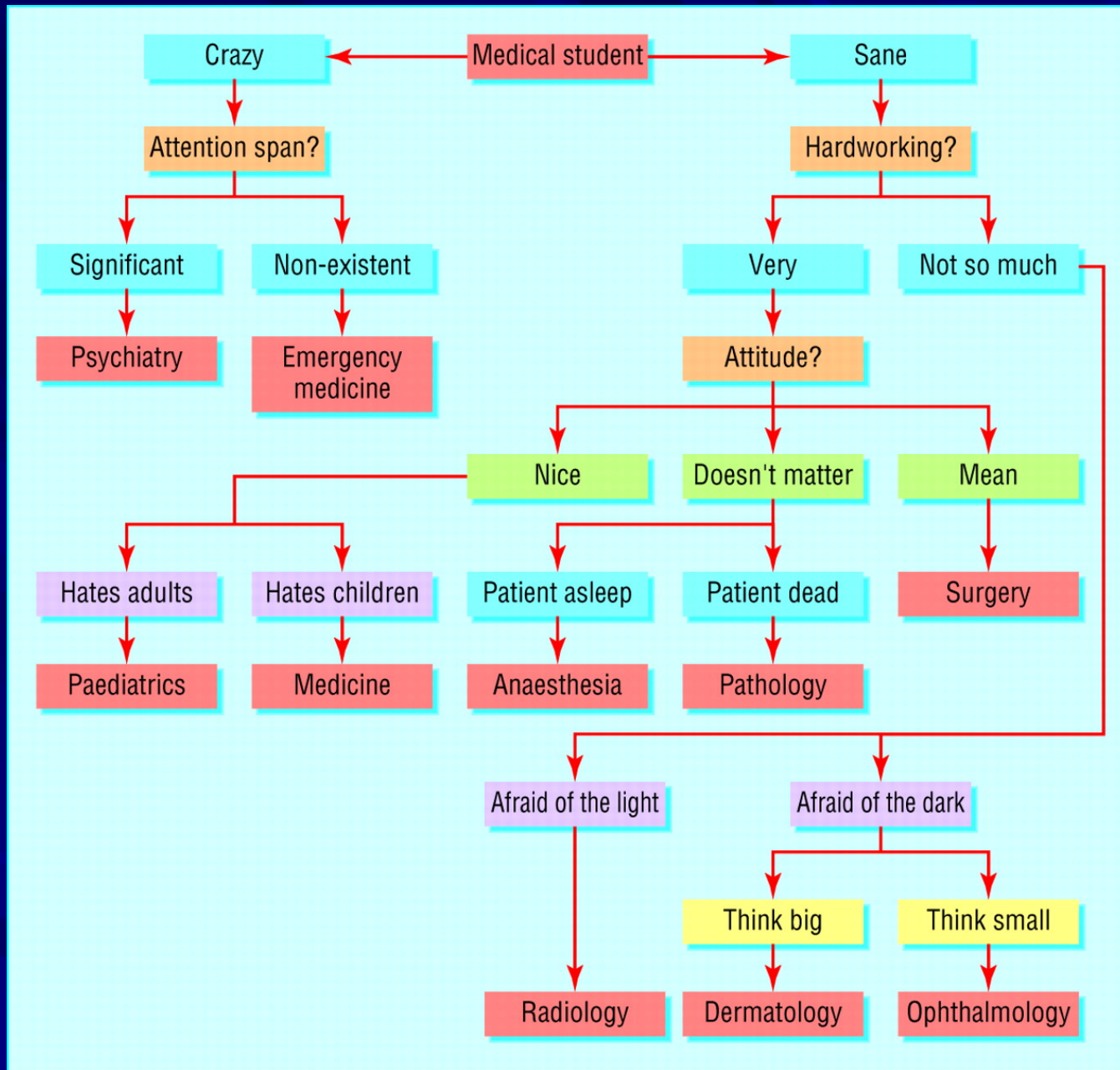
# Workforce “Supply Chain”

Early Student Interest

Medical School

GME Training

Career/Employment



# Workforce “Supply Chain”: Impressions Developed in Medical School

- What Shapes Student Preferences?
  - Earning Power
  - Role Models
  - Lifestyle of Specialty and its Training

