Envisioning a Future Governance and Funding System for Undergraduate and Graduate Medical Education

Jeffrey P. Gold, MD, Jim P. Stimpson, PhD, and Kelly J. Caverzagie, MD

Abstract

Funding for graduate medical education (GME) and undergraduate medical education (UME) in the United States is being debated and challenged.1 Since the inception of Medicare and Medicaid in 1965,2 federal agencies and Congress to reduce federal spending, have drawn the GME fund would cover learners’ UME tuition, potentially eliminating their UME debt, in return for their provision of health care services (after completing GME training) in an underserved area or specialty. This proposed model attempts to increase transparency and enhance accountability in medical education by linking funding to the development of a physician workforce that is able to excel in the evolving health delivery system. Achieving this vision requires physician educators, leaders of academic health centers, policy makers, insurers, and patients to muster the courage to embrace transformational change.

In recent years, the funding of graduate medical education (GME) in the United States has been widely debated and challenged.1 Since the inception of Medicare and Medicaid in 1965,2 federal and state governments have appropriated billions of dollars each year for the education of physicians training at teaching hospitals and academic health centers (AHCs). In 2012, Medicare and Medicaid contributed approximately $13.6 billion (B) to GME.3 This amount, coupled with the suggestions of several federal agencies and Congress to reduce federal spending, have drawn the GME governance and funding system into question, especially given the reported inconsistent outcomes of GME (i.e., variable clinical outcomes).1,3 The result of this scrutiny and ongoing debate is an increasingly uncertain future for the half-century-old structure and funding system in the United States.4

Along with the high costs of GME, the continually rising costs of attending medical school have come under scrutiny. For 2015 medical school graduates, the median four-year cost of attending a public MD-granting medical school was $226,447, up 3% from the preceding year, and 43% of these graduates was $180,000, up 3% from the preceding year, which in turn all directly impact the health of the public.6–11

In addition to the overall costs associated with medical education, access to and the quality and (as mentioned) the ultimate outcomes of this lengthy process are of concern to policy makers. In spite of the intense focus on GME, some have voiced concerns that some physicians are completing residency and fellowship programs without critical process are of concern to policy makers. In spite of the intense focus on GME, some have voiced concerns that some physicians are completing residency and fellowship programs without critical skills in communication, leadership, management, and systems thinking—all of which are necessary to effectively and efficiently work in ambulatory and inpatient settings.12 In addition, some have suggested that physicians graduating from procedural residencies (e.g., general surgery) may lack the skills and experience necessary to independently perform common clinical procedures (e.g., laparoscopic cholecystectomy).13

Because AHCs remain the major setting of physician education in the United States, their leaders and the clinical instructors working in them must develop and educate a physician...
workforce that is capable of providing care for the individuals and communities of the United States and, in many instances, the world. Yet, many Americans continue to experience inadequate access to medical services, at least in part due to the uneven distribution of physicians by specialty and geographic location. These and other documented challenges are why policy makers and others have suggested that AHCs and other teaching hospitals are not fully achieving their mandate, which is to provide for the nation’s health workforce needs.\(^3\)\(^,\)\(^15\)\(^,\)\(^17\)

Recognizing the mismatch between the needs of the U.S. population and the demonstrated outcomes of GME training programs, the Institute of Medicine (IOM) convened the Committee on the Governance and Financing of GME, which issued a report in July 2014. This report, titled “Graduate Medical Education That Meets the Nation's Health Needs,” outlines the limitations of the current GME system and proposes reforms that would improve the transparency, accountability, and innovation of the U.S. medical education system.\(^3\) The authors of the IOM report recommend phasing out the current Medicare GME payment system and replacing it with a two-part Medicare system that comprises (1) an operations fund to finance ongoing residency training activities and (2) a transformation fund to finance the development of new programs, infrastructures, evaluation methods, payment protocols, and other priorities. This new transformation fund, intended to be performance based, would be developed and overseen by new organizational structures within the federal government. Medicaid funding of GME would be left to the discretion of states, but the institutions and physicians receiving funding would be required to maintain the same level of transparency and accountability required of the Medicare GME funding mechanisms as outlined in the IOM report.\(^3\)

