

Financing Radiology Graduate Medical Education: Today's Challenges

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Radiology graduate medical education (GME) is exposed to huge financial challenges. First, there is a continuous increase in demand for imaging services by referring doctors and the general population, aggravating the staff shortage. Second, there has been an important decline in reimbursements. Third and probably most important is the progressive reduction of federal funds subsidizing GME. Medicare is the largest single contributor to GME. The Balanced Budget Act (BBA) of 1997 introduced reductions in Medicare payments to the major teaching hospitals calculated at \$5.6 billion over the first 5 years after implementation. The BBA also brought other changes directly affecting GME. Financial changes in health care over the past decade have increased the pressure on academic institutions, which must preserve or improve the quality of training and the quality of care and manage an increased workload with fewer funds available and a narrow margin for errors. Yet the use of new technology promises to help simplify processes, decreasing workloads for residents and faculty members and increasing overall productivity, and new sources of funding have been suggested. By reviewing the financial challenges of radiologic training in today's academic centers, the authors reach the conclusion that there is still space for improving academic quality and the quality of care within current financial boundaries. But more reliable data about the specific benefits and drawbacks of having a residency program in a clinical radiology department are required.

Key Words: Radiology residency, educational costs, education funds

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INTRODUCTION

Radiology teaching needs are increasing faster than ever. New techniques need to be taught; deeper knowledge in each organ-based subspecialty requires further explanation; higher quality imaging demands more detailed reading; and managerial, ethical, financial, and other skills are needed as the clinical practice of diagnostic radiology becomes more complicated. These are challenges common to many educational fields. The key issue resides in the fact that more educational demands come at a time of major changes. Increasing service use, declining reimbursements, staff shortages [1,2], and govern-

mental pressure to contain health care and graduate medical education (GME) costs [3] are some of the changes that have come along. Today, more interest is given to the development of new techniques and technologies. Therefore, more funds are available for research, although radiology education seems to lag behind as an unwanted need for government, hospitals, and private payers.

Academic radiology education today includes the training of more than 67,000 medical students distributed among the 125 medical schools in the United States. Residencies are available in 190 diagnostic radiology programs, which account for nearly 4,300 positions (according to the Accreditation Council for Graduate Medical Education [ACGME]). The residency programs are organized in a 4-year curriculum, after at least 1 year of clinical internship. In addition, there are 260 subspecialty fellowship programs accredited by the ACGME. Fellowships offer a further 500 positions. All of these activities are carried out in approximately 1,200 hospitals nationwide, 400 of which are major teaching hospitals (with intern/resident-to-bed ratios of 0.25 or greater) [4,5].

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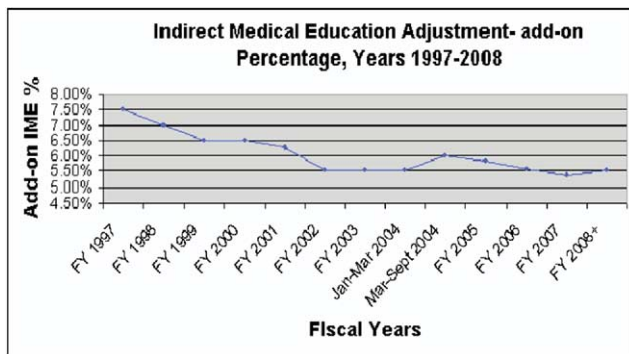


Fig. 1. Graph showing the reduction in the IME adjustment payment to academic medical centers between fiscal years 1997-2008.

Radiology GME is experiencing major changes as imaging services continue to expand. Radiologists' clinical practice has become more complicated as more knowledge has become available and imaging techniques have improved. Another major change is the movement of radiologists from their traditional "interpretative" duties to managerial positions. To this end, the ACR and the Association of Program Directors in Radiology have introduced a noninterpretative skills program, making ethical, social, and managerial subjects obligatory for all programs [6,7]. The idea is to align market needs and the training provided in the programs.

In a general perspective, the growth and aging of the US population has translated into the increased use of health care services [8]. Increased use and health care expenses have placed additional strain on health care budgets [2], forcing the government to review and try to optimize health care system expenditures. The era of cost containment began with the legislation establishing "prospective payment." Under this system, the implementation of a standardized reimbursement system (diagnosis-related groups [DRGs]) was set. Similar payment systems were later adopted by most private insurers. Prospective payment changed the rules of hospital economics. From that moment on, efficiency has mattered, because financial success relies on it [3,9]. Prospective payment and the proliferation of managed care has adversely affected GME and academic medical centers (AMCs) [3]. Decreased reimbursement forced AMCs to increase their volumes of patients to generate profit. Increased clinical services evolved into the main source of revenue and the only way to keep organizations profitable. Imaging services became among the most profitable departments inside hospitals. Also, radiology began being used for earlier diagnosis and to control lengths of stay. Converting radiology departments is the center of attention. Radiology departments today get much attention from hospital administrators and payers, the former

wishing to increase profits and the latter to control expenses.

The federal government, through the Medicare program, subsidizes GME. Medicare is the major supporter of GME. Funds are distributed under 2 modalities: direct medical education and indirect medical education (IME) adjustments. Direct costs are related to the salaries and benefits of residents and faculty members for teaching time, whereas indirect adjustment covers the costs of extra tests, offering a wider range of services, using more intensive treatment advancing technology and research, indigent care, and slower services because of the presence of residents [9,10]. In 1997, the Balanced Budget Act (BBA) was signed as an attempt by the federal government to contain health care costs. The bill marked the start of an era of revision in the way GME is funded that has yet to end (Figure 1).

Academic institutions today are faced with the challenge of being financially successful without sacrificing the quality of their training. We summarize these current academic and financial challenges and their proposed solutions. We center our attention on residency and fellowship programs, because they are the educational group with most constraints. Residents' and fellows' workloads are continuously rising, in opposition to what is happening to their studying, learning, and formal training time [3].

MAIN DILEMMAS AND DEMANDS OF GME IN RADIOLOGY

Decreased Fiscal Support

Federal subsidies of GME through Medicare have changed. The BBA directly affected AMCs, reducing the IME adjustment from 7.7% to 5.5% in a 2-year period. After the BBA was approved, 2 pieces of legislation were passed to ameliorate IME payment reductions. First, IME adjustment was rescheduled to reach the 5.5% goal in fiscal year 2002, per the Balanced Budget Refinement Act of 1999. Later, the Medicare Prescription Drug Improvement and Modernization Act of 2003 increased the IME adjustment to 6% in April 2004 and scheduled it to decrease to 5.5% again in fiscal year 2008 (Table 1) [11,12]. The BBA also capped the total number of residents funded by Medicare at the 1996 level and mandated a 1-year lagged cap on the intern/resident-to-bed ratio. The BBA provisions affecting the Medicare IME adjustment were estimated to reduce payments to teaching hospitals by \$5.6 billion over 5 years [13,14]. Furthermore, proposals to eliminate all federal financing of GME have been raised. Sympathizers presume that this would force residents and hospitals that provide training to face the real costs and benefits of having a residency program, bringing clarity to the issue. This would lead

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