*Most of this is based on personal  
experience in the clinical setting  
i.e. “the hidden curriculum”*

# Workforce “Supply Chain”: What Shapes The “Hidden Curriculum” ?

- Most Medical Schools Are Driven By Profitable Subspecialty Care
  - Cardiac
  - Cancer
  - Neuroscience
- Most Deans see neither margin nor mission for primary care

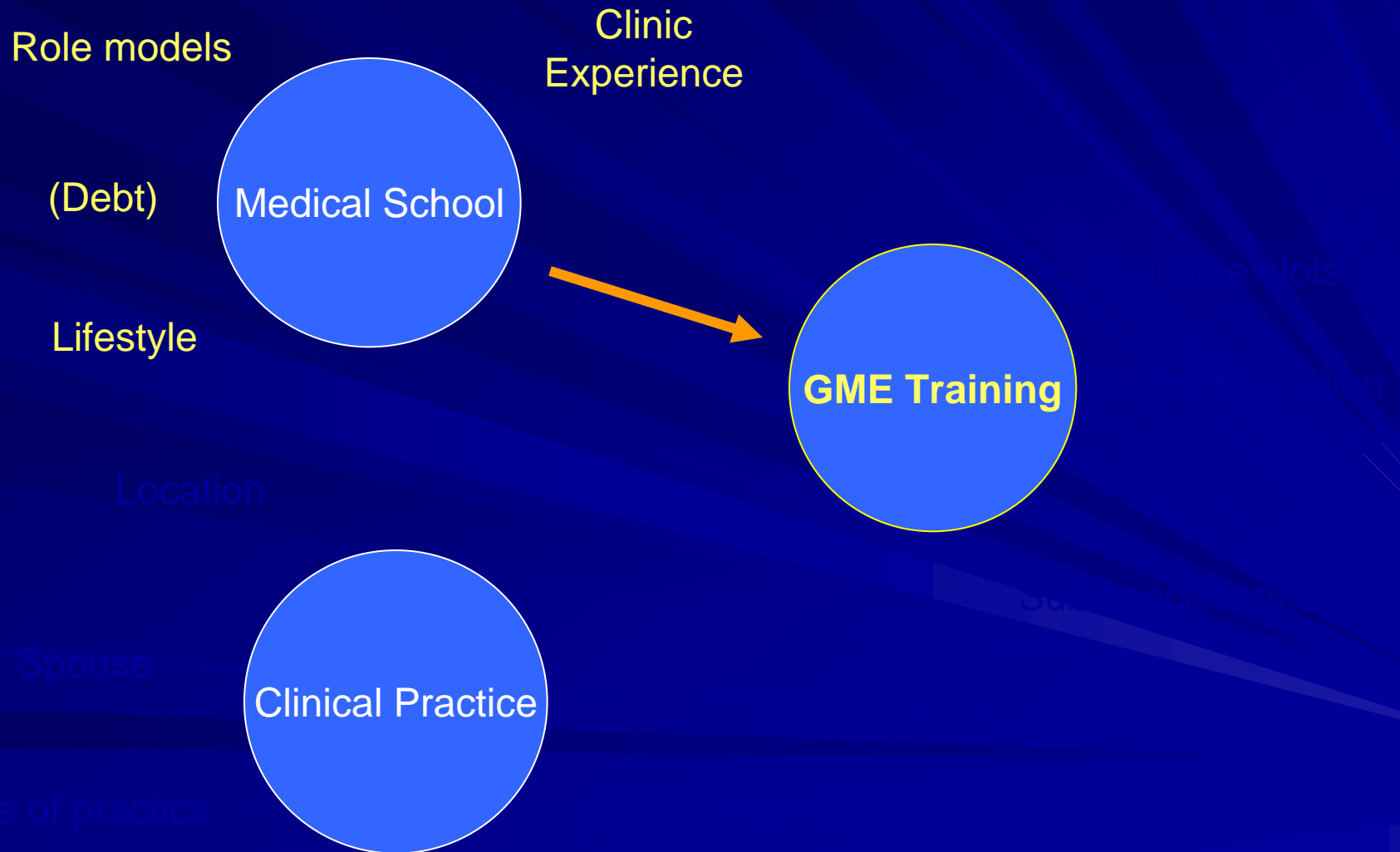
*Primary Care has little traction in academic rewards system*