While setting the stage for transforming GME funding and accountability, the IOM report has not provided specific details about how to proceed and has, thereby, effectively encouraged proposals of sufficient detail to achieve the desired changes. In this Perspective, we propose a novel all-payer system for GME funding that, along with a “tuition-for-service” (TFS) program designed to fund the majority of undergraduate medical education (UME), could serve as a model for achieving the IOM’s goal of a physician workforce that is able to better serve in the evolving U.S. health care delivery system. Our aim is to provoke thought (and possibly to inspire change) and to engage all of the stakeholders in a detailed philosophical, pragmatic discussion of the funding and structure of medical education in the United States.

To place this discussion in the context of the overall scope of the U.S. health care system, Table 1 outlines the 2012 and 2013 national health expenditures (NHE) by payer source,\(^18\) and Table 2 outlines the absolute and relative contribution of those payer sources to GME funding by comparing actual 2012 funding contributions\(^3\) with what would have been predicted for 2013 using the funding mechanisms we outline in the model proposed below.

### The Medical Education Workforce Trust Fund Model

We believe that—as outlined in the IOM report\(^3\)—the key to achieving substantive change in medical education begins with the revision of current GME funding mechanisms; however, we feel that simply allocating Medicare dollars into two separate GME funds will not go far enough to establish the fiscal transparency and accountability desired by stakeholders. Instead, we propose the establishment of a novel all-payer system whereby government, commercial, and private entities, as well as self-pay individuals, invest in the education of all physicians in exchange for the highest quality of health care. This system, which would replace the historic and heavy dependence of GME on Medicare and Medicaid, would be managed and financed by a Medical Education Workforce (MEW) trust fund through which all centrally funded GME support would flow. In addition, the MEW fund would also address the unsustainable costs of UME tuition through the implementation of a voluntary medical service option for medical school graduates. Ideally, the GME and UME components of this transformative model would be implemented together; however, we believe that a sequential implementation approach is also possible.

#### Impact on GME

**The educational assessment**

To establish the revenue for the MEW fund, professional and facility fees charged to all government and nongovernment health care payers (Medicaid, Medicare, private insurers, others) for services provided by physicians, hospitals, ambulatory centers, and nursing facilities as well as payers of other health-care-related services (e.g., prescription medications, devices, durable medical equipment) would be assessed a nominal surcharge which we refer to as the educational assessment (EA). Table 2 illustrates the impact of the EA by comparing actual 2012 GME payer source contributions against what those contributions would have been in 2013 if an EA of 0.6% had been applied. We chose this percentage (0.6%) because it approximates the percentage of total NHE spent on GME in 2012 as demonstrated in Table 2. When applied to the known 2013 NHE, all payers would

### Table 1

**2012 and 2013 U.S. National Health Expenditure (NHE) by Payer Source**\(^*\)

<table>
<thead>
<tr>
<th>Payer Source</th>
<th><strong>2012 expenditure, total (%)</strong></th>
<th><strong>2013 expenditure, total (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$5678 (20.1)</td>
<td>$5868 (20.1)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$4248 (15.1)</td>
<td>$4498 (15.4)</td>
</tr>
<tr>
<td>Private insurance</td>
<td>$9368 (33.2)</td>
<td>$9628 (33.0)</td>
</tr>
<tr>
<td>Patients</td>
<td>$3298 (11.7)</td>
<td>$3398 (11.6)</td>
</tr>
<tr>
<td>Other(^a)</td>
<td>$5638 (20.0)</td>
<td>$5838 (20.0)</td>
</tr>
<tr>
<td><strong>Total NHE</strong></td>
<td><strong>$2,817B</strong></td>
<td><strong>$2,919B</strong></td>
</tr>
</tbody>
</table>

*Abbreviation: B indicates billion.\(^*\)

