

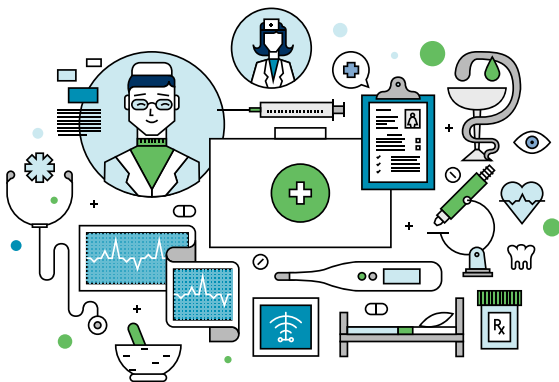
Graduate Medical Education: Training Tomorrow's Physician Workforce

Graduate medical education (GME) is the supervised hands-on training after medical school that all physicians must complete to be licensed and practice independently. The length of this training varies but generally lasts at least three to five years for initial specialty training; subspecialty training may last up to 11 years after graduation from medical school. Training is generally coordinated and funded by teaching hospitals and medical schools, though clinical experiences occur in a variety of settings, including inpatient, outpatient, and community.



The Roles of Teaching Hospitals in GME

- Their education, patient care, and research missions enable teaching hospitals to offer patients the most advanced expertise, services, and technology.
- The physicians who staff teaching hospitals provide a diverse range of around-the-clock specialty care and standby services — such as trauma centers and neonatal intensive care units — and are prepared to care for the nation's most critically ill or injured patients.
- 92% of all residency programs train residents in nonhospital settings, such as academic ambulatory clinics, community health centers, private physicians' offices, VA ambulatory clinics, and ambulatory surgical centers.²



Federal Support for Residency Training

- Hospitals that train residents incur **real and significant costs for this training** beyond those customarily associated with providing patient care.
- **Medicare Direct Graduate Medical Education (DGME)** payments offset a portion of the direct costs associated with training physicians (for example, resident stipends and benefits, supervising physician stipends and benefits, and GME office overhead costs).
- Medicare **supports only a portion** (the “Medicare share”) of the costs associated with training a resident. This share is a hospital-specific amount that reflects each hospital's Medicare volume.
- Teaching hospitals incur **\$19.2 billion** in direct training costs each year, with **Medicare supporting \$3.98 billion of that total.**³
- Medicare support for training residents has been effectively frozen since 1997 despite an aging, growing population. While many state Medicaid programs also help offset the training costs, not all state Medicaid programs participate in GME. Teaching hospitals must often still offset a portion of each resident's training costs.

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The Physician Shortage

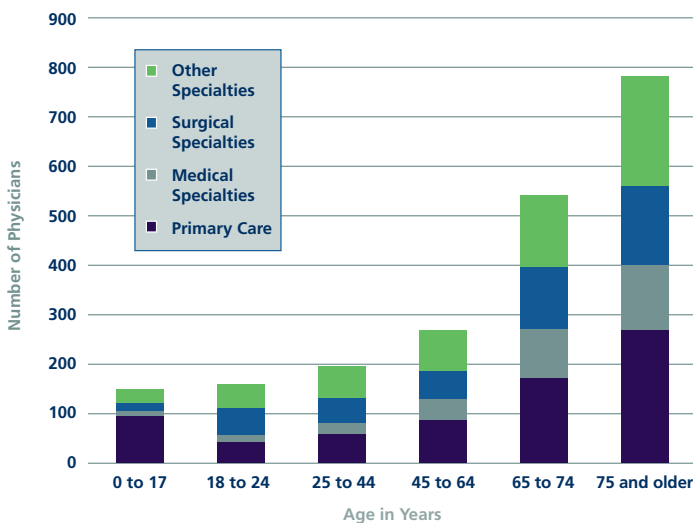
The United States Is Facing a Shortage of Between 54,000 and 139,000 by 2033⁴

- Between 21,400 and 55,200 primary care physicians.
- Between 33,700 and 86,700 surgeons and other specialists.

What Is Driving the Physician Shortage

- By 2033, the number of Americans over age 65 will grow by 45%.⁵ Seniors also have a much higher per capita consumption of health care.
- Medical advances have increased the number of people living with multiple chronic illnesses.
- More than two out of every five doctors are over age 65 and likely to retire in the next decade. Further, the past decade has seen a trend toward physicians of all ages working fewer hours.
- Though demand is increasing, supply is not increasing at the same pace because of a cap Congress imposed on Medicare GME support.

Physician Utilization per 100,000 People, by Age



Source: Health Resources and Services Administration. *The Physician Workforce: Projections and Research Into Current Issues Affecting Supply and Demand*. Washington, DC: U.S. Department of Health and Human Services; December 2008.

Federal GME Policy Is NOT a Significant Driver of Physician Specialty Choice — Payment Rate IS

“The single most important way Medicare can influence the mix of physicians ... is to reform how it pays for services. [Medical school graduates] reasonably look at future earnings prospects when choosing a specialty ... payment rates can influence that choice.”

-MedPAC June 2010 Report to Congress

Lifting the Cap on Medicare GME Funding Will Help Alleviate the Doctor Shortage

Currently, House and Senate versions of the Resident Physician Shortage Reduction Act of 2019 (H.R. 1763, S. 348) would help address the doctor shortage by increasing residency slots by 15,000 over five years. This increase would account for one-quarter of the doctors necessary to meet the country's workforce needs.

For more information, visit aamc.org/news-insights/gme

NOTES

1. AAMC. *Investment in Teaching Hospitals Benefits All Americans*. Washington, DC: AAMC; September 2018. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/49/bc/49bc37dc-717e-409f-a9db-8651a2bae905/teaching_hospitals_-_harvard_mortality_studies_fact_sheet_-_20180918.pdf.
2. Accreditation Council for Graduate Medical Education. *Data Resource Book, Academic Year 2017-2018*. Chicago, IL: ACGME; 2018. acgme.org/About-Us/Publications-and-Resources/Graduate-Medical-Education-Data-Resource-Book.
3. AAMC analysis of Medicare FY 2017 Healthcare Cost Report Information System Q2 2019 Release. October 2019.
4. AAMC. *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033*. Washington, DC: AAMC; 2020. Note: The range of the projected shortfall for total physicians is smaller than the sum of the ranges of the projected shortfalls for the specialty categories. The demand scenarios modeled project future demand for physician services, but scenarios can differ in whether future demand will be provided by primary care or nonprimary care physicians. Likewise, the shortfall range for total nonprimary care is smaller than the sum of the shortfall ranges for the specialty categories.
5. U.S. Census Bureau. 2017 National Population Projections Datasets. <https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html>. Published 2018. Accessed Dec. 12, 2019.