# Workforce “Supply Chain”

## The Choice of Specialty and the Match

- Few students choose primary care
  - Earning Power—poor
  - Role Models—very few in medical school
  - Lifestyle of Specialty –too much work—”sick old people”; unpredictable hours

# The Training of a Physician



# GME Positions Are Not Aligned With Public Needs

- ACGME approved 6500 new positions from 2002-2006 (6.3% growth)
- Virtually All were self-funded
- Virtually None were entry level slots

*Conclusion: GME is supporting local clinical operations, esp. in subspecialty fellowships*

(Iglehart, NEJM 2008, 359: 643)

# Workforce “Supply Chain”: GME Programs Reward High Tech

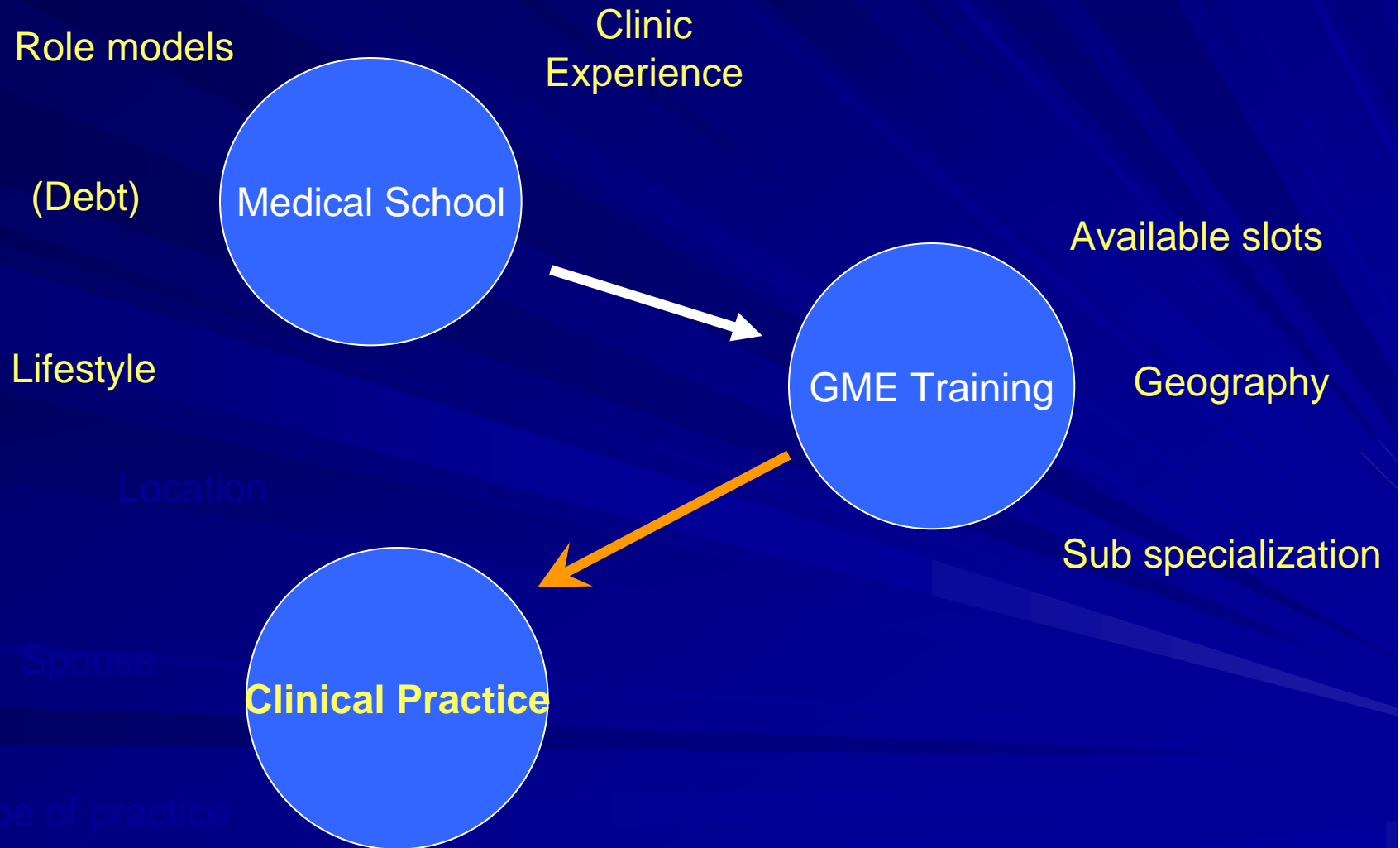
- Teaching Hospitals Are Driven By Subspecialty Care to Provide Service/Profit
  - GME Slots are used to support high margin programs:
    - Cardiac
    - GI
    - Critical Care
    - Surgical Specialties