\(^a\)Includes health-related spending for Children's Health Insurance Program (CHIP), Titles XIX and XXI, U.S. Department of Defense, U.S. Department of Veterans Affairs, other third-party payers and programs, public health activities, and investments.
Table 2
Graduate Medical Education (GME) Expenditures by Payer Source Before (2012) and After (2013) the Implementation of the Proposed Medical Education Workforce (MEW) Model and the Application of the Educational Assessment (EA) on All Health Care Payers

<table>
<thead>
<tr>
<th>Payer source</th>
<th>GME expenditures before EA 2012</th>
<th>GME expenditures after EA 2013</th>
<th>Difference in GME expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total^a % NHE^b % GME^c</td>
<td>Total^a % NHE^b % GME^c</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>$9.7B 0.34 62.6</td>
<td>$3.5B 0.12 20.0</td>
<td>$-6.2B</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$3.9B 0.14 25.2</td>
<td>$2.7B 0.09 15.4</td>
<td>$-1.2B</td>
</tr>
<tr>
<td>Private insurance</td>
<td>$0.0B 0.0 0</td>
<td>$5.8B 0.20 33.0</td>
<td>$5.88</td>
</tr>
<tr>
<td>Patients</td>
<td>$0.0B 0.0 0</td>
<td>$2.0B 0.07 11.4</td>
<td>$2.08</td>
</tr>
<tr>
<td>Other</td>
<td>$1.9B 0.07 12.3</td>
<td>$3.5B 0.12 20.0</td>
<td>$1.68</td>
</tr>
<tr>
<td>Total GME</td>
<td>$15.5B 0.55 100</td>
<td>$17.5B 0.6 100</td>
<td>$2.08</td>
</tr>
</tbody>
</table>

Abbreviations: NHE signifies national health expenditure; B, billion.
^aPercent contribution of each payer source as a function of the 2012 total NHE. For example, the 2012 Medicare GME contribution of $9.7B was 0.34% of the 2012 total NHE ($2,817B; see Table 1). The total GME expenditure by all payer sources equals 0.55% of 2012 total NHE.
^bPercent contribution of each payer source as a function of the 2012 total NHE. For example, the 2012 Medicare GME contribution of $9.7B was 62.6% of the 2012 total GME expenditures. Together, Medicare, Medicaid, and other governmental sources account for 100% of total GME expenditures. Percentages may not total 100 because of rounding.
^cPercent contribution of each payer source as a function of the 2013 total NHE. For example, the 2013 Medicare GME contribution of $3.5B was 0.6% of the 2013 total Medicare NHE ($586B; see Table 1). The total GME expenditure by all payer sources equals 0.6% of 2013 total NHE.
^dPercent contribution of each payer source as a function of the 2013 total NHE. For example, the 2013 Medicare GME contribution of $3.5B would be 0.12% of the 2013 total NHE ($2,919B; see Table 1). The total GME expenditure by all payer sources equals 0.6% of 2013 total NHE.
^ePercent contribution of each payer source as a function of the 2013 total NHE. For example, the 2013 Medicare GME contribution of $3.5B would be 20.0% of the 2013 total GME expenditures. Together, Medicare, Medicaid, and other governmental sources account for only 55.4% of total GME expenditures. Percentages may not total 100 because of rounding.
^fIncludes GME spending for Veterans Administration and the Health Resources and Services Administration.

Collectively contribute $17.5B toward GME funding. (All calculations were made using the actual 2012 and 2013 NHE data listed in Table 1.)

The EA fee, which would be collected on a per encounter basis through the use of a conventional billing code modifier, would be pooled together to serve as the primary source of revenue for the GME portion of the MEW fund as noted in Chart 1. (We describe the sources of funding to support the UME system below.)

The educational incentive
To encourage engagement in the education of physicians, we propose that providers and facilities that actively contribute to the education of a medical student, resident, or fellow (through the provision of clinical encounters) would receive an incremental educational incentive (EI) payment from the MEW fund, also using a billing code modifier, to help cover the costs associated with supervising learners and maintaining an effective learning environment. To be a significant incentive for an individual, we propose that the EI equate to an additional 10% payment per clinical encounter for those physicians actively engaged in teaching. Compensating hospitals or institutions through the facility incentive portion of the MEW fund would mirror the encounter-based payments of individual providers; the facility incentive would effectively function like the indirect medical education (IME) dollars that are currently distributed to those facilities and be proportionally similar in amount.