*GME program portfolio locally and nationally is not regulated –and, by default, is highly influenced by hospital bottom line*

# Workforce “Supply Chain”: Fix the Teaching Environment

- GME Portfolio – Regulate?
  - Slots Increased?-maybe
  - Regulate for mix? –politically difficult but necessary—free market not working
  - *How can we fail to manage a \$10B program?*
- Medical Schools—incentives for more primary care?
  - Teaching Venues
  - Faculty development/rewards
  - Create role models

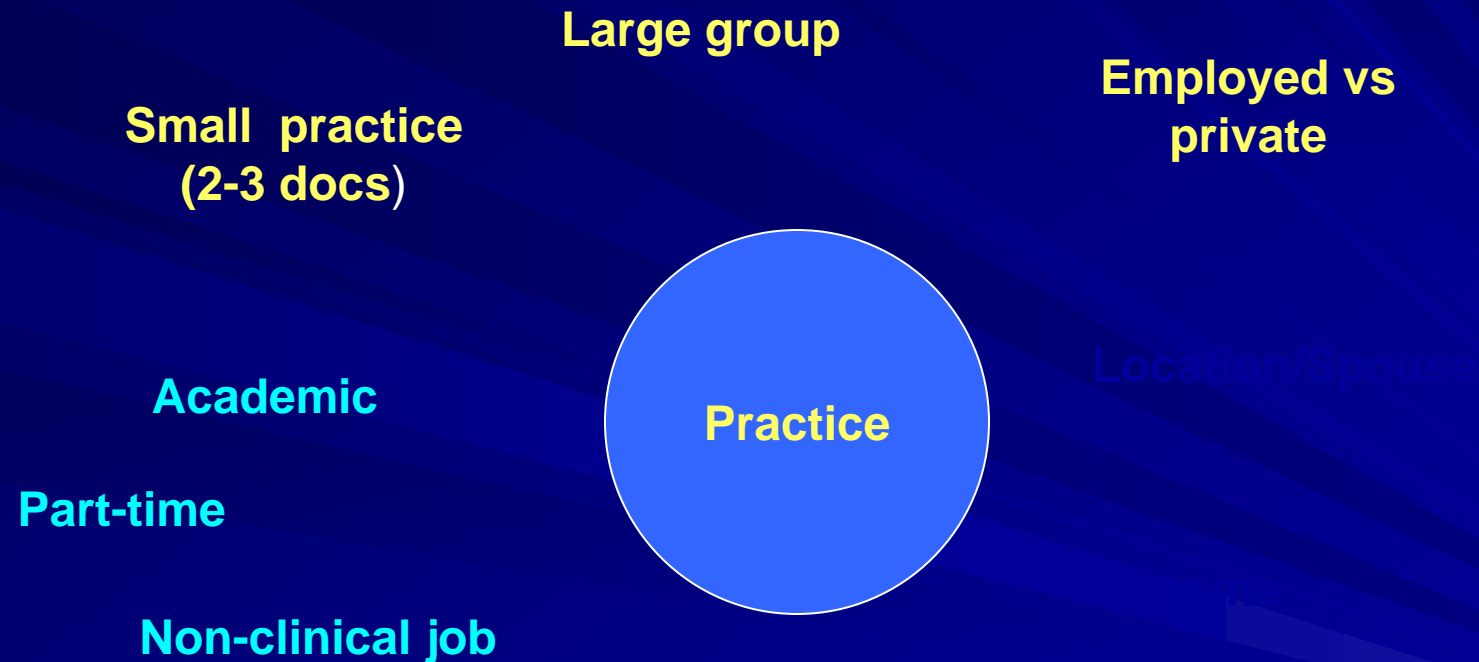
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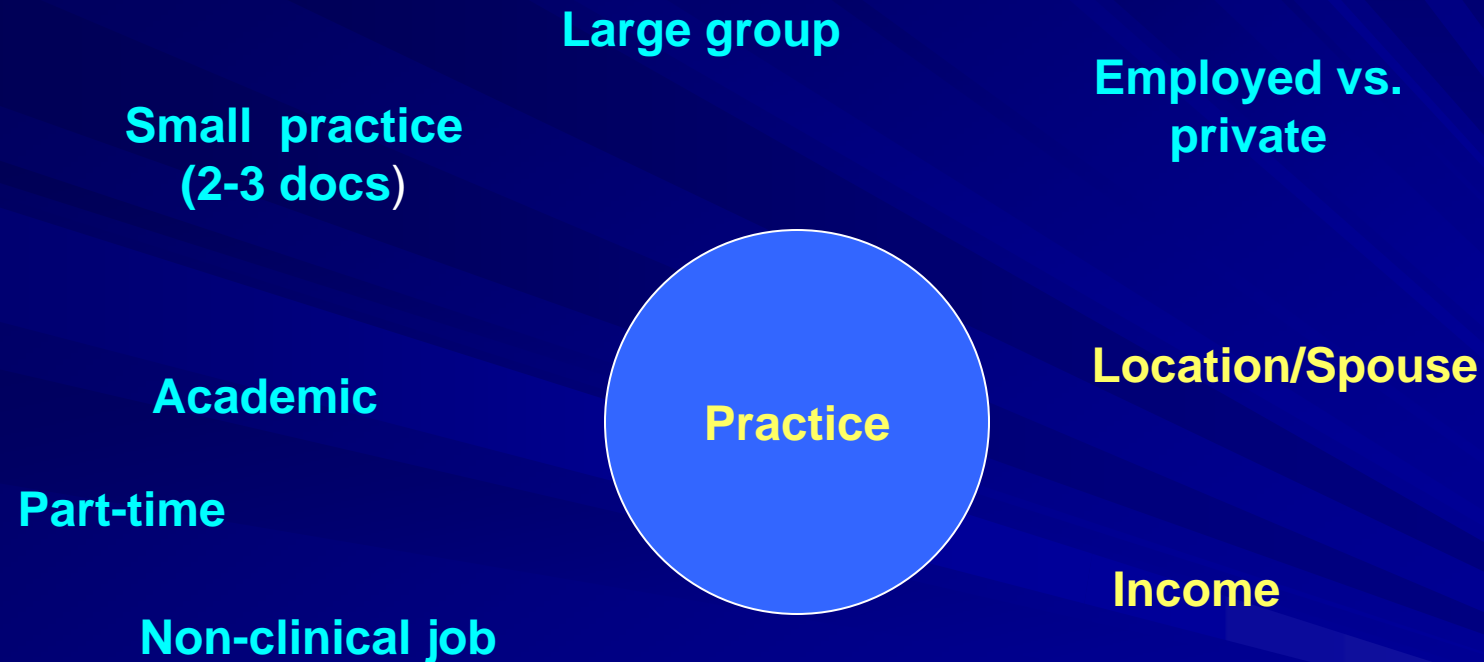
# Decisions for Newly Trained Physicians