To determine the total cost of the EI to the MEW fund, we estimate that 10% of all physician and clinical professional services, which had a 2013 NHE of $587B, occurred in a teaching setting. If half of those encounters are from a physician providing the service, a 10% per encounter payment to physicians would equate to an estimated $2.9B expensed to the MEW fund for participating in physician education as illustrated in Chart 1.

GME funding revenue and expenditures summary
In summary, all GME revenue flowing into the MEW fund would come from applying the 0.6% EA fee to all payers in the health care system including the federal and state governments, private insurance companies, pharmaceutical and device manufacturers, and health care consumers. The 0.6% rate approximates the percentage of total NHE spent on GME in 2012 (see Table 2). The dollars traditionally referred to as direct medical education (DME) and IME funds that are used to support teaching hospitals and clinics will continue to flow as always—but through the MEW fund rather than directly through existing Medicaid and Medicare funds. The difference lies in the origin of those dollars through the all-payer system.

We fully expect the rates of the EA and EI to be variable; these would be adjusted by a MedEd Advisory Commission which would administer the entire program (similar to the GME Center and Policy Council proposed by the IOM report).
The goal of this commission is to support a strong and vibrant physician workforce that can meet the nation’s health care needs. We propose, similar to the plan outlined in the IOM report, that in five years, the EI payment rates would be tied to predefined educational measures of quantity and quality that UME and GME teaching faculty, programs, institutions, and learners would be expected to meet.

**Impact on UME**

**The TFS Program**

To encourage physicians to practice in communities and specialties lacking access to physicians and health care, the MedEd Advisory Commission would also oversee the TFS program. Through this program, the MEW fund would finance the entire cost of tuition and fees for up to an estimated 92,300 students attending accredited U.S. osteopathic (n = 19,988) or MD-granting medical schools (n = 72,312) medical schools (authors will provide full details on sources and numbers upon request). In return for the tuition remission, the physicians who participate would provide, after completing their GME training, service in their chosen specialty to designated communities or populations in need. To determine these designated areas, the MedEd Advisory Commission would rely on state and regional workforce studies that would be compiled annually to determine geographic and specialty needs. Given the dynamic nature of workforce projections, the MedEd Advisory Commission would have to partner with organizations that maintain expertise in the area of health care workforce studies.

Through the TFS program, physicians who choose not to participate in the service component of the program would be required to repay their tuition and fees through a market rate educational loan, including the compounded interest, consistent with existing federal loan programs. Time spent in service to the military, the Department of Veterans Affairs health system, and other recognized public service corps could fulfill all or some of the service requirements. Likewise, the receipt of private funding, scholarships, work study, or other recognized means of repayment during UME or GME training could also fulfill all or some of the requirements. Physicians who fulfill the service requirement would receive an advanced-residency-level salary and benefits directly from the MEW fund, in accordance with their level of postgraduate training, specialty, and location of practice.

To cover the costs of the physician’s salary and benefits, as well as the costs of paying for UME tuition, the MedEd Advisory Commission would charge the participating physician’s clinic, practice, or hospital employer the direct cost of that physician’s salary and benefits, as well as a “TFS fee” which should average $40,000 per physician per year. We chose this figure ($40,000) because it approximates the 2014–2015 median cost of tuition and fees for first-year in-state students in public MD-granting medical schools ($34,133), and public osteopathic medical schools ($44,320). For example, if 75% of eligible physicians (n = 69,225) were to complete the service component of the program and if their employers were assessed a TFS fee of $40,000 per physician per year, the MEW fund would recover $2.8B in revenue. Likewise, the complementary 25% of eligible physicians (n = 23,075) not participating in the service requirement would repay the cost of their tuition. Using an estimated total repayment of $328,000 for a student who enters forbearance during residency and scheduled repayments for 10 years post residency, the average yearly repayment would be $82,000 per year, allowing the MEW fund to recover $1.9B. Combined, the TFS fee and tuition repayment would generate $4.7B in revenue for the MEW fund. The MEW expenditures (tuition and fees) to accredited medical schools would equate to $3.4B, as illustrated in the UME portion of Chart 1. Of note, total (including both UME and GME) MEW revenue exceeds total MEW expenditures by $0.4B.

From the standpoint of the clinic, practice, or hospital that employs the eligible physician post GME training, the MEW fund would be advantageous in return for the tuition remission, (authors will provide full details on sources and numbers upon request).

### Chart 1

**2013 Predicted Medical Education Workforce (MEW) Revenue and Expenditures Using the Proposed MEW Fund Model**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>GME</td>
<td></td>
<td>UME</td>
<td></td>
</tr>
<tr>
<td>• Educational assessment (EA)</td>
<td>$17.5B</td>
<td>• Tuition-for-service (TFS) fee</td>
<td>$2.8B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tuition repayment</td>
<td>$1.9B</td>
</tr>
<tr>
<td>UME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tuition-for-service (TFS) fee</td>
<td>$2.8B</td>
<td>• Tuition and fees</td>
<td>$3.4B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GME and UME combined</td>
<td>$22.2B</td>
<td>All sources</td>
<td>$21.8B</td>
</tr>
</tbody>
</table>

Abbreviations: GME indicates graduate medical education; B, billion; DME, direct medical education; IME, indirect medical education; UME, undergraduate medical education.

*This illustration does not account for annual cost-of-living increases.

*Notably, revenues exceed expenditures, allowing a margin of $0.4B.
because the expenses of the advanced-resident-level salary and benefits, even combined with the $40,000 per year TFS fee, are very likely to be significantly less than a standard recruitment package, typically approaching or matching the first year’s base salary, for a physician entering into practice at that location. Similarly, the physician completing the service component of the program would have significantly less, perhaps no, UME tuition-related debt. Finally, communities in need of primary care and specialty-trained physicians would have greater access to qualified care providers and a better chance for their long-term retention.

UME funding revenue and expenditures summary
We estimate that the majority of the UME revenue for the MEW fund would be generated through assessing a fee of the community clinic, practice, or hospital employing the physician during the TFS interval. That fee would approximate the cost of the physician’s salary, benefits, and UME tuition and fees. The fee would vary according to the percentage of graduating residents participating in the TFS program, which would require the MedEd Advisory Commission to appropriately encourage participation. The remaining UME revenue would be generated by those graduating residents who choose not to participate in the TFS program and instead repay their own tuition and fees, including interest as per our current system. Chart 1 provides an outline of the UME funding revenue and expenditures.

The Financial Context of the MEW Fund Model
To better understand the financial impact of our proposed UME and GME funding system, we performed a review of the current state of educational funding as a component of the U.S. annual NHE. As noted previously, Table 2 compares the expenses and revenue of the current system and our proposed MEW Fund Model. Through the MEW Fund Model, the GME expenses to Medicare would decline by $6.2B or 66%, and the expenses to Medicaid would decrease by $1.2B or 31% with the all-payer system actually creating a $2.0B surplus which could facilitate needed reinvestment in the educational system. Table 2 also demonstrates how GME, which prior to now has been exclusively government funded, accounted for a fraction (approximately 0.55%) of total U.S. NHE in 2012 while generating no revenue to support its cost.

As shown in Chart 1 and outlined above, the all-payer MEW Fund Model would actually generate a small surplus that could be reinvested into the GME system. Using conservative estimates of the cost to educate one internal medicine resident (about $130,000), just $0.2B of this extra revenue could fund over 1,500 new residency positions or approximately 500 new graduates per training year, thereby supporting recent efforts to increase the number of funded GME positions and providing significant relief to the current bottleneck within graduate physician training. This potential to flexibly expand the GME workforce on the basis of need represents a key component of the MEW Fund Model.