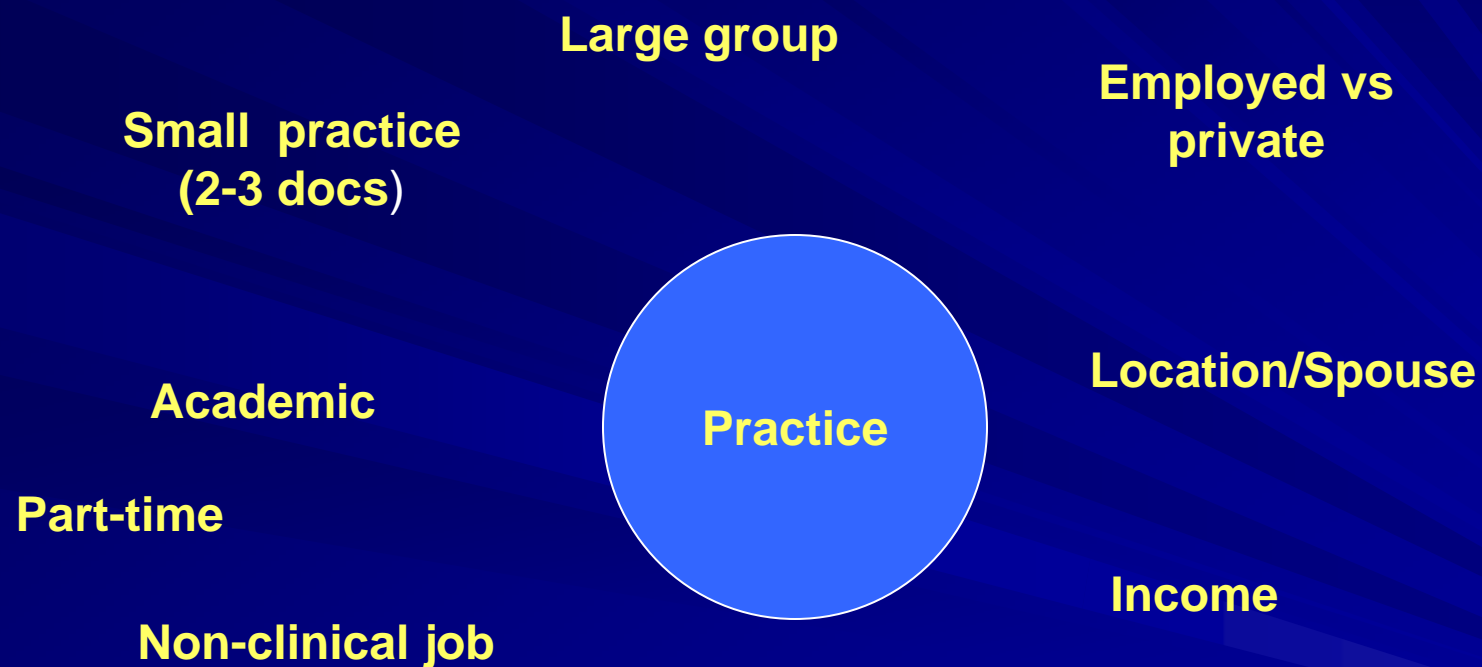
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# Decisions for Newly Trained Physicians



*All vulnerable to economics and regulation*

# Workforce “Supply Chain”: Fix the Employment Options

*Health Care Reform must make primary care more attractive, while reducing costs and improving quality:*

- IT systems—necessary but not sufficient
- Organized Systems of Care
  - Among physicians - **how?**
  - Between hospitals and physicians - **how?**
- Payment reform matters—capitation, Medical Home, bundled payments?

# Workforce “Supply Chain”: Employment Options Evolving !!

*While awaiting health reform, market is on the move:*

- Group practice - more appealing for reliable job, flexibility, no investment
- With flat reimbursement, physicians seek employment to gain access to technical revenue
- Medical practice is becoming segmented: hospitalists, ED physicians; ambulatory primary care

# Workforce “Supply Chain”: Possible Health Reform Actions

- “Early Interest” – more student loans to shape workforce
- Medical School – more \$\$ to support role models, time to teach; primary care curriculum
- GME Training -- regulation of portfolio for national needs, ?more slots
- Career/Employment---payment reform for primary care; incentives to organize care: eg “Medical Home”, accountable care organizations

# Health Care Reform and Physician Workforce Must be Linked Together

*To separate them will defeat all efforts !!*

## ■ Examples:

- Shortage of Primary Care—defeated by SGR and procedure-driven RVU model;
  - Result: no coordination of care; “turnstile mentality”
- GME funds—program portfolios driven by desires of teaching hospitals
  - Result :more subspecialists

# Why Have We Reached This Health Care Crisis?

- Health Care in the United States is not supported by consistent public policy and funding
- Health care policy has been based on free market economic model, which is fundamentally flawed
- The developed countries, so often cited as models, plan and regulate health care as national policy....

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*Do we have the political will to do the same?*



# Health Care is an Engineering Project..... Not a Lab Experiment