Potential Advantages of the MEW Fund Model
As described above, we propose a transparent, accountable, budget-neutral all-payer UME-GME funding system that would yield many positive returns for learners, patients, payers, communities, and stakeholders. Specifically, in the area of enhanced education and training, the MEW Fund Model we propose would enable new residency positions in multiple specialties—all of which would be grounded in evidence-based, geographic (state and regional), and specialty workforce needs. Additionally, medical education debt would no longer factor into trainees’ decisions regarding their medical specialty or practice location.

The MEW Fund Model would also advance the medical profession’s commitment to service. Learners, faculty, and practicing physicians would be more effective at meeting the needs of patients and communities deemed to be underserved. By better aligning the regional workforce needs with the workforce of trained physicians, the model would increase the engagement of physicians in the social contract of providing service to patients and communities, as well as to learners.

In addition to the advantages to education and training and to the increased commitment to service, the MEW Fund Model would improve learner and patient access to, respectively, educational programs and excellent health care. The TFS program would allow learners of all socioeconomic backgrounds to have equitable opportunity to attend medical school and complete residency. Concomitant with this more equitable access to medical education, physicians participating in the TFS program would, over time, decrease the number of federally designated underserved areas by fulfilling their TFS obligations during their service interval and perhaps by later establishing permanent practices.

The financial advantages to all stakeholders are also clear. Funding of GME and UME efforts would be transparent and directly linked to the outcomes produced by the teaching faculty and clinical facilities in which the education occurs. Market-based considerations (e.g., in either a volume- or value-based payment system) would drive the costs of health care coverage premiums, including the MEW fund’s EA and EI transaction fees. These EA revenues and EI expenses, which mirror the traditional process of federal and state IME and DME funding, would pass through the MEW fund and be, at worst, budget neutral. Medicare and Medicaid GME expenses would be initially reduced by, respectively, about 66% and 31%, facilitating transformation and reinvestment in the educational system. The mechanics of student tuition, financial aid, and other increasingly complex enrollment and debt management logistics would be eliminated.

The MEW Fund Model, Other Models, and Pilot Projects
The MEW Fund Model we propose is similar to the plan outlined in the IOM report in that it maintains the current level of government support for GME and in its overall operational design. The differences lie in the specific mechanism through which revenue is generated to support GME (the all-payer system) as well as in the incorporation of UME funding as one mechanism to support a more balanced geographic and specialty distribution of physicians.

Over the years, others have proposed or recommended creating an all-payer
appropriate role of third-party payers
appropriation process; and what the
permanent or based on an annual
influencing the health care workforce;
patients should cover these); how active
represent patient care or educational
workforce should be borne by everyone.26
therefore the cost of providing that
a well-trained medical workforce, and
argument in support of all-payer systems
projections of physician workforce needs
Encourage buy-in. Trusted processes for
to build inclusive and comprehensive
to work with private payers and providers
federal and state governments would need
implementing this innovative model. First,
Multiple challenges stand in the way of
Fund Model
system accountable for achieving specific
redistribution in the physician workforce
appropriate and necessary growth and
physicians. Finally, this model expedites
training, and such a request might very
specialties and locations. We believe this
reciprocity is a key component for any
all-payer system to appropriately meet the
nation’s workforce needs. Additionally,
we provide specific details with regard to
how funding in an all-payer system would
be managed.

We readily acknowledge that our
financial estimates are complex and that
nuances and special circumstances must
be considered. The implementation
of the model outlined in this proposal
would require extensive economic and
operational analysis and is, thus, beyond
the scope of this Perspective. Further, we
believe that a series of demonstration
or pilot projects to test the concepts and
work through the systems changes would
be helpful. Once again, the goal of this
Perspective is to start a philosophical,
pragmatic discussion about, if not a
transformation in, the structure and
financing of U.S. medical education. The
discussion and change should involve all
stakeholders in the medical community,
including both those who pay for it and
those who benefit from it.

The Challenges Facing the MEW Fund Model
Multiple challenges stand in the way of
implementing this innovative model. First,
federal and state governments would need
to work with private payers and providers
to build inclusive and comprehensive
economic models that would support and
courage buy-in. Trusted processes for
developing accurate and timely short-term
projections of physician workforce needs
would need to be developed, applied,
and tested to create longer-term plans.
Medical education and governmental
regulatory bodies would need to examine
internal existing policies and procedures
(e.g., time-based graduation requirements
in UME and GME, payments only to
large AHC facilities and not to teaching
physicians, ambulatory sites) to avoid
becoming barriers to transformation.

Among the most difficult challenges of
establishing any new paradigm, including
one like the MEW Fund Model that integrates federal and state
resources, is garnering the needed
legislative approval and endorsement of
executives and leaders across multiple
levels. The establishment of a MedEd
Advisory Commission, which would
have independent governance authority
regarding financial and workforce
management decisions, would be
necessary. As evidenced over the past
20 years, the current national political
climate has not been supportive of
transforming the funding of programs
directly related to health professions
education and delivery. We remain
optimistic, however, because the MEW
Fund Model would create an innovative
and transparent mechanism for funding
that is in contrast to the current,
misaligned, opaque GME funding system.
Overcoming these challenges would
require considerable political alignment,
great fortitude, and strong leadership—
very strong leadership.

Challenges also exist within the broader
health care professions and academic
medicine. Faculty, learners, providers,
and institutions are familiar and
comfortable with the current system of
medical education and funding; change
is difficult, and resistance to change is
strong. If the all-payer MEW Fund Model
were to be implemented, leaders and
change agents in other health professions
may also seek funding for graduate
training, and such a request might very
well be considered over time in exchange
for similar service commitments.
Further, the current system of medical
education across the continuum is highly
segregated; that is, all levels of medical
training are replete with a variety of
independent, significantly siloed
regulatory, accrediting, and oversight
bodies. The MEW Fund Model requires
the leaders of educational programs to be
increasingly self-regulating, accountable
for achieving predetermined evidence-
based educational measures, which
indicate that graduating physicians can
provide high-quality health care in an
ever-evolving, value-based health care
system.

In Sum
To overcome the limitations of the current
expensive and increasingly questionably
effective GME system and to truly
transform the UME and GME systems, an
innovative restructuring of the medical
education governance and funding system
is needed. The proposal we describe in
this Perspective would eliminate most or
all medical student debt and, at the same
time, eliminate the current heavy reliance
on traditional Medicare and Medicaid
funding. In the UME and GME system
we propose, all stakeholders, including
federal and state governments, private
insurance companies, and patients,
contribute; in return, physicians provide
enhanced multispecialty access and the
highest-quality health care. Our proposed
system also includes a mechanism for
voluntary service-based tuition repayment
that would require participants to work
in underserved locations or specialties.
Our proposed model allows for a phased
series of components including strategic
expansion of the physician workforce
that balances specialty and geographic
needs to enable better access to care for
underserved populations. By welcoming
an outcomes-driven framework for
medical education (by using incremental
incentives or tying educational payments
with predetermined learning metrics),
this model would facilitate innovation
in medical education, with the goal of
preparing learners to better serve patients
and their communities.

Among the many advantages of this
system are that it is transparent and
directly distributes the costs of medical
education equitably among those
who benefit. Our proposed MEW
Fund Model also recognizes and
rewards the significant commitment
of faculty, teaching institutions, and
nontraditional facilities (e.g., outpatient
facilities, federally qualified centers)
that contribute to the education of
physicians. Finally, this model expedites
appropriate and necessary growth and
redistribution in the physician workforce
while holding the medical education
system accountable for achieving specific
learning outcomes, maintaining budget neutrality, and significantly decreasing the tax-based burden passed through federal and state governments. In summary, a transformational redesign of UME and GME funding would serve as the foundation of medical education for future generations of physicians. What remains is rallying the necessary collective courage and tenacity required to work together to achieve this transformation.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

Previous presentations: This work was previously presented at the 2014 Spring Meeting of the Association of American Medical Colleges Council on Deans/Council on Teaching Hospitals, New Orleans, Louisiana, March 2014.